Handbook of PLAY THERAPY

SECOND EDITION

EDITED BY
KEVIN J. O’CONNOR
CHARLES E. SCHAEFER
LISA D. BRAVERMAN

WILEY
Handbook of Play Therapy
Pthomegroup
Handbook of Play Therapy

Second Edition

Kevin J. O’Connor, PhD, ABPP, RPT-S
Charles E. Schaefer, PhD, RPT-S
Lisa D. Braverman, PhD

WILEY
With thanks to the children, families, students, and fellow professionals who have contributed to our understanding of the value of play and to the growth of the field of play therapy.
Pthomegroup
Contents

Preface xi
About the Editors xiii
Contributors xv

Part 1: Introduction

1 An Introduction to the Field of Play Therapy 3
   John W. Seymour

2 The History of Play Therapy 17
   Jane L. Johnson

3 The Therapeutic Powers of Play 35
   Athena A. Drewes and Charles E. Schaefer

Part 2: Core Theories

4 Psychoanalytic and Jungian Play Therapy 63
   Audrey F. Punnett

5 Child-Centered Play Therapy 93
   Geri Glover and Garry L. Landreth

6 Cognitive-Behavioral Play Therapy 119
   Susan M. Knell

7 Filial Therapy 135
   Risé VanFleet and Glade L. Topham
8 Theraplay®: Creating Secure and Joyful Attachment Relationships 165
Phyllis B. Booth and Marlo L.-R. Winstead

9 Ecosystemic Play Therapy 195
Kevin J. O’Connor

10 Prescriptive Play Therapy 227
Charles E. Schaefer and Athena A. Drewes

Part 3: Core Techniques

11 Sandtray/Sandplay Therapy 243
Linda E. Homeyer

12 Metaphors and Stories in Play Therapy 259
Pat Pernicano

13 Expressive Arts in Play Therapy 277
Julia Gentleman Byers

14 Using Drama in Play Therapy 289
Steve Harvey

15 Board Games in Play Therapy 309
Jessica Stone

Part 4: Applications for Special Populations

16 Play Therapy Across the Life Span: Infants, Children, Adolescents, and Adults 327
Heidi Gerard Kaduson

17 Parent–Child Interaction Therapy With Children With Disruptive Behavior Disorders 343
Lauren Borduin Quetsch, Nancy Wallace, Meredith Norman, Ria Travers, and Cheryl McNeil

18 DIR®/Floortime™: A Developmental/Relational Play Therapy Approach Toward the Treatment of Children With Developmental Delays, Including Autism Spectrum Disorder (ASD) and Sensory Processing Challenges 357
Esther B. Hess
19 Play Therapy With Children With Attachment Problems 381
Sarah C. Patton and Helen E. Benedict

20 Play Therapy With Children With Disabilities 397
Karla D. Carmichael

21 Play Therapy With Survivors of Interpersonal Trauma: Overcoming Abuse and Crime 417
Charles Edwin Myers

22 Play Therapy With Children Experiencing Medical Illness and Trauma 437
Laura Nabors and Jessica Kichler

23 Play Therapy and Crisis Intervention With Children Experiencing Disasters 455
Jennifer N. Baggerly

Part 5: Play Therapy in Nontraditional Settings

24 Play Therapy in Medical Settings 473
Kristin S. Bemis

25 Play Therapy in Schools 485
Kristi L. Perryman

26 Play Therapy and the Legal System 505
Daniel S. Sweeney

Part 6: Professional Issues

27 Ethics in Play Therapy 523
Cynthia A. Reynolds

28 Limit-Setting in Play Therapy 539
Allan M. Gonsher

29 Play Therapy Supervision 549
Jodi Ann Mullen
Part 7: Contemporary Issues

30 Play Therapy Research: Issues for 21st Century Progress  563
Janine Shelby, Ruth Ellingsen, and Charles E. Schaefer

31 Neuroscience and Play Therapy: The Neurobiologically-Informed Play Therapist  583
Edward F. Hudspeth and Kimberly Matthews

32 Issues of Culture and Diversity in Play Therapy  599
Eliana Gil and Lexie Pfeifer

33 Technology in the Playroom  613
Kevin B. Hull

Part 8: Research

34 Methodologies Suited to the Study of Play Therapy  631
Dee C. Ray and Hayley L. Stulmaker

35 The Empirical Support for Play Therapy: Strengths and Limitations  651
Sue C. Bratton

Author Index  669
Subject Index  681
Preface

The Handbook of Play Therapy, published in 1983, has been considered the primary reference source for practitioners, teachers, and students involved in conducting and studying play therapy. The Handbook of Play Therapy, Volume Two: Advance and Innovations, published in 1994, considerably expanded on the first volume. After just over two decades, The Handbook of Play Therapy, Second Edition is a major revision of both of those landmark books. It includes comprehensive coverage of the theoretical, technical, methodological, and research advances in the steadily growing field of play therapy.

In order to match the standard created by the first two volumes, we did three things. First, we have once again invited leading authorities on the various aspects of play therapy to write original chapters presenting developments that have occurred in the field since 1994. Second, we have included material that is interdisciplinary in approach, eclectic in theory, and comprehensive in scope. And, last, we have attempted to reflect the growing trend toward the implementation of empirically supported treatments by including the emerging evidence in support of play-based interventions wherever and whenever possible.

The Handbook of Play Therapy, 2nd Edition, begins with an overview and history of the field of play therapy as well as a discussion of the general powers of play. In the second section, the major theoretical approaches to play therapy, including the psychoanalytic, client-centered, cognitive-behavioral, filial, Theraplay, ecosystemic, and prescriptive approaches are discussed. The third section includes chapters on core play therapy techniques. The fourth section covers the use of play therapy with special populations whose mental health needs are sometimes overlooked. The fifth section covers the use of play therapy in settings other than those where mental health services are traditionally provided, such as within medical, legal and educational settings. The seventh section includes chapters on contemporary issues in the field of play therapy, such as the provision of empirically supported treatments, ethics, limit-setting, and supervision. Finally, the last section includes chapters on the state of play therapy research and ideas for expanding the scientific support for this important therapeutic modality.

Psychiatrists, psychologists, social workers, nurses, and counselors at all levels of training and experience will find the Handbook of Play Therapy, Second Edition, informative, thought provoking, and clinically useful.
About the Editors

**Kevin J. O’Connor, PhD, ABPP, RPT-S**, is a Clinical Psychologist. He is a Distinguished Professor, Coordinator of the Ecosystemic Clinical Child Psychology Emphasis, and Director of the Ecosystemic Play Therapy Training Center at Alliant International University, Fresno, California. He is cofounder and Director Emeritus of the Association for Play Therapy. He is the author of numerous books, including *The Play Therapy Primer, Second Edition*, and coauthor of *Play Therapy Treatment Planning and Interventions, Second Edition*, and co-editor of *Play Therapy Theory and Practice, Second Edition*. He regularly presents workshops across the United States and abroad, having presented in Canada, Israel, Italy, Japan, Korea, Kuwait, the Netherlands, Mexico, Portugal, Singapore, and South Africa. Finally, Dr. O’Connor is a Board Certified Clinical Child and Adolescent Psychologist and Fellow of the American Psychological Association who maintains a small private practice treating children and adults.

**Charles E. Schaefer, PhD, RPT-S**, is Professor Emeritus of Psychology at Fairleigh Dickinson University in Teaneck, New Jersey. He is cofounder and Director Emeritus of the Association for Play Therapy. He is a frequent presenter at national and international play therapy conferences. Dr. Schaefer is the author/coauthor of more than 100 research articles and author/editor of over 60 professional books, including *Foundations of Play Therapy, Second Edition; Short-Term Play Therapy, Third Edition; Play Therapy for Preschoolers; Play Diagnosis and Assessment; and The Therapeutic Powers of Play, Second Edition*. He maintains a private practice for children in Hackensack, New Jersey.

**Lisa D. Braverman, PhD**, is a clinical psychologist who specializes in the areas of pediatric oncology, child abuse, and trauma. She treats children and their families, and is also a Guardian ad Litem for ProKids in Cincinnati, Ohio. She co-edited the first and second editions of *Play Therapy Theory and Practice*. 
Contributors

Jennifer N. Baggerly, PhD, LPC-S, RPT-S
University of North Texas at Dallas
Dallas, Texas

Kristin S. Bemis, MEd, LPC, RPT
Therapy Dallas
Dallas, Texas

Helen E. Benedict, PhD, RPT-S
Baylor University
Waco, Texas

Phyllis B. Booth, MA, LCPC, LMFT, RPT-S
The Theraplay Institute
Evanston, Illinois

Sue C. Bratton, PhD, LPC-S, RPT-S
University of North Texas
Denton, Texas

Julia Gentleman Byers, EdD, ATR-BC, LMHC
Lesley University
Cambridge, Massachusetts

Karla D. Carmichael, PhD, LPC, NCC, RPT-S
Capella University
Minneapolis, Minnesota

Athena A. Drewes, PsyD, RPT-S
Astor Services for Children and Families
Washingtonville, New York

Ruth Ellingsen, MA, C Phil
University of California at Los Angeles
Los Angeles, California

Eliana Gil, PhD, LMFT, ATR, RPT-S
Gil Institute for Trauma Recovery and Education
Fairfax, Virginia

Geri Glover, PhD, RPT-S
New Mexico Highlands University
Las Vegas, New Mexico

Allan M. Gonsher, LCSW, RPT-S
Kids-Incorporated
Overland Park, Kansas, and Omaha, Nebraska

Steve Harvey, PhD, BC-DMY, RPT-S
Infant, Child, and Adolescent Mental Health Service, Taranaki District Health Board
New Plymouth, New Zealand

Esther B. Hess, PhD, RPT-S
Center for the Developing Mind
Los Angeles, California

Linda E. Homeyer, PhD, LPC-S, RPT-S
Texas State University
San Marcos, Texas

Edward F. Hudspeth, PhD, NCC, LPC, RPh, ACS, RPT-S
Henderson State University
Arkadelphia, Arizona
Kevin B. Hull, PhD, LMHC  
Hull and Associates, PA  
Lakeland, Florida

Jane L. Johnson, LCSW, RPT-S  
The Play Therapist’s Workshop  
Fort Collins, Colorado

Heidi Gerard Kaduson, PhD, RPT-S  
The Play Therapy Training Institute, Inc.  
Monroe Township, New Jersey

Jessica Kichler, PhD  
Cincinnati Children’s Hospital Medical Center  
Cincinnati, Ohio

Susan M. Knell, PhD  
Case Western Reserve University  
Cleveland, Ohio

Garry L. Landreth, EdD, RPT-S  
University of North Texas  
Denton, Texas

Kimberly M. Matthews, MEd, NCC  
The University of Mississippi  
University Mississippi

Cheryl McNeil, PhD  
West Virginia University  
Morgantown, West Virginia

Jodi Ann Mullen, PhD, LMHC, RPT-S  
State University of New York  
Oswego, New York

Charles Edwin Myers, PhD, LCC, NCC, NCSC, ACS, RPT-S  
Northern Illinois University  
DeKalb, Illinois

Laura Nabors, PhD  
University of Cincinnati  
Cincinnati, Ohio

Meredith Norman, MS  
West Virginia University  
Morgantown, West Virginia

Kevin J. O’Connor, PhD, ABPP, RPT-S  
California School of Professional Psychology  
at Alliant International University  
Fresno, California

Sarah C. Patton, PsyD  
North Florida/South Georgia Veterans Health System  
Gainesville, Florida

Pat Pernicano, PsyD  
Spalding University  
Louisville, Kentucky  
Personal Counseling Service, Inc.  
Clarksville, Indiana

Kristi L. Perryman, PhD, LPC, RPT-S  
University of Arkansas  
Fayetteville, Arkansas

Lexie Pfeifer, PhD, LMFT  
House of Hope  
Salt Lake City, Utah

Audrey F. Punnett, PhD, JA, CST-T, RPT-S  
Private Practice  
Fresno, California

Lauren Borduin Quetsch, MS  
West Virginia University  
Morgantown, West Virginia

Dee C. Ray, PhD, RPT-S  
University of North Texas  
Denton, Texas

Cynthia A. Reynolds, PhD, LPCC-S, CSC, RPT-S  
University of Akron  
Akron, Ohio

Charles E. Schaefer, PhD, RPT-S  
Farleigh Dickinson University  
Teaneck, New Jersey
Contributors xvii

John W. Seymour, PhD, LMFT, RPT-S
Minnesota State University
Mankato, Minnesota

Janine Shelby, PhD, RPT-S
David Geffen School of Medicine, University of California at Los Angeles
Los Angeles, California
Division of Child and Adolescent Psychiatry, Harbor-UCLA Medical Center
Torrance, California

Jessica Stone, PhD, RPT-S
Private Practice
Fruita, Colorado

Hayley L. Stulmaker, PhD, LPC, NCC, RPT
Sam Houston State University
Huntsville, Texas

Daniel S. Sweeney, PhD, LMFT, LPC, RPT-S
George Fox University
Portland, Oregon

Glade L. Topham, PhD, LMFT
Oklahoma State University
Stillwater, Oklahoma

Ria Travers, MS
West Virginia University
Morgantown, West Virginia

Risë VanFleet, PhD, CDBC, RPT-S
Family Enhancement and Play Therapy Center and its Playful Pooch Program
International Institute for Animal Assisted Play Therapy
Boiling Springs, Pennsylvania

Nancy Wallace, MS
West Virginia University
Morgantown, West Virginia

Marlo L. R. Winstead, MSW, LCSW, LSCSW, RPT-S, Theraplay®, Trainer and Supervisor
Enriching Families, LLC
Tallahassee, Florida
University of Kansas
Lawrence, Kansas
PART
1

Introduction
The field of play therapy in the Western tradition began when the early pioneers of psychotherapy began to apply and adapt their emerging approaches to psychotherapy with adults to the mental health needs of children. Early on, play was identified as a child's natural way of establishing relationships, communicating, and problem solving. Sigmund Freud saw play as a child-like form of free association, and as such, thought it could provide a window to the inner workings of the child's mind (D’Angelo & Koocher, 2011; Ellenberger, 1981). Hermione Hug-Hellmuth (1921) published and presented the first professional paper using the term play therapy. Anna Freud (1936/1966) and Melanie Klein (1932) focused on extending and applying psychoanalytic approaches to children, and each wrote of the role of play in their work with children (Donaldson, 1996). Play in therapy was seen as developmentally appropriate for interacting with children and as a vital part of the psychotherapeutic process (Carmichael, 2006; O’Connor, 2000). Initially, however, play was not seen as a separate modality from analysis but as a seamless part of the therapy process. As Donald Winnicott (1971) described:

Psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist. Psychotherapy has to do with two people playing together. The corollary of this is that where playing is not possible then the work done by the therapist is directed towards bringing the patient from a state of not being able to play into a state of being able to play. (p. 53)

Since these early beginnings, a number of clinical models of psychotherapy for adults (behavioral, client-centered, cognitive, and gestalt) began to develop that both built on and challenged the assumptions of the early analytic models (Prochaska & Norcross, 2010). Many of these models were then adapted for use with children, utilizing play as a way to engage, assess, communicate, and positively impact their young clients (Carmichael, 2006; Kottman, 2011; Landreth,
Throughout its history, play therapy has been practiced by a variety of child mental health professions, each of which adapted it through the lens of their own evolving disciplines, responding to the needs of children in their distinct historical times, and creating applications for their treatment settings. Play therapy was not so much seen as a professional field distinct from the broader field of psychotherapy, but as a particular way of extending psychotherapy to children in a form better matched to their developmental, emotional, cognitive, and relational abilities.

**CHALLENGES TO PSYCHOTHERAPY AND PLAY THERAPY**

Mental health professionals continued to develop various psychotherapy models, and by the 1970s there were almost 100 models (Saltzman & Norcross, 1990) with competing claims of applicability, efficacy, and primacy. Research findings on the effectiveness of psychotherapy ranged widely, from studies showing little or no benefit to any type of psychotherapy to studies showing substantial benefit for many types of psychotherapy (Prochaska & Norcross, 2010; Saltzman & Norcross, 1990). Simultaneously, child development research had been growing since the 1950s and was being incorporated into the practice of child psychotherapy. Behavioral models were becoming more widely used. These emphasized a more psychoeducational approach to clinical practice, with less emphasis on the relational and dynamic processes that had characterized the field up until then. This proliferation of models and claims resulted in a call for more dialogue between researchers and practitioners, the development of integrated models, more accountability for therapeutic outcomes, and the development of more research-based prescriptive psychotherapy adaptations (Duncan, Miller, Wampold, & Hubble, 2010; Norcross, VandenBos, & Freedheim, 2011; Wampold, 2001).

Through the 1960s and into the 1980s (and for that matter, even today) play therapy has continued to be practiced by child mental health professionals from various disciplines using the whole range of existing psychotherapy models. This combination of interdisciplinary practice and the variety of therapeutic models has created a rich play therapy tradition. Yet, these same qualities made it difficult for play therapy as a field to provide a unified response to competing trends that challenged the use and effectiveness of play therapy as a form of child psychotherapy. Louise Guerney and Charles Schaefer, active proponents of play therapy during this period, have reflected on the challenges the field faced (Association for Play Therapy, 2010b, 2010d). There were few, if any, books or articles being published in the field, training opportunities were limited, and there was no professional group specifically identified to promote the field. It was, as Guerney described it, “the dark ages of play therapy” (Association for Play Therapy, 2010b).

**THE FIELD OF PLAY THERAPY BEGINS TO EMERGE**

Out of those challenges came a proposal by Charles Schaefer to form an organization to revitalize the field of play therapy. In 1982, he enlisted Kevin O’Connor as a cofounder and formed the Association for Play Therapy, initially bringing together a group of play therapy professionals for the exchange of information, establishment of training, and creation of collaborative networks of researchers, educators, and practitioners (Association for Play Therapy, 2010d). O’Connor took the lead in creating the association’s first newsletter, and Schaefer coordinated the first few national conferences. Along with Schaefer and O’Connor, the original directors included Louise Guerney, Eleanor Irwin, Ann Jernberg, Garry Landreth, Henry Maier, Borislava Mandich, and
Eileen Nickerson (Association for Play Therapy, 2014). Two years later, the association offices moved to California and were housed at the California School of Professional Psychology, where O'Connor had been appointed as a faculty member. The association began to grow, and over time it began to realize the vision of its founders.

Developing a Strong Professional Organization

The early group of networking play therapy practitioners, instructors, and researchers would need the strength and resources of a much larger organization. Seeing the need to involve a wider base of play therapists, the board of directors named Lessie Perry as the first membership campaign chair in 1988 to lead this effort (Association for Play Therapy, 2010c). In 1991, the association launched a companion fundraising organization, the Foundation for Play Therapy, to help fund play therapy research and public awareness campaigns. In 1992, the first two state branches were chartered in Oregon and Texas (Association for Play Therapy, 2014) in an effort to begin to better serve the networking and training needs of play therapists on a more regional basis.

The association held its first annual conference in 1984, hosting over 50 mental health professionals committed to the emerging field of play therapy. The first three conferences were held in New York. The fourth conference was hosted by the University of North Texas in 1987 under the direction of Garry Landreth. Since then, the conference site has been rotated among geographic areas of the United States of America and Canada to expand the reach of the organization and its mission. There were over 1,100 attendees at the 10th conference held in Atlanta in 1993, and overall membership stood right at 3,000. The 10th conference provided a forum for a number of leaders in the field to offer their insights on the developments in the field over the past 10 years and the challenges that lay ahead (Berner, Duke, Guillory, & Oe, 1994). John Allan identified opportunities for growth including the need for qualified play therapy supervisors; the development of well-equipped play therapy rooms in schools, agencies, and hospitals; more collaboration between play therapy and family therapy; and more play therapy research. Kevin O'Connor expanded on the research challenges by calling for the increased identification of basic play therapy processes and the development of a comprehensive theoretical model. Charles Schaefer called for research to identify whether specific disorders would benefit from specific types of play therapy. These themes have shaped the association’s mission since then and are woven into many of the current programs and initiatives.

In this same general time frame, Phillips and Landreth (1995, 1998) conducted an extensive survey of mental health professionals practicing play therapy, including many members of the association and a number of other professionals identified through related interests and organizations. They found the greatest number of play therapists self-reported having an eclectic theoretical orientation, followed by those who reported having a client-centered orientation. Most of those surveyed had received their play therapy training through continuing education rather than university-based graduate course work. Most reported minimal training in child development, with most of that training coming through continuing education. Phillips and Landreth suggested graduate education opportunities in both play therapy and child development would need to be expanded to support both good practice and the kind of research needed to better define the field. There would also need to be more opportunities for new practitioners to receive play therapy supervision and mentoring in order to ensure adherence to the best standards of practice.

Kevin O'Connor remained as the executive director until 1998, leading the association from its early days as a networking group to a multifaceted professional organization. The association had grown to the point that a full-time professional association executive was needed, and in 1999, William Burns was named executive director (later becoming president and CEO).
The association has maintained its office in the Fresno, California, area throughout its history, with its current office in nearby Clovis. Three of the first staff members, Kathryn Lebby, Diane Leon, and Carol Muñoz Guerrero, have been part of the organization since the 1990s. The association transitioned from an appointed to a membership-elected board of directors, with the board chair elected by the directors themselves. Over the first 20 years, the organization made strides in cultivating new leadership, reshaping organizational governance, and creating a more stable financial foundation to support the association's evolving mission.

As the association approached its 20th anniversary, Ryan, Gomory, and Lacasse (2002) surveyed the membership, which at that point included just over 4,000 members. Based on the results of the survey, there was a renewed call for strengthening the quality of continuing education and encouraging the development of more graduate-level classroom and clinical training in play therapy. Although play therapy services were being provided to a wider range of clients, the play therapists providing the services were likely to be Anglo or Euro American females, which was a more narrow demographic than the populations served. It was recommended the association support efforts to recruit a more diverse membership, to support more culturally informed training, and to improve access to play therapy services.

In reflecting on his years with the association, Burns (Association for Play Therapy, 2013) noted two accomplishments in which he took particular pride. One of these was the launching of the Leadership Academy in 2005. The academy used an online learning platform to train current and future association leaders in the organizational mission and governance model. Since then, the academy has graduated cohorts annually, producing over 200 leaders better equipped for service to the association and the field of play therapy. The other accomplishment was the transformation of the association newsletter into a full-color, quarterly magazine, Play Therapy, in 2006. The new magazine was designed to highlight major organizational initiatives and feature articles on current interests and trends in play therapy.

Over the years other changes have also occurred. Membership has continued to grow from those initial 50 members in 1982 to a new high of 6,074 members at the time of this writing (K. Lebby, personal communication, July 27, 2014). Not only are there more members, but membership has expanded geographically not only across the United States of America, but throughout North America and into over 20 other countries around the world. William Burns retired as president and CEO in March 2014, and Katheryn Lebby, the first employee of the association originally hired in 1992, was named president and CEO.

Building a Strong Foundation for Play Therapy Practice and Research

The early leaders in the field and the growing membership of the association began to turn their attention from networking and organizing to the work of developing the field of play therapy by establishing a strong theoretical, technical, and research base for the field. There was a renewal of professional writing in the field to stimulate conversations on theory, practice, and research. Graduate education opportunities were expanded, and better training and supervision opportunities were developed. A credentialing process was established for play therapists and supervisors to help define the specialty area for other mental health professionals, as well as for members of the public who might access these services. A review of existing play therapy research by Roger Phillips in 1985 noted, “surprisingly little is known about play therapy from experimental work” (p. 752). Most of what had been written about play therapy had been written from a clinical perspective rather than a research perspective. Much of what had been published had been anecdotal and presented to illustrate a particular model of therapy rather than to rigorously study the specific impacts of play on therapeutic outcomes. For research to proceed, play and its
therapeutic components, as well as play therapy, would need to be operationally defined to allow for empirically based outcome measures.

**Defining Play Therapy**

Not long after play was first incorporated into clinical work with children, multiple definitions of play, of psychotherapy, and of play in psychotherapy were developed. Many people also recognized that play, in its many forms, was beneficial and might be used by those interacting with children to promote children’s well-being. But what made play therapeutic? What was play therapy? One of the association’s early initiatives was the development of a shared, operational definition of play therapy that would serve as the foundation for the development of comprehensive theories, rigorous research, and unified efforts in promoting the field to other professionals and the public. After much review and discussion, the board of directors adopted this definition in 1997:

> Play therapy is the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties to achieve optimal growth and development. (Association for Play Therapy, 1997)

**New Publications in Play Therapy**

A new generation of publications in play therapy began with *Handbook of Play Therapy* (Schaefer & O’Connor, 1983), which included contributions from a number of those early members of the association. The *Handbook* was followed by a second volume (O’Connor & Schaefer, 1994) with updates on recent trends in the field. These early volumes were the predecessors of this current book. The first 10 years of this new emphasis on professional publications included books by authors such as John Allan (1988), Eliana Gil (1991), and Garry Landreth (1991).

In response to the need for new play therapy research, the *International Journal of Play Therapy* was first published by the Association for Play Therapy in 1992 under the direction of then executive director Kevin O’Connor and guest editor-in-chief Cynthia K. Bromberg. Following the premier issue, the journal was published semiannually and then expanded to quarterly issues in 2009. The association now contracts with the American Psychological Association for the distribution of the journal, which includes electronic archiving of all issues so these are available to researchers around the world.

**Developing Graduate Education Specific to Play Therapy**

Garry Landreth established the Center for Play Therapy in 1980 at the University of North Texas in Denton. The center has become the largest play therapy training program in the world, providing graduate training at the master’s and doctoral levels and continuing education for professionals and serving as the site of ongoing play therapy research and training. The center includes a comprehensive library of play therapy resources for practice and research and sponsors an annual Summer Play Therapy Institute and Fall Play Therapy Conference (Landreth, 2012).

At the time the center was established, there were approximately 40 universities in the United States offering at least some coursework in play therapy. As of December 2013, 177 universities reported offering coursework as well as increasing opportunities for clinical practicum experiences (Burns, 2014).

In 2009, the association adopted standards for Approved Centers of Play Therapy Education to continue to encourage the training of practitioners and researchers in play therapy. Modeled on the example set by the Center for Play Therapy at the University of North Texas, the purpose
of these standards was to encourage the training of highly qualified practitioners and researchers who could produce new, peer-reviewed publications and generate research to advance the field of play therapy in the professional community and among the public. The Center for Play Therapy became the first approved center in June 2009, and at the time of this writing, there were 23 approved centers across the United States of America supporting play therapy theory, research, and practice (K. Lebby, personal communication, July 27, 2014).

Establishing Credentialing and Standards of Practice

In the early 1990s, Diane Frey (Association for Play Therapy, 2010a) and other leaders began developing a credentialing process for play therapists to help identify the core knowledge and skills mental health professionals of any discipline who practiced play therapy should have. Registration was seen as an important way to encourage high standards of training and practice of play therapy to better protect clients and to raise professional and public awareness of the field. In 1993, the Registered Play Therapist (RPT) and Registered Play Therapist-Supervisor (RPT-S) credentials were first offered, and at the end of 2013, there were 1,184 RPTs and 1,785 RPT-Ss recognized around the world.

To ensure play therapists were able to obtain high quality continuing education, the association established standards for Approved Providers of Play Therapy Continuing Education (Association for Play Therapy, 2010a). Each year, thousands of hours of continuing education are offered across the country by such approved providers. In 2001, the association launched its first web-based continuing education program to make high-quality training available to anyone with Internet access. The association’s E-Learning Center was launched in 2008, offering a wide range of noncontact continuing education hours for new and experienced play therapists (Association for Play Therapy, 2014).

Play therapists are a multidisciplinary group made up of psychologists, counselors, family therapists, social workers, clinical nurse practitioners, and others. Each of these mental health disciplines has its own standards of practice, codes of ethics, and licensing regulations. To supplement these varied guidelines, regulations, and codes of ethics, the Association of Play Therapy developed guidelines specific to the practice of play therapy. These address situations that are more common in play therapy and/or in clinical work with children. The Voluntary Play Therapy Practice Guidelines developed in 2003 were updated in 2009 and 2012 as the Play Therapy Best Practices (Association for Play Therapy, 2012c). In addition, the association’s “Paper on Touch: Clinical, Professional, and Ethical Issues” (Association for Play Therapy, 2012b) addresses issues specific to the use of therapeutic touch in play therapy.

Establishing a Research Base

Historical debates on the value of psychotherapy were primarily internal debates among practitioners and researchers regarding the validity of particular theoretical models. Today’s debates involve many more stakeholders, such as third-party payers, health policy leaders, and consumers, with an emphasis on outcomes for specific clients and with specific problems. Developed from empirical research methods in the medical field (Norcross, Beutler, & Levant, 2006), play therapy research has followed this trend toward evidence-based practice, moving from studies that mostly compared the effectiveness of various models of play therapy to research focusing on the therapeutic relationship, the matching of the therapeutic approach to clients served, and the identification of the therapeutic mechanisms of play therapy across play therapy models (Drewes, 2011a, 2011b).
Baggerly and Bratton (2010) outlined a progression of controlled outcome studies in play therapy that have occurred since early leaders in the association began their push to establish a substantial body of play therapy research. Meta-analytic studies of previous research have demonstrated that play therapy can be effective in treating a number of presenting problems (Bratton & Ray, 2000; Bratton, Ray, Rhine, & Jones, 2005; LeBlanc & Ritchie, 2001; Ray, Bratton, Rhine, & Jones, 2001). The Foundation for Play Therapy, the association’s fundraising partner, has sponsored research forums for a number of years, and several years ago it made several substantial financial grants for play therapy research projects that showed promise for meeting evidence-based standards. Edited books by Reddy, Files-Hall, and Schaefer (2005) and Drewes (2009) offered examples of play therapy researchers responding to the call for research to help create an evidence base for the practice of play therapy.

PLAY THERAPY PRACTICE AND RESEARCH ADVANCING INTO THE FUTURE

Kazdin (2009) has pointed out that although there is a wealth of research literature on child psychotherapies, our empirical understanding of the process and outcomes is still limited. In an interview in 2010, Charles Schaefer characterized play therapy research as still “in its infancy” (Association for Play Therapy, 2010d), and he called for well-designed and well-controlled studies that would compare favorably to the types of research being done to create an evidence base for other forms of psychotherapy. To inform an evidence-based practice of play therapy today, there are specific needs for more rigorous research on the therapeutic mechanisms and therapeutic outcomes and effectiveness. D’Angelo and Koocher (2011), in their review of existing play therapy research, noted that there had been a dramatic increase in publications on play therapy over the past 10 years, and they noted a shift from more theory-specific approaches to a “more pragmatic and eclectic version of play therapy, frequently blended with more directive treatment” (p. 442).

In 2010, the International Journal of Play Therapy featured updates on the status of play therapy research. The quantity and quality of play therapy research have both certainly improved since Phillips’s (1985) review 25 years earlier (Baggerly & Bratton, 2010). Urquiza (2010) described a division within the field of play therapy regarding research. Some people in the field are encouraging continued efforts to empirically demonstrate the value of play therapy to the larger field of mental health and to the stakeholders who pay for those services and expect results. Others have offered a strong critique of the use of medical model-type research and the applicability of such methods to psychotherapy research. While these groups have differed in research methodology, they both have the common goal of therapists being wise and intentional in their work and being accountable for the outcomes of their work. Urquiza made a number of recommendations to help move play therapy research efforts ahead, such as conducting more specific research examining the types of interventions to be used and the types of problems to be addressed, creating manualized treatments that can be readily replicated, and doing a better job of assessing subjects pre- and postintervention to better capture the range of possible relationships between the treatments provided and outcomes observed. He also outlined a progression of empirically supported research steps that might move play therapy research from preliminary studies to randomized controlled trials with results that can show particular play therapy approaches to be empirically “well established” or “probably efficacious” by evidence-based standards.

In 2010, Phillips updated the review of play therapy research he conducted in 1987. While acknowledging the surge of research and publications since then, he still came to the conclusion that “a body of credible scientific evidence for most of PT [play therapy] still does not exist”
He offered the observation that some of the problem has to do with researchers’ inability to operationalize play and play therapy in such a way as to meaningfully confirm that what is done in session is indeed play therapy and that the outcomes attributed as results of these actions are truly the result of what is being called play therapy. He urged more research focusing on the “therapeutic mechanism issue” (p. 22). In contrast to Phillips’ conclusions, Baggerly and Bratton (2010) reviewed recent play therapy research and had a considerably more positive conclusion; they state play therapy researchers “have made steady progress in conducting research of sufficient rigor to help establish play therapy as an evidence-based treatment” (p. 36).

Play Research and Interpersonal Neurobiology

D’Angelo and Koocher (2011) observed that research in child development is having a significant impact on current play therapy research and practice. Early psychoanalytic views of play were rooted in a 19th-century view of imagination as being primarily the internal activity of an individual on behalf of that individual. Recent research on the role of natural play has expanded and challenged those views. Natural play, as currently defined, is not only about personal imagination and self-expression but also about connecting with others and making meaning of one’s experience in the social and cultural context. Play is interactional, impacting both the development of the child and the child’s environment. Sutton-Smith (2008) described natural play as the child’s first efforts to regulate personal responses to real conflicts, and play continues to be the child’s major effort and handling conflict through life (Brown, 2009; Russ, 2004). When seen in the context of overall human development, play is a precursor to humans’ abilities to parent empathically, foster friendships, relate intimately in partnerships, and pursue adult occupations with zest (Slade & Wolf, 1994). Eberle (2014) put it this way: “Play is an ancient, voluntary, ‘emergent’ process driven by pleasure that yet strengthens our muscles, instructs our social skills, tempers and deepens our positive emotions, and enables a state of balance that leaves us poised to play some more” (p. 231).

Schore (2012) and Siegel (2012) describe how advances in imaging technologies have given us new ways of understanding the interactions of brain and body as humans interact with each other and their environments. These findings have given us new information about the role of play in child development, informing our understanding of how play mediates the therapeutic relationship and becomes the source of a number of the underlying therapeutic mechanisms at work between therapist and client. Years ago, Bateson (1972) observed “the resemblance between the process of therapy and the phenomenon of play is, in fact, profound” (p. 191). Future therapeutic approaches in play therapy will need to incorporate these developmental understandings of play in conceptualizing the therapeutic alliance and in developing new play interventions (Russ, 2004).

Based on these new findings, Perry and colleagues (Barfield, Dobson, Gaskill, & Perry, 2012; Perry, 2006; Perry & Hanbrick, 2008; Perry, Pollard, Blakley, Baker, & Vigilante, 1995) developed the Neurosequential Model of Therapeutics. This model describes a progressive process of providing therapeutic interventions (including play interventions) sequenced to match the order of brain development. Interventions move from those aimed at remediating the function of the brain stem to those aimed at remediating the higher order functions of the frontal cortex. Initial therapeutic interventions, then, should be geared more toward sensory integration and self-regulation, and later interventions should be geared to more complex affective, cognitive, and relational work.
Play Therapy Integration and Therapeutic Powers of Play

Much like the broader field of psychotherapy, the field of play therapy has been gradually shifting away from model-specific treatments to more integrated and prescriptive models (Drewes, 2011a, 2011b; Drewes, Bratton, & Schaefer, 2011; Schaefer & Drewes, 2010, 2011, 2014). These models focus more on multimodal methods of assessing children's needs, matching these needs with interventions based on an understanding of the therapeutic mechanisms common in most models of child therapy and the factors that establish and maintain the therapeutic relationship. O'Connor (1991) developed one of the first integrative models of play therapy, Ecosystemic Play Therapy. Using an integrative theoretical approach (Drewes, 2011a, 2011b), O'Connor combined a number of elements of psychoanalytic therapy, child-centered therapy, developmental therapy, cognitive-behavioral therapy, Theraplay®, and Reality Therapy (Glasser, 1975) into a comprehensive model of play therapy assessment and treatment (O'Connor, 1991, 2000, 2001, 2011; O'Connor & Ammen, 1997, 2013).

Schaefer has proposed integrative play therapy approaches with an emphasis on the common factors of play therapy and prescriptive methods of tailoring play therapy interventions for specific clients and conditions (Drewes, 2011a, 2011b). In The Therapeutic Powers of Play, Schaefer (1993) originally identified 14 change mechanisms common to all play therapy models, and he recently expanded the list to 20 in The Therapeutic Powers of Play: 20 Core Agents of Change (Schaefer & Drewes, 2014). Kazdin (2009), in a review of research on therapeutic processes in child therapy, observed that the focus needs to be on the mechanisms of therapeutic change so continued efforts to describe these therapeutic powers of play can lead to studies focused on how and why these therapeutic powers work. Schaefer sees this as one of the promising avenues for future research in play therapy (Association for Play Therapy, 2010d).

Integrative and common-factor research in the broader field of psychotherapy has also reinforced the importance of the therapeutic relationship and the need to better understand how the relationship of therapist and client, in and of itself, is therapeutic (Duncan et al., 2010). Play was initially incorporated into child psychotherapy as a way of developing and enhancing the therapeutic relationship (Carmichael, 2006; O'Connor, 2000). Ginott (1959), Guerney (2001), Landreth (2012), and others (Cochran, Nordling, & Cochran, 2010; Van Fleet, Sywulak, Sniscak, & Guerney, 2010; Wilson & Ryan, 2006) have greatly expanded our understanding of the dynamics of the therapeutic relationship in play therapy. This emphasis on the therapeutic relationship has been reinforced by recent research in interpersonal neurobiology. Schore (2012) suggested that the work of psychotherapy “is not defined by what the therapist does for the patient, or says to the patient (left brain focus). Rather, they key mechanism is how to be with the patient, especially during affectively stressful moments (right brain focus)” (p. 44).

Play Therapy and Special Populations

Play therapy approaches have begun to spread well beyond the focus of individual client dynamics and the world of young children. Parents and other family members began to be included in therapeutic sessions. The non-verbal and experiential aspects of play therapy began to be included in therapeutic applications to a range of client ages, from adolescents to adults in later life.

1Theraplay is a registered service mark of The Theraplay Institute, Evanston, IL.
Parent and Family Involvement in Play Therapy

Louise Guerney explained that when she and her spouse/coresearcher Bernard Guerney began to include parents in play therapy work they were doing, “parents were not seen as agents of change” (Association for Play Therapy, 2010b). Landreth today refers to the Guerney’s development of Filial Therapy as “the most significant development in play therapy over the past 50 years” (Association for Play Therapy, 2012a). As Landreth sees it, involving parents creates an “intergenerational process—a bridge to addressing issues on a societal level,” impacting the lives of children served in ways far beyond the therapy room. Meta-analytic studies of play therapy outcomes have indicated that parent involvement is one of the key factors to success in play therapy (Bratton et al., 2005; LeBlanc & Ritchie, 2001).

Play Therapy Through the Life Cycle

Frey (Association for Play Therapy, 2010a), Landreth (Association for Play Therapy, 2012a), and Schaefer (Association for Play Therapy, 2010d) all point to the future of play therapy as including clients of all ages. Contemporary research on natural play emphasizes the functions of play throughout the life cycle to maintain emotional balance and connection with significant others. Play therapists are finding new ways of applying the therapeutic powers of play with adolescents, adults, and senior adults.

Cultural Competency in Play Therapy

O’Connor (1991, 2000) and later O’Connor and Ammen (1997, 2013) dedicated full chapters in their books to the importance of considering diversity issues in all aspects of play therapy practice. O’Connor also wrote a comprehensive article on the topic for the journal Professional Psychology: Research and Practice (2005). Gil and Drewes (2005) edited the first major book on cultural dimensions in play therapy to stimulate the conversation about culture and diversity in the play room. Subsequently, the Association for Play Therapy adopted as policy the recognition, incorporation, and preservation of diversity in play and play therapy (Association for Play Therapy, 2014). One of the association’s recent national conferences featured diversity as the conference theme, with many of the branch associations taking similar initiatives. All professional continuing education proposals approved by the association now must include details on how diversity issues impact the subject matter.

The Future of Play Therapy Is Now

Recent research in natural play and in interpersonal neurobiology have provided the field of play therapy with a fresh look at how to understand both the experience of play and play therapy. Yet, with the new truth is also a very old truth: Play is an integral part of how we connect with our loved ones, our world, and our selves. Play is how we rehearse for the challenges of life and refresh ourselves after taking on those challenges. The therapeutic powers of play are the therapeutic powers of life and renewal.

REFERENCES

Association for Play Therapy. (1997). A definition of play therapy. The Association for Play Therapy Newsletter, 16(1), 7.
An Introduction to the Field of Play Therapy


Association for Play Therapy. (2013). History speaks: Burns interview. Retrieved from http://www.youtube.com/watch?v=PT8hJi1_JPQ&feature=share&list=UU0DXBcxC-d63IZDtMzzFotA&index=2


An Introduction to the Field of Play Therapy


Play comes naturally to children. Throughout history, there is evidence children played if their environment and situation allowed it. Knowing the history of play therapy deepens our understanding of theoretical roots of the models and techniques we use. History also broadens our view of the whole field of play therapy.

HISTORICAL GROUNDWORK: THE PATH TO PLAY THERAPY

Prior to the 20th century, children were possessions, a source of labor, a source of income, and a means of survival of the species, or at least the family name. In the 18th and early 19th centuries, socioeconomic status often determined how a child spent the day: being tutored or attending school, working in the fields or factories, apprenticing, or surviving in the streets. With industrialization and settled growing communities, survival was secured for many families. By the late 1800s, more people could attend to quality of life for themselves and for others in their community. Childhood came to be seen as a separate stage of life.

Social movements, social reform, and humanitarian efforts all brought to light the behavioral and emotional needs of children, and thus the need for mental health services. In 1909, two important events contributed significantly to the development of child psychotherapy, and ultimately play therapy.

The National Committee for Mental Hygiene (NCMH) was founded through the work of Clifford Beers. He persuaded Adolf Meyer, a leading psychiatrist, and Harvard psychologist William James, along with other professionals, of the need to prevent mental illness and reform the care of the insane. Research authorized by this committee shifted its focus to understanding the behavior and personality of the child, as treating the mental illness of adults depended upon understanding causative factors from childhood (Horn, 1989; Jones, 1999). The work of the NCMH led to development of mental hygiene programs in schools and the establishment of child guidance clinics.
In 1909, G. Stanley Hall, who had launched the child study movement in the 1890s, invited Sigmund Freud and Carl Jung to come to Clark University to lecture and receive honorary degrees (Jones, 1999; Peery, 2003). Freud presented his recently published case of the psychoanalysis of Little Hans. Jung presented the case of Anna, based on his 4-year-old daughter. These case presentations were published in English, and this event is identified as the starting point for child psychotherapy in the United States. Psychoanalytic theories about child development, treatment methods, and play dominated early child guidance work.

Theoretical and Conceptual Roots: Grandfathers of Play Therapy Theories

With the symptoms and conflicts invariably originating in early childhood identified in his adult patients, Freud turned his attention to children. He spent hours making direct observations of children and urged his colleagues and followers to do the same (Lebo, 1955). Freud observed children creating a world of their own in their play, arranging things to suit themselves (Mannoni, 1970). By 1920, he had become interested in children's tendencies to repeat overwhelming, unpleasant experiences in their play. Through repetition, children mastered the experience to regain a sense of control. The central position of childhood in psychoanalytic theories opened the door for child analysis, and Freud believed it would confirm his theories (Mannoni, 1970). Because free association or talking about the past was not appealing to children, it was clear they would need a more suitable approach. Freud's followers, Hermine von Hug-Hellmuth and Melanie Klein, along with his daughter, Anna Freud, understood that children's inclination to play was a necessary component to their analysis (Lebo, 1955).

In 1904, Freud formed the Vienna Psychoanalytic Society. Alfred Adler was the first president of this society, and he went on to found the Society of Individual Psychology based on his own theory of individual psychology. Adler's model gives equal importance to the individual's social and community connections as it does to the internal experience. Adler focused on family dynamics and influenced the work in parenting of Rudolf Dreikurs and Don Dinkmeyer, his followers. His contribution to play therapy can be seen in Terry Kottman's Adlerian Play Therapy Theory (Kottman, 1995).

Carl Jung also served as president of the Psychoanalytic Society, but was later denounced by Freud when his ideas about children did not align with Freud's theory of infant sexuality. One of Jung's early followers, Michael Fordham, applied Jungian principles in his work with children (Peery, 2003). The symbols identified in expressions of the personal and collective unconscious, including archetypes of the collective unconscious, have come to life in the collections of many play therapists who include sandtrays in their playrooms. Although Margaret Lowenfeld is credited with the inclusion of the sand tray with miniatures in the playroom, she was not a follower of Jung per se. It was Dora Kalff who brought together Lowenfeld's world technique and Jungian principles to develop sandplay therapy (Turner, 2004).

Otto Rank, one of the younger members of the Psychoanalytic Society, continued to work with Freud until 1924. His own publication, The Trauma of Birth, disagreed with Freud's theory about early trauma in a child's life. Rank focused on the emotional relationship between therapist and client in the "here-and-now" and saw individuation and connection as a lifelong process. Unlike the psychoanalysts, he believed emotional expression should be part of the therapy. Carl Rogers embraced Rank's ideas and credited his influence in the development of client-centered therapy. Rank also influenced others, including Frederick Allen and Clark Moustakas, who followed existential philosophy and developed variations of relationship therapy (James, 1997).

Most of today's play therapy models can trace their theoretical roots back to the work of Freud, Adler, Jung, and Rank. In addition to studying childhood experiences as the etiology of adult disturbances, these theorists focused their attention on the analysis of children and issues of child
development. Application of these models to children involves developing a therapeutic relationship, translating theory into the child's play process, and operating within the limits of a child's stage of development. Early analysts attempting to use the methods of adult psychoanalysis found they could not engage children in free associations or discussions about their past, even if they could develop a warm relationship with them (Lebo, 1955). Play is the key element in adapting adult theories for work with children (Freud, 1927/1974; Hug-Hellmuth, 1921; Klein, 1932).

**Early Pioneers of Play Therapy**

Hermine Hug-Hellmuth is the first psychoanalyst to develop techniques for child psychoanalysis as distinct from adult methods (Geissmann & Geissmann, 1998). Hug-Hellmuth made direct observations of children, including many observations of their play, and presented her first paper to the Psychoanalytic Society in 1913. She then published a monograph integrating Freud's theory of infant sexuality (Hug-Hellmuth, 1919). Although it has been referenced as the first record of play therapy, it only describes her observations of children and theoretical conclusions about their play (Geissmann & Geissmann, 1998).

In a subsequent article, “On the Technique of Child Analysis,” published in 1921, Hug-Hellmuth describes how play could be used to better understand a child's symptoms and establish a relationship. She observed play is symbolic and enables the child to communicate without words (Geissmann & Geissmann, 1998). Although Hug-Hellmuth did not invent play therapy, her work certainly represents the prototype used by Melanie Klein and Anna Freud to develop their models of play therapy.

Melanie Klein's work in child psychoanalysis was initially inspired by studying Freud's writing and then by her analyst, Sandor Ferenczi (Grosskurth, 1986). Unlike other analysts, she believed young children have the capacity for insight. Central to her model, which she named psychoanalytic play technique or play analysis, is the interpretation of the child's play and the symbolic meaning of the toys (Klein, 1955). The toys she found to be best suited for analysis were small, simple, and nonmechanical, thus allowing the children to project their own meaning onto the toy. She strictly abided by a schedule of 50 minute sessions, five times per week (Geissmann & Geissmann, 1998). She began to offer interpretations in the first session and noted that children responded with an expression of relief from the anxiety they were feeling. There were times when children who had improved at first began to act out more as the analysis continued and they were working through more difficult conflicts (Klein, 1955). When sharing her interpretations with children, Klein used the children's expressions or symbols in the context of what they were playing out. She believed play provides the outlet for expressing unacceptable wishes and feelings.

Klein was comfortable with analysis of both positive and negative transferences. She would allow children to assign her the role of child and punish her while they assumed the role of the authority figure. To maintain safety, she set limits on the aggression but accepted the children's aggressive needs, interpreting the motives in the negative transference. There was concern about probing so deeply into a child's unconscious given the undeveloped superego. Based on her observations of very young children and infants, Klein argued that the superego starts to form much earlier than previously thought (Geissmann & Geissmann, 1998). Internally, the infant forms a good and bad object. Projected onto this object is an intimidating, punishing superego, which is often observed in the aggressive, punitive play of young children. Klein had the support of students and followers in England, including Donald Winnicott, who went on to join the object relations school, which is the middle ground between Kleinian and Freudian theories (Mitchell & Black, 1995).
Klein's approach was published in *The Psychoanalysis of Children* (Klein, 1932). Although the Kleinian school of child psychoanalysis does not endure as a major approach to play therapy, Melanie Klein made significant contributions to the understanding of play as the symbolic language of the child and to the selection of toys and playroom materials.

Anna Freud is the third of the pioneers whose work led to the development of play therapy. Whereas Melanie Klein determined children’s play could be used as free association, Anna Freud disagreed as she argued the method loses its effectiveness when too many modifications are made to the underlying theory (Freud, 1965). As with adult analysis, the goal with children is to free unconscious material and help children gain insight about their struggles. Freud used play to establish rapport with children but offered interpretations very sparingly. Technically, the great challenge to overcome in child analysis is the child's inability or unwillingness to produce verbal free associations in order to access the unconscious (Freud, 1965).

After the introductory phase of building relationship and motivating children to participate in more verbal stages, Freud would move into analysis of children's dreams and daydreams. Finally, she would engage children in free association by prompting them to create fantasy pictures in their mind and describe them to her (Freud, 1965). In later years, she abbreviated the first phase of the child's analysis, in which she persuaded the child to participate in analysis. She focused instead on positive transference. She also reversed her early position that young children could not benefit from psychoanalysis due to their undeveloped superegos (Geissmann & Geissmann, 1998). Although her use of play was limited, Anna Freud's explanation of technical difficulties in child analysis is instructive to all play therapists. She had many followers, especially in the United States; among them is Margaret Mahler, best known for her work on the separation-individuation process of the infant (Geissmann & Geissmann, 1998).

The fourth pioneer in the field of play therapy is Margaret Lowenfeld. Her career started in pediatric medicine before she established a private practice and a clinic of her own in London (Urwin & Hood-Williams, 1988). Her influences espousing the importance of play were Piaget; the progressive educators, Froebel and Montessori; and the child study theorists. When she opened her clinic in 1928, Lowenfeld was inspired by H. G. Wells' book *Floor Games*, in which he describes his play with his two sons, creating many different kinds of scenes with miniatures and other small materials on the living room floor. She began to collect small toys and play materials for her sessions with children, stored in what came to be known as the “Wonder Box” (Thompson, 1990).

After moving to a larger clinic, she added two trays, one tray filled with water and the other with sand, along with a large cabinet to store her miniatures. Children soon began to take miniatures from the cabinet and place them in the tray of sand, and their constructions were called “worlds.” This medium created by the children came to be named “the world technique” (Thompson, 1990). When the children came to the clinic, they were told they could play with anything in the playroom and what they choose to say or play with would not be shared with their parents. Lowenfeld believed children would find ways to make sense of their world and personal experiences given the right tools and materials. Staff were expected to observe and to follow the child's play, including making worlds, without intruding or offering direction or interpretation (Urwin & Hood-Williams, 1988). There was less emphasis on building a relationship with the child and more emphasis on the child's cognitive process.

While the world technique is central to her work and its use widespread, Lowenfeld also published research studies contributing to the fields of child development and play. The clinic expanded and was renamed the Institute of Child Psychology, providing learning opportunities for many students, one of whom was Dora Kalff (Turner, 2004).
Play Therapy Comes to America

In the 1920s, behaviorism, with its focus on discipline and habit training, was used with and found helpful for families in crisis (Horn, 1989). With the interest in underlying emotional factors causing children’s problems, psychodynamic ideas replaced the more rigid behavioral approach. The challenge in developing effective methods of child psychotherapy was translating theoretical knowledge to practical techniques suited for children.

Interest in mental hygiene for children prompted the Commonwealth Fund to sponsor the development of child guidance clinics. In 1927, The Institute for Child Guidance was funded to provide training as well as to offer services to families. To improve the quality of clinical treatment and clinical skills, the mission of the institute included research and advisory services to the network of child guidance clinics (Horn, 1989). David Levy (1933), the director of research, conducted a variety of studies over the six years the institute operated. One of his research projects used a standardized play situation to measure the release of hostile feelings related to sibling rivalry. This experiment introduced a prescribed play situation using family figures. During a therapy session, the child was prompted by the therapist to complete a standard play scenario with two siblings and a mother. Therapy sessions for these children usually included using spontaneous play to work out their feelings. Levy (1933) suggested these play situations initiated by the therapist could be used therapeutically with a variety of problems.

Levy went on to pursue the use of this play technique, which was later identified as release therapy (Levy, 1938, 1939). He proposed this set of techniques for children who presented with specific symptoms after a stressful life event or trauma. Essentially, the therapist sets up the traumatic situation, begins to re-play what happened, and prompts the child to reconstruct the event and recreate the emotional experience. According to Levy, once the release of emotions, or abreaction, is complete, symptoms and problem behaviors would quickly dissipate. Expanding on Levy’s work, Gove Hambridge (1955) further developed the release techniques and renamed this treatment method structured play therapy. With Levy’s support and guidance, Hambridge provided guidelines for when and how to use the play situations in the larger therapeutic process. He emphasized the need to first establish a relationship with the child and then to focus specifically on the problem for which the child entered therapy.

In the 1930s, many child guidance professionals were experimenting with play techniques, either the spontaneous and free or the controlled and standardized (Newell, 1941). Jacob Conn (1939, 1997) described the play interview, a technique he developed to help children express themselves through the use of family dolls. The therapist sets up play to depict some aspect of the child’s current situation. Through play reenactment, the child is encouraged to project thoughts and feelings onto the dolls. Conn took a noncritical, accepting stance to alleviate children’s fear of being judged for releasing frustrations. The children could then take responsibility for their part in their current circumstances and let go of the need to act out. He used the play interview as a diagnostic tool and as part of a larger treatment process.

Joseph Solomon, a close colleague of Conn’s, used Conn’s interview ideas to develop a treatment method he named active play therapy (Solomon, 1938). The reference to active distinguishes this play therapy from the passive approaches in which the therapist follows the child’s lead using free play techniques (Solomon, 1938). In this approach, the therapist takes an active role in using dolls and other props to play out the client’s problems. Through question and answer, the therapist engages the child in telling and showing what happens and how the doll feels in a situation much like the child’s own. The play links together the symptoms, behavior, and emotional conflicts for the child. In the context of the play, the therapist is able to offer some suggestions, and
the child sees the situation in a new light. He later placed more emphasis on the child’s emotional responses in the play than to the dramatic aspects of the play situation (Solomon, 1948).

Unlike the child analysis approach of seeing children multiple times a week for long periods, child guidance clinicians needed a direct, effective, short-term treatment. Like Levy’s release play therapy, active play therapy was developed in response to this need (Solomon, 1938). None of these play therapy techniques was intended for work with children experiencing long-standing problems or serious parent–child conflicts (Conn, 1939; Levy, 1938; Solomon, 1938).

Jessie Taft began her work as a therapist under the supervision of Otto Rank, and subsequently published a book titled *The Dynamics of Therapy in a Controlled Relationship* (1933). In her book, she identified the need for play therapists to assert boundaries around the therapeutic relationship. She offered guidance to a new profession as she discussed what constitutes professional conduct in the practice of therapy with children. The case analysis demonstrated the here-and-now quality of the interaction, the focus on thoughts and feelings that come up during the play, and the impact of time as part of the therapeutic process. Clients must adapt themselves to the time they have in each session and to the number of sessions leading to the end of therapy (Taft, 1933). In contrast to other types of therapy, she explained the therapist’s goal is not to reform the child but rather to make growth and development possible. The therapist’s passive role is necessary to allow the will of the child to come to terms with self.

Frederick Allen further developed the application of Otto Rank’s theories to therapy with children (Allen, 1942). As director of the Philadelphia Child Guidance Center, he promoted a relationship-based approach to therapy focused on the present. Allen believed children could use the relationship itself to understand themselves and to work through their struggles. He based his approach to therapy on two principles: accept children as they are, and accept his own limitations (Allen, 1934). Allowing children to be themselves without specific expectations relieves him of the need to defend against being helped. Allen did not believe he had the power to cure the child. If the therapist assumes that power, it would prevent children from taking responsibility for making changes within themselves. Allen saw play and play materials as children’s tools for relating themselves. Toys for the playroom were selected based on their usefulness in expressing emotions and in relating to the therapist (Allen, 1934). Allen also identified a pattern of stages in the therapy process. In the beginning, he observed children discovered the therapist is not trying to change them and that this is going to be a very different kind of relationship. Using the relationship as they experience it within the playroom, they play out what is troubling them to accomplish change. At the end of therapy, separating and bringing this special relationship to an end is signaled by children’s new-found abilities to accept responsibility for themselves and to relate to others in their lives. To share his approach to therapy with children, he wrote numerous articles, along with his book, *Psychotherapy with Children* (1942).

The Legacy of Virginia Axline

Despite the use of play by these earlier psychoanalysts and psychiatrists, Virginia Axline is credited as the mother of play therapy. Both of her books, *Play Therapy: The Inner Dynamics of Childhood* (1947) and *Dibs: In Search of Self* (1964), have been read by people all over the world and are still in print. Her model, originally named *nondirective play therapy*, has also been referred to as *client-centered play therapy* (Dorfman, 1951) and *child-centered play therapy* (Ginott, 1959).

As a student at Ohio State University, Axline studied with and co-authored an article with Carl Rogers that describes the use of nondirective techniques with a child (Axline & Rogers, 1945). In 1945, Rogers moved on to the University of Chicago and Virginia Axline worked there as a research associate. Some of the case examples in *Play Therapy: The Inner Dynamics of*
Childhood (1947) are from a play therapy group conducted at the University of Chicago Counseling Center (Rogers, 1951).

Some of the practical issues with the use of nondirective methods of play therapy included limit-setting, criteria for selection of toys, and age differences. Limit-setting and permissiveness were central issues in the practice of nondirective play therapy (Axline, 1979; Bixler, 1949; Ginott, 1959; Ginott & Lebo, 1963). To what extent are limits important to the therapeutic relationship and the process of play therapy? If the therapist is to be permissive, where is the limit set on allowing children to do as they please? These were questions asked not only by therapists, but also by others concerned by this radical idea of permissiveness. Bixler (1949) offered guidelines for limit-setting and clarified how limits should be well-defined and set only when needed. Ginott (1959) later revisited a more detailed discussion of timing and types of limits he believed were most beneficial. Ginott (1982) and Lebo (1979) recommended toys and playroom equipment be carefully selected to facilitate communication, relationships, catharsis, and insight. Because toys are an important variable in the process of play therapy, Lebo (1979) recommended selection be more objective and take age differences into consideration.

Haim Ginott (1961) further developed Axline's application of nondirective play therapy to groups. He found the interaction in group play therapy provides opportunities for social learning that are not possible with individual play therapy. In nondirective group play therapy there are no group goals, and the therapist's focus remains with the children individually. Ginott also described his particular style of Axline's model and renamed it child-centered play therapy in his book Group Psychotherapy with Children: The Theory and Practice of Play Therapy (1961).

Clark Moustakas is sometimes included in the list of Virginia Axline's followers because there are some similarities in their theoretical backgrounds and their techniques. He was a student of hers and followed the nondirective approach during his first 2 years on the faculty at the Merrill-Palmer Institute. In time he realized "sitting in a chair" making reflective statements did not fit his way of being with children (Moustakas, 1997). Moustakas gradually developed his own approach to play therapy incorporating the theories of Otto Rank and the therapeutic ideas of Jessie Taft (Moustakas, 1953, 1997). Some of the Axline principles fit within his own theoretical framework, including permissiveness, accepting children where they are, setting limits, and maintaining a belief in the child. Like Axline, he believed children have the capacity to do their own problem solving and he encouraged them to take responsibility for their own choices in the playroom (Axline, 1947 Moustakas, 1959). What sets Moustakas apart from Axline is the level of participation and interactive communication with the child. For Axline (1947), the healing may be more in the environment—"the good growing ground" (p. 16)—whereas for Moustakas (1953, 1959), the healing is in the relationship.

In addition to his research, Moustakas published four books on play therapy, including: Existential Child Therapy: The Child's Discovery of Himself (1966). Theoretically, Moustakas may be identified with existentialists, but his work also reflects some of the client-centered model (James, 1997). Given that Carl Rogers drew some of his technical ideas from Otto Rank and Jessie Taft, the interweaving of theories evident in Moustakas's and Axline's play therapy approaches can now both be appreciated as humanistic. Along with Abraham Maslow and Carl Rogers, Moustakas played an important role in founding humanistic psychology. In 1997, Moustakas wrote Relationship Play Therapy and recorded a taped session and reflections on relationship play therapy for the Center for Play Therapy at the University of North Texas.

The Rise and Fall of Play Therapy: 1960s–1970s

In the early 1960s, child guidance clinics remained primary service providers for children and families in many communities. Because it was believed parents’ problems were causal factors
in the problems of the child, the social worker worked with the parent, most often the mother (Guerney, 2003; Tulchin, 1964). Looking for a better way to strengthen the parent–child relationship, Bernard Guerney conceived of and developed Filial Therapy with the help of his wife, Louise Guerney (Guerney, 2003). He had noticed parents were more often lacking in parenting skills than exhibiting psychopathology. Child-centered play therapy worked well with parental support, so it seemed logical it might also be effective if parents were trained to be primary providers of child-centered play therapy with their own children (Guerney, 2003). Because Axline’s work did not offer a detailed methodology, the Guerneys took great care in translating her model to ensure the skills they were practicing were theoretically consistent with Axline (1947) and Rogers (1951). They were then able to develop specific skills they divided into teachable sections for the Filial Therapy Model (Guerney, 2003; Van Fleet, Sywulak, & Sniscak, 2010).

The primary goal of Filial Therapy was for parents to relate more positively to their children. A second goal was to eliminate the threat a therapist posed to the bond between parent and child. Filial Therapy proposed parents could learn to respond appropriately to the immediate behavior and verbal expressions of their children with teaching and supervision in the use of child-centered play therapy. Pilot studies and research showed parents could be taught these skills and reach a level of performance equivalent to the therapist. The research was well-designed; the Guerneys were able to develop a skills training approach replicable by other practitioners, and it has proven to be an effective intervention. Despite this, Filial Therapy was not widely adopted at that time.

As the 1970s approached, other factors were at work shifting professional interest away from child-centered play therapy, or for that matter, any play therapy. The child guidance clinic psychiatrists and psychologists were pursuing more expedient modalities such as medication, family therapy, and behavior modification. Methods like operant conditioning had a significant impact on behavioral and learning disorders and quickly gained popularity in the treatment plans of agency programs. As a result, nonbehavioral play therapy approaches were abandoned by many clinics. Behavioral treatment could offer short-term intervention that was more cost-efficient than more traditional psychotherapy approaches, such as play therapy.

During this same time period, some important seeds were being planted that would eventually contribute to the value of play therapy. Donald Winnicott was a member of a group of psychoanalysts in Great Britain, known as the Object Relations School, that had taken the middle road between the Freudians and the Kleinians (Mitchell & Black, 1995). A student of Melanie Klein, Winnicott was influenced by Klein’s early ideas about object relations and her belief in an “infant wired for human interaction” (Mitchell & Black, 1995, p. 113). He may be best known for his explanation of transitional objects. According to Winnicott, children often insist these items go everywhere with them because they are not only a substitute for the mother, but also an extension of the child’s self (Mitchell & Black, 1995). His extensive work with mothers, infants, and small children led Winnicott to develop concepts such as good-enough mothering, the holding environment, and the false self. All of these concepts contribute to the theoretical basis for his approach to play therapy. In his book Playing and Reality (1971), Winnicott shares case examples to illustrate how these concepts contribute to the therapy. His theoretical constructs have been a significant influence in the area of object relations and attachment.

John Bowlby, another member of the object relations school, theorized the child is instinctively motivated to attach to the mother and the mother responds instinctively to the child’s needs. Through his study of attachment and loss, we have learned the importance of attachment to a child’s psychological development. When the primary attachment figure is consistently available and responsive, the child develops with confidence and emotional security (Mitchell & Black, 1995). When the primary caregiver is unavailable, unresponsive, or hurtful, the child develops problems relating to people, accepting care, and making transitions. Children can
be easily frustrated, angry, and have difficulty soothing themselves when stressed (Jernberg & Booth, 2001).

In the research on attachment, one of the characteristics observed in a securely attached relationship is the parent's affectively attuned play (Jernberg & Booth, 2001). Inspired by the work of John Bowlby and Donald Winnicott on attachment and object relations theories, Ann Jernberg and Phyllis Booth created Theraplay®, a treatment model designed to replicate the positive interactions observed in healthy parent–infant relationships (Jernberg & Booth, 2001). Theraplay addresses disruption in the parent–child bonding experience and uses focused eye contact, nurturing touch, and playful interactions. This approach has proven to be most effective with attachment disordered children and those with serious behavioral and developmental disorders.

With attachment theory as a framework, Viola Brody's formulation of developmental play therapy was inspired also by her supervisor, Austin Des Lauriers; Janet Adler, a movement therapist; and by Martin Buber's concept of the I–Thou relationship (Brody, 1997). This concept is based on the idea that touch is essential to the development of a healthy child. Brody expressed concern that children are not touched enough in healthy ways to facilitate bonding in our society. When bonding does not happen, children cannot move on to the next stage of development. In developmental play therapy, Brody started where the children were developmentally and her goal was to help them move on to the next stage of development. She conducted separate sessions with parents to train them in touch and appropriate limit-setting. Toys were not available in her playroom because she believed they distracted the child from a relationship with the therapist. The developmental playroom includes a rug, rocking chair, table and chairs, paper, crayons and pencils, and a bottle of lotion. Later, play therapy approaches including Object Relations Play Therapy, developed by Benedict (2003); Filial Therapy for attachment-disrupted and disordered children (Van Fleet & Sniscak, 2003); and the inclusion of play therapy techniques in attachment-based interventions by Whelan and Stewart (2013) demonstrated the value of play therapy in dealing with attachment disorders and building healthy attachments for children and their caregivers. These different approaches can all be traced back to Winnicott and Bowlby’s theoretical formulation of attachment and object relations.

In the 1970s, Violet Oaklander (1978) developed gestalt play therapy based on gestalt therapy developed by Fritz and Laura Perls and her own experiences in teaching and special education. Gestalt play therapy is humanistic, process oriented, and relationship based, with a focus on the whole organism. Like other humanistic models (Allen, 1942; Moustakas, 1959), it emphasizes the therapeutic value of the relationship between child and therapist (Oaklander, 2003). The gestalt therapist takes an active role with goals and plans for the child, offering activities to meet the child’s needs. However, if the child has other ideas and takes the lead in the session, the therapist will follow. Oaklander created a variety of expressive, creative, projective techniques using art, sandtrays, role play with puppets or costumes, music, breathing, and body activities (Oaklander, 1978, 2007). Oaklander’s primary goal for therapy was helping children uncover and express emotions they have blocked. The children’s aggressive energy is used to take action, to be able to bring out buried emotions, and to help the children learn healthy ways to express those feelings (Oaklander, 2003). She believed self-nurturing is a necessary goal for children to accomplish in order to resolve negative beliefs, let go of the hateful parts of themselves, and build self-acceptance (Oaklander, 2003). In 2007, her second book, *Hidden Treasure: A Map to the Child's Inner Self*, was published, reflecting her 30 years of experience. Violet Oaklander retired in 2008, but her work continues through the Violet Solomon Oaklander Foundation.

1 Theraplay is a registered service mark of The Theraplay Institute, Evanston, IL.
The Return of Play Therapy

Although play therapists such as Bernard and Louise Guerney, Garry Landreth, Ann Jernberg, and Phyllis Booth taught and practiced play therapy in the 1970s, they were geographically scattered and operated in isolation. There was little research being published and almost no continuing education for play therapy. In 1982, Charles Schaefer and Kevin O’Connor founded the Association for Play Therapy (APT) to promote play therapy as a viable treatment modality for children. Over the next 15 years, a board of directors was created for the association, annual conferences were nationally advertised and held in cities around the country, a national membership campaign launched, and the chartering of state branches begun. APT also began the process of building credibility for play therapy through several major projects, including the publication of the *International Journal of Play Therapy*, the creation of a credentialing program for Registered Play Therapists and Registered Play Therapists-Supervisors, and publication of a listing of providers of APT-approved continuing education in play therapy.

Historically, educating play therapists had been accomplished through the process of completing one’s own psychoanalysis (Geissmann & Geissmann, 1998) and studying under or being supervised by a master psychoanalyst (Taft, 1933). In the United States, universities and medical schools offered some classes and internship experiences, such as Moustakas’ training with Virginia Axline. These play therapy training opportunities appeared to decline by the 1970s in many universities. Landreth’s courses in play therapy at the University of North Texas are a remarkable exception. By 1988, Garry Landreth was able to establish the Center for Play Therapy in the department of counseling. In addition to play therapy classes and a graduate play therapy program, the Center for Play Therapy began to offer workshop training and conduct research (Landreth, 2002). This program continues to lead the academic field in educating play therapists. For many professionals, training in play therapy has been acquired through continuing education, workshops, intensive seminars, conferences, and training institutes.

Charles Schaefer’s efforts to educate others about play therapy actually began in the 1970s. His first book about play therapy, *The Therapeutic Use of Child’s Play* (1979), incorporates the work of leaders in the field, including Virginia Axline, Melanie Klein, Anna Freud, and David Levy. He has since edited and co-edited books covering the full range of play therapy theories and techniques. In an early book, *Therapies for Children* (1977), Schaefer, together with Howard Millman, argues a prescriptive approach should be taken when deciding what treatment approach to use with a child. Using a prescriptive approach to the practice of play therapy entails developing a treatment plan based on assessment to determine what treatment approach by which therapist will work best for the child. Schaefer challenges the allegiance to one theory of play therapy, suggesting therapists must be pragmatic and realistic in selecting what will work best based on the child’s needs, not the therapist’s personal preference (Schaefer, 2003).

At the University of North Texas, Garry Landreth taught his first play therapy class in 1967. In 1982, Landreth edited and published his first textbook, *Play Therapy: Dynamics of the Process of Counseling with Children*. Primarily intended for students of play therapy, this text provided practical suggestions and guidelines for conducting play therapy and working with various problems children face. Landreth further developed and refined Virginia Axline’s child-centered play therapy (1947). In those refinements there is evidence of the work of other child-centered play therapists, including Haim Ginott and Clark Moustakas (Landreth, 2002). Together with Sue Bratton, Landreth has also developed and promoted a 10-session, Filial Therapy model titled *Child–Parent Relationship Therapy* (2006). Filial Therapy and the child–parent relationship therapy program have been researched extensively at the University of North Texas (Landreth & Bratton, 2006). Landreth’s contributions to play therapy in elementary school counseling date back to the 1960s, and his influence is still seen in research on school-based play therapy (Drewes,
Based on his experiences as a teacher and school counselor, Landreth (1983, 2002) has promoted the importance of play therapy in school to help children work through issues that may be interfering with school and to restore their readiness to learn.

Landreth joined APT and was on the original board of directors. In 1987, he brought the annual play therapy conference to Texas, utilizing national advertising to greatly expand attendance and ultimately the membership of APT. It was one of his students, Lessie Perry, who joined the APT board as membership director in 1988, launching the first membership campaign and then organizing the chartering of state APT branches. Landreth retired from the APT board in 1999 and taught and directed the play therapy program at the University of North Texas until his retirement in 2002. He continues to help with research and teaches workshops on child-centered play therapy.

Louise Guerney, another member of the original APT board of directors, continued to teach, practice, and write about Filial Therapy. She too has adhered to the theory and principles of child-centered play therapy in her teaching, supervision, and practice (Guerney, 1983; Van Fleet et al., 2010). Following their initial research and practice with Filial Therapy, the Guernseys went on to focus on relationship enhancement for families through marital and family therapy. Louise Guerney taught many students, among them Risë Van Fleet, who further developed Filial Therapy and its application to various issues including adoption, attachment, and trauma (Van Fleet, 2005). Guerney (1983) describes child-centered play therapy as “a complex, systemic approach” and cautions against “drifting into other methods” (p. 28).

Kevin O'Connor developed Ecosystemic Play Therapy, which has evolved over time, and in collaboration with Sue Ammen, to include a well-integrated theory, as well as detailed intake strategies and a treatment planning model (O'Connor, 1991, 2000; O'Connor & Ammen, 2013). The ecosystemic model views the child as embedded in a series of interrelated systems. The impact each system has upon the child, both psychologically and pragmatically, is assessed, and the information is used to organize a comprehensive treatment plan (O'Connor & Ammen, 2013). Besides the systems perspective, the other organizing framework guiding this model is cognitive-developmental theory, which takes into consideration the child's age and stage of development. O'Connor initially described the approach as a hybrid drawing its theoretical foundation from an integration of psychoanalytic, child-centered, cognitive-behavioral, Theraplay, and Reality Therapy (O'Connor, 2001). As it has evolved and been refined, it has become a freestanding model of play therapy.

The Color-Your-Life Technique was developed by O'Connor (1983) to give children a concrete way of understanding and discussing their feelings. Still a favorite technique of many play therapists, it has been used and adapted as an assessment tool to quantify emotions and it has been used therapeutically to aid in labeling and discussing the child's feelings (O'Connor & New, 2002). O'Connor also developed a quick version of the technique using the simple outline of a thermometer so play therapists could help children measure their emotional “temperature” or status between sessions.

EXPANSION OF PLAY THERAPY MODELS

Psychoanalytic and Psychodynamic Play Therapies

Psychoanalytic theories continue to influence some of the current play therapy approaches (Benedict, 2003; Bromfeld, 2003; Cangelosi, 1993; Lee, 1997; O'Connor, 1991). It should, however, be noted that the three schools, Kleinian, Freudian, and object relations, each offer their own variation and those who reference their approach as psychoanalytic or psychodynamic play therapy
may draw upon one or more of these schools of thought for their theoretical foundation (Bromfield, 2003).

**Jungian Play Therapies**

After his introduction to Jungian theory during graduate school, John Allan pursued the application of Jungian concepts to school counseling. Core concepts of Jungian theory focus on the interaction between conscious and unconscious parts of the self (Allan & Levin, 1993). The collective unconscious, having gathered the history of human experience, contains archetypal patterns that have evolved over time (Allan, 1988; Allan & Levin, 1993). In these unconscious areas not only are preverbal wounds stored, but also the archetype of the self that holds the capacity for self-healing. The Jungian play therapist activates this self-healing archetype by building a rapport with the child, forming a therapeutic alliance, and then following the unconscious processes expressed in play therapy. Following Jung's method of using expressive arts to access the unconscious material and bring it to consciousness, John Allan characterizes Jungian play therapy as “playing, making, doing, enacting fantasies in the safety of the therapeutic container” (Allan & Levin, 1993, p. 210). The playroom is viewed as a protected space, which Jungians call “temenos,” where children can play, free from the pressure of the outer world. A traditional playroom equipped with toys, art supplies, wet and dry sandtrays, and miniatures provides the necessary resources for children to do their self-healing work. Concepts from child-centered play therapy have been added to the Jungian principles, especially for work in schools and clinics (Allan, 1988; Allan & Bertoia, 1992).

Others who have contributed to the development of play therapy based on Jungian theory include Gisela DeDomenico (1994), J. Craig Peery (2003), J. P. Lilly (1998), and Eric Green (2011). Peery (2003), Lilly (2012), and Green (2011) identify their work as Jungian analytical play therapy to better reflect Jung’s use of the term analytical to distinguish his approach from Freud’s psychoanalysis (Peery, 2003). Through their published work and conference presentations, these Jungians continue to generate interest in Jungian analytical play therapy.

Sandplay (Kalff, 2003) was derived from Dora Kalff’s analysis and study with Carl Jung, her yearlong study with Margaret Lowenfeld, and her interest in Eastern thought. Gisela DeDomenico, who studied the world technique and Kalff’s sandplay has created her own approach to the sandtray: the Sandtray-Worldplay (Boik & Goodwin, 2000). Her work includes use of different shaped sandtrays and different colors of sand. Through Sandtray Therapy: A Practical Manual (1998), Linda Horneyer and Daniel Sweeney (1998) have also offered practical guidelines for play therapists to use the sandtray.

The use of metaphors in play therapy is another technique derived from Jung’s ideas about symbol and Milton Erikson’s use of metaphor. Mills and Crowley (1986) have formulated a process for designing and using therapeutic metaphors, and their work is published in Therapeutic Metaphors for Child and the Child Within (1986). Metaphors and symbols are important instruments of healing in play therapy especially suited to children (Mills & Crowley, 1986; Norton & Norton, 1997). Children engage naturally in symbolic play from the time they are about two years old, and they understand the metaphors in fairy tales and stories. Their approach engages children in the creation and use of therapeutic metaphors through play, art, and storytelling.

**Experiential Play Therapy**

Experiential play therapy, developed by Carol and Byron Norton (1997), is based on their observation children process information about their world experientially. Experiential play therapy
The History of Play Therapy

is based on the belief play of children is highly metaphorical and it is how they express their experiences and feelings about themselves (Norton & Norton, 1997, 2006). This approach was also influenced by the nondirective theory of Axline (1947), particularly the belief in children’s capacity to direct their own healing process. Unique to this approach is the identification of symbolic meaning of the various toys, animal figures, and environments children create in the playroom. Suggested meanings are used to form a hypothesis about the theme or metaphor communicated in the child’s play (Norton & Norton, 1997). In experiential play therapy, children create their own metaphors to communicate their experiences and to understand and resolve painful experiences and emotions.

Adlerian Play Therapy

Alfred Adler, another member of Freud’s original group who parted theoretically, was an inspiration to Terry Kottman (1995), who developed a four-phase model for Adlerian Play Therapy. The first phase centers around building an egalitarian relationship, during which the therapist will follow the child’s lead in the playroom but is also active in playing with the child and asking questions. The second phase involves exploring the child’s lifestyle in order to better understand patterns of thinking, feeling, and behavior the child uses to gain a sense of importance and belonging, as well as create a treatment plan. In the third phase, Kottman begins to help the child gain insight into him or her lifestyle through the use of drawings and metaphors. The fourth phase provides reorientation and re-education to help the child learn and practice new positive attitudes and behaviors to help him or her form a constructive lifestyle (Kottman, 1995; 2003). Kottman continues to work on refining this model and has recently written a manual for conducting research using the Adlerian Play Therapy Model (Kottman, 2011).

Cognitive Behavioral Play Therapy

Susan Knell (1993) brought together the theory and techniques of cognitive therapy and behavior therapy with the principles of play therapy to create cognitive-behavioral play therapy, a developmentally appropriate intervention for children ages 2½ to 6 years old. She devised play-based activities to accomplish behavioral interventions such as systematic desensitization, positive reinforcement, shaping, stimulus fading, and extinction (Knell, 1993, 2003). Cognitive interventions that have been adapted include recording dysfunctional thoughts, countering irrational beliefs, and using coping self-statements. She uses modeling, role-playing, and behavioral contingencies using toys, stuffed animals, and puppets that are fun and engaging for young children. Knell has applied these methods to help children with a variety of emotional and behavioral problems, including selective mutism, phobias, encopresis, and separation anxiety (Knell, 2003).

Janine Shelby (2000; Shelby & Felix, 2005; Shelby & Berk, 2009) has also promoted the integration of cognitive-behavioral therapy with play therapy. Her use of cognitive-behavioral techniques has primarily been in the area of trauma (Shelby, 2000; Shelby & Felix, 2005) but she has also advocated for more use of developmentally sensitive methods in providing cognitive-behavioral therapy with diagnoses such as depression and posttraumatic stress disorder (Shelby & Berk, 2009). The publication of Blending Play Therapy with Cognitive Behavioral Play Therapy (2009) has generated more interest and acceptance of play therapy by the larger community of mental health professionals. Included in this resource book are descriptions of empirically supported treatments that focus on problems with anxiety, aggression, trauma, and school adjustment.
Family Play Therapy

Family play therapy has evolved as an integrated model combining family therapy and play therapy. A very early attempt to include caregiver and child together in the playroom was made by Safer (1965), who introduced conjoint play therapy, which brings the caregiver into the playroom and has the therapist join with them in play activities chosen by the child. Irwin and Malloy (1975) developed the family puppet interview to stimulate both verbal and nonverbal communication and engage the family in organizing itself to complete a goal or task. Griff (1983) described a short-term model for family play therapy in which she models new ways for caregivers to interact and communicate with their children, facilitates interactions, and joins the play activities.

In *Family Play Therapy*, edited by Charles Schaefer and Lois Carey (1994), a variety of family play therapy techniques were presented to describe how to use play with families and demonstrate the benefits of integrating these two models. For the past 20 years, Eliana Gil has been the face of family play therapy, beginning with her book, *Play in Family Therapy* (1994). Her model, based on family systems theory and an integrated play therapy approach, is designed to achieve systemic change (Gil, 2003).

Two other family play therapy models have evolved since the 1990s: Steve Harvey's dynamic family play therapy (1993, 2006) and Shlomo Ariel's strategic family play therapy (1994, 2005). Harvey's model draws from attachment theory, humanistic family therapy models, and creative problem solving. Play activities are creative and expressive, using dance movement, drama, and art to encourage the family's spontaneity, to create metaphors illustrating emotional states and family relationship problems (Carmichael, 2006), and to increase their capacity for attuned play (Harvey, 2006). Strategic family play therapy makes it possible for young children to fully participate because it uses make-believe play as its primary strategy. Built on an integrated multi-systemic foundation, this model uses information processing theory to help families understand their programs for interacting and communicating (Ariel, 2005). The field of play therapy continues to flourish and grow, both in terms of ever-expanding treatment modalities as well as types of populations served.

CONCLUSION

From a small group of 50 charter members in 1982 to a membership of over 6,000 play therapists in 2014, the APT has spread across the United States. Continuing education has expanded beyond the annual conference to include state branch conferences, the E-Learning Center, and numerous workshops offered by over 200 approved providers of play therapy, and 20 graduate programs have received designation as Approved Center of Play Therapy Education. Through the support of its members and the development of programs supporting research, education, and marketing, the APT has made a significant contribution in raising the status of play therapy.

The history of play therapy is in the books that have been published, reprinted, and reissued in subsequent editions. It can be found in early volumes of the *Journal of Orthopsychiatry*, the APT newsletter, and the *International Journal of Play Therapy*. Some books have changed with history and some, like *Dibs* by Virginia Axline, have changed the history of play therapy. Perhaps there is another *Dibs* in our future. We might imagine a future where, in the blink of an eye, we see a child's brain light up. The child will have a headset reading all the areas of his brain. His Jungian, eco-cognitive play therapist plays with him and gets signals telling how much of the brain is responding. The data gathered is indisputable; play therapy is most definitely efficacious. The only better evidence is the smile on the little child's face and the parents' report that life is good.
REFERENCES

Conn, J. (1939). The child reveals himself through play; the method of the play interview. Mental Hygiene, 23, 49–70.


Lilly, J. P. (2012). Interpretation of children’s play: Perspectives from analytical child psychotherapy. Workshop presented at 18th Annual Colorado Association for Play Therapy Conference, Denver, CO.


CHAPTER 3

The Therapeutic Powers of Play

ATHENA A. DREWES AND CHARLES E. SCHAEFER

Several reviews of the play therapy outcome research have shown play therapy to be effective, with effect sizes ranging from medium to large (Bratton & Ray, 2000; Bratton, Ray, Rhine, & Jones, 2005; Ray, Bratton, Rhine, & Jones, 2001). Two questions remain, however, why and how does play therapy work? To answer these questions, it is necessary to study the mechanisms of change underlying play therapy in order to understand the specific forces that cause therapeutic improvement in a client.

THERAPEUTIC FACTORS

Therapeutic factors are the actual mechanisms that effect change in clients (Yalom, 2005). They represent a middle level of abstraction between general theories and concrete techniques. Theories, such as humanistic, psychodynamic, and cognitive-behavioral, comprise the highest level of abstraction. They offer a framework for understanding the origin and treatment of problematic behaviors and, often, a philosophical view on the nature of human life. Therapeutic factors, the middle level of abstraction, refer to specific clinical strategies such as catharsis, counterconditioning, and contingency management used to obtain the desired change in a client’s dysfunctional behavior. Techniques, the lowest level of abstraction, are observable clinical procedures designed to implement the therapeutic factors (e.g., sand play, role-playing with puppets, storytelling).

Therapeutic factors have been given various names in the psychotherapy literature, such as therapeutic powers, change mechanisms, mediators of change, causal factors, and principles of therapeutic action. These terms have been used interchangeably to refer to the same concept: the overt and covert activities various theoretical systems use to produce change in a client. A therapeutic power may involve a thought or a behavior. What they have in common is their effectiveness in producing a positive change in the client’s presenting problem.

Therapeutic powers transcend culture, language, age, and gender. They are considered to be “specific” factors versus “common” factors in psychotherapy (Barron & Kenny, 1986). Specific factors refer to causal agents of change specific to a particular therapeutic approach, such as a
therapeutic method like child centered or integrative treatment. Common factors, on the other hand, refer to change agents common to all theoretical orientations, such as establishing a supportive relationship and the instilling hope.

**HISTORICAL BACKGROUND**

Initially, the literature on therapeutic powers was largely anecdotal and consisted of clinicians describing the change principles they found effective in treatment. Corsini and Rosenberg (1955) are considered the first to offer a taxonomy of therapeutic factors in psychotherapy. They reviewed the group psychotherapy literature for observations reflecting therapeutic powers and compiled a list of nine factors. Irving Yalom (2005) expanded the list to 11 factors, which he described in his classic group psychotherapy text. In accord with his belief that other group members are the major source of change for group members, his factors included “universalism” (the realization you are not alone and others are struggling with the same problem), “vicarious learning” (client improves in response to the observation of another group member’s experience), “catharsis” (release of pent-up feelings in the group), and “interpersonal learning” (learning from personal interactions with other clients in the group).

Interest in identifying and researching the specific therapeutic powers in other forms of psychotherapy (e.g., individual, couples, and family therapy) has grown in recent years (Ablon, Levy, & Katzenstein, 2006; Holmes & Kivlighan, 2000; Spielman, Pasek, & McFall, 2007; Wark, 1994).

**THERAPEUTIC POWERS OF PLAY**

The therapeutic powers of play refer to the specific targeted aspects within treatment in which play initiates, facilitates, or strengthens the therapeutic effect. These powers of play act as mediators that positively influence the desired change in the client (Barron & Kenny, 1986). In other words, play actually helps produce change in the child’s feelings, thoughts, and behavior during therapy. Play is an integral part of the treatment process. Play is not just a medium for applying other change agents, nor does it just moderate the strength or direction of the therapeutic change. It is not an ancillary add-on to the treatment approach, but is rather a key component essential within the treatment approach.

Based upon a review of the literature and the clinical experiences of play therapists, Schaefer (2012) identified 20 core therapeutic powers of play. Among these therapeutic powers are change agents, specific components that improve a client’s attachment formation, self-expression, emotion regulation, resiliency, self-esteem, and stress management, among other things.

**TRANSTHEORETICAL MODELS OF PLAY THERAPY**

The therapeutic powers of play transcend particular models of play therapy by defining treatment in terms of cross-cutting principles of therapeutic change (Castonguay & Beutler, 2005; Kazdin & Nock, 2003) seen within the client’s treatment. Some play therapists will be interested primarily in the narrow range of change agents underlying their preferred theory. For example, therapists who prefer cognitive-behavioral therapy focus on thoughts, feelings, and behaviors. These are
consistent with the therapeutic powers of problem-solving skills, role-playing, and self-esteem, but they do not address others, such as the power of attachment. A growing number of play therapists will seek to understand and apply all of the multiple change agents in the play therapy sessions they conduct.

By adopting a transtheoretical orientation (Prochaska, 1995), play therapists avoid becoming locked into a single theory they then must apply to all clients in a one-size-fits-all, procrustean bed manner. Clearly, no single theoretical approach has proven strong enough to resolve all the diverse presenting problems of clients. Indeed, empirical research has supported the differential therapeutics concept that certain change agents are more effective for specific disorders than other agents (Frances, Clarkin, & Perry, 1984; Siev & Chambless, 2007).

Transtheoretical play therapy entails having a solid theoretical base with which you initially view the whole treatment case, symptoms, and so on. Once solidly grounded in this one theoretical frame, play therapists can begin to select and add to their repertoire the best change agents from among all the major theories of play therapy. Among the underlying premises of this transtheoretical approach to psychotherapy are the following:

- Each of the major theories of play therapy has practical change agents that can increase one’s clinical effectiveness (Prochaska, 1995).
- The more therapeutic powers of play in one’s repertoire, the better able the play therapist will be to integrate, in a prescriptive and flexible way, the selection of the therapeutic powers with the best empirical support for treating a particular disorder (Schaefer, 2011).
- With multiple therapeutic powers at their disposal, play therapists can implement an evidence-based treatment plan that prescriptively tailors the play intervention to meet the individual needs, symptoms, and preferences of a client and is based on the play therapist’s own skills and judgment (Schaefer, 2001). The overarching aim of prescriptive play therapy is to individualize a treatment plan so as to answer Gordon Paul’s famous question: “What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances, and how does it come about?” (1967, p. 111).
- Therapists who have mastered multiple therapeutic powers can integrate several of them so as to strengthen the impact of a play intervention when the client’s psychopathology is complex, multidetermined, and/or long-lasting.

Theoretical integration involves the synthesis of two or more therapeutic powers in the belief the resulting integration will surpass the effect of a single therapeutic power. The integrative movement, in which therapists shift from adherence to a single theory to a broader orientation, has become particularly strong of late in the field of play therapy (Drewes, Bratton, & Schaefer, 2011). However, it is important to underscore that play therapists should first become solidly grounded in one theoretical approach before integrating additional theoretical approaches into their treatment work.

The field of play therapy is advanced by the trend toward the application of a transtheoretical approach to play therapy. Although various labels have been applied to the transtheoretical play therapy movement (e.g., prescriptive, prescriptive/eclectic, integrative play therapy), it is characterized by dissatisfaction with single-school approaches and a simultaneous desire to look beyond school boundaries to determine what play therapy change mechanisms contained in other theories can be learned and added to one’s practice. The ultimate aim of doing so is to enhance one’s effectiveness and efficiency as a play therapist.
MAJOR THERAPEUTIC POWERS OF PLAY

The therapeutic powers listed below are the actual mechanisms that bring about change in our clients. Play initiates, facilitates, or strengthens their therapeutic effect (Schaeffer, 2012).

Facilitate Communication

1. Self-expression
2. Access to the unconscious
3. Direct teaching
4. Indirect teaching

Foster Emotional Wellness

5. Catharsis
6. Abreaction
7. Positive emotions
8. Counterconditioning of fears
9. Stress inoculation
10. Stress management

Enhance Social Relationships

11. Therapeutic relationship
12. Attachment
13. Sense of self
14. Empathy

Increase Personal Strengths

15. Creative problem solving
16. Resiliency
17. Moral development
18. Accelerated psychological development
19. Self-regulation
20. Self-esteem

1. Self-Expression

The ability to communicate is one of the most powerful tools we possess. In therapy, it allows clients to express their conscious/unconscious ideas and emotions, and it allows therapists to impart their knowledge and wisdom to clients. Play is the most universal of all languages, and it is used as a form of expression by people of all ages in every country across the world.

Self-expression as a therapeutic factor in play therapy and in facilitating healing in children has been written about by numerous noted clinicians (Axline, 1969; Badenoch, 2008; Elkind, 1981; Landreth, 1993; Piaget, 1951). Providing a safe and open relationship in which children lead the play activates areas of the limbic system (Badenoch, 2008). Once this system is activated, the release of dopamine provides a sense of enjoyment, focus, and the drive to complete tasks. In the presence of a supportive adult, children can find access to this system quickly (Badenoch, 2008). Further, the circuits of the middle prefrontal area and emotions of the
limbic system balance and eventually help the child to develop the capacity for self-regulation (Badenoch, 2008).

Among the reasons client self-expression is therapeutic are it promotes a deeper awareness of one’s disturbing thoughts, feelings and conflicts; it allows for the validation and normalization of one’s thoughts and feelings, as well as the correction of erroneous beliefs; and it strengthens one’s sense of self. The features of play that facilitate clients’ self-expression are: natural language, talking in the third person, an “as if” or not-real-life quality, indescribable, engrossment, and doing while talking.

**Natural Language**

Characteristically, young children do not have the vocabulary or abstract thinking abilities needed to verbally express their inner worlds. However, they can readily express their thoughts, feelings, and wishes through their natural medium of expression: play.

Piaget (1951) stated, “Play provides the child with the live, dynamic, individual language indispensable for the expression of his subjective feelings for which collective language alone is inadequate” (p. 166). He cited evidence from developmental studies on cognition indicating that for children in primary school (ages 5 to 11), the use of concrete play materials and activities is more suitable than verbal abstractions as a means of self-expression. According to Landreth (1993), toys are used like words by children, and play is the child’s language. He observed that play allows children to play out their problems, concerns, and feelings in a manner similar to the process of talk therapy with adults.

**Talking in the Third Person**

Pretend play allows children to talk in the third person, that is, to have dolls, puppets, and make-believe characters express or act out the thoughts, feelings, and behaviors that are too difficult or threatening for children to express directly. This symbolic play allows for indirect expression and provides the necessary psychic distance from reality so the child does not become overwhelmed with negative affect or embarrassing thoughts. For example, it is common for child victims of physical abuse to have miniature child dolls being hit by parent dolls, and then to have them hitting the parents back.

**An “As If” or Not-Real-Life Quality**

Because make-believe play is apart from real life, children can express emotions, drives, and thoughts in play that they would not express in real life. Play presents clients with “plausible deniability concerning upsetting material, i.e., it permits clients to suspend and if necessary to disavow its reality. After all it’s just pretend or a game” (Levy, 2008, p. 284).

**Indescribable**

At times, we cannot express inner states well in words, but we may be able to depict them better in one of the creative arts such as drawing, dance, or play creations. Isadora Duncan, a world-renowned dancer, once said, “If I could say it, I wouldn’t have to dance it (2015).”

A sandtray creation, for example, can translate a personal experience into concrete three-dimensional form. Just as a picture can say more than a thousand words, a sand scene can express feelings and conflicts for which the client previously had no verbal language. Hence, the sand scenes constructed in the playroom can offer a rich and highly individualized medium for preverbal and nonverbal expression.
Engrossment
The intense affective involvement typical of play tends to result in overcoming self-consciousness. As a result, children are more likely to inadvertently express things they would ordinarily not express. In the safe, enjoyable environment of the playroom, children are likely to let their guard down and reveal their inner self, both in words and in play activities.

Doing While Talking
Often, doing something like playing allows a child a level of ease that facilitates talking.

2. Access to the Unconscious
Sigmund Freud (1913/1919) defined “dream work” as the mental processes that transform unacceptable, unconscious wishes and impulses into acceptable, if often undecipherable, conscious dream images. This dream work is adaptive because it allows people to sleep undisturbed by thoughts and impulses that, if known, would awaken them and cause distress. According to Elkind (1981), “play work” is a parallel mental process and serves as the royal road to the child’s unconscious. Interpretation by the play therapist is often needed to decipher the hidden meaning and provide the client with insight into unconscious mental processes.

In both play work and dream work, one primarily bypasses the censorship of the superego by fostering the use of the defense mechanisms of projection, displacement, symbolization, sublimation, and fantasy compensation.

Projection
Projection is a process in which one attributes unacceptable parts of oneself, such as thoughts, feelings, or impulses, to individuals or play objects. This can be done in either a conscious or an unconscious manner. It’s a way of believing certain characteristics belong to someone or something else rather than taking responsibility for them.

Displacement
Displacement in the playroom involves taking out one’s frustrations, feelings, and impulses on play objects because they are less threatening. Displacement of aggression is a common example of this defense mechanism. Rather than verbalizing angry feelings toward the mother, a child may spank a doll in the playroom when the child really would like to hit mother for having been punished by her.

Symbolization
Symbolization means using a concrete thing to represent an abstract concept (e.g., a skeleton to represent death, a volcano to represent hostile feelings, a boat in a storm to represent feelings of vulnerability). The process of symbolization enables one to establish meaningful connections between different realms of experience based on proximity and likeness. Symbols allow us to express that which is inexpressible in words. For example, a school-age boy drew a series of images of parrots with powerful male bodies but weak wings. In real life, the boy was being given much adult responsibility but little freedom to make his own decisions or to pursue his own interests.
Sublimation

Sublimation is a defense mechanism that allows one to channel libidoinal drives, both aggressive and sexual impulses, into socially acceptable activities such as art and sports. Sand, water, paint, and clay play provide excellent ways to gratify unconscious anal and urethral drives. Cap guns, sparklers, and flashlights can help sublimate fire-setting impulses into socially acceptable play activities. A teenager experiencing difficulty controlling anger or hostile feelings might take up football or kickboxing as a means of finding a useful outlet for such feelings.

Fantasy Compensation

The principle of compensatory activity is familiar to all of us. When one's needs, impulses, and wishes are unfulfilled, one tries to obtain satisfaction through fantasy gratification, such as pretend play, movies, and books. Fantasy compensation is a defense mechanism in which the weak can become strong, the neglected are nurtured, and the poor become rich (Robinson, 1920; Vygotsky, 1978). For example, a young boy whose father went bankrupt played as if his family lived in a 100-room mansion.

3. Direct Teaching

In direct teaching, the therapist imparts knowledge or skills through such strategies as instruction, modeling, guided practice, and positive reinforcement. Children learn and remember best when they are taught in an interesting and enjoyable manner, such as through play activities. When we make learning fun and enjoyable, we increase children's motivation to spend time and effort learning. Studies of children's television shows such as Sesame Street and Blue's Clues have provided strong evidence of the value of combining learning and play. The best teachers have always tried to make learning fun and enjoyable. When this happens, changes in the chemical balance in the blood have been found to boost the production of the neurotransmitters needed for alertness and memory. John Locke, the eminent British philosopher, once said:

I have always had a fancy that learning might be made like play and recreation to children; and that they might be brought to a desire to be taught, if only learning were proposed to them as a thing of delight and recreation, not a business or a task. (1693, p. 9)

Apart from increasing the motivation to learn when the play therapist makes a learning task playful (Webster & Martocchio, 1993), the special qualities of play that foster learning by directive teaching include the following.

Attention Is Captured

Toys and play materials attract and hold a child's attention through their colorful and novel appearance (Wood, 1986). Only after the play therapist has a child attending and listening can the play therapist teach the lesson.

Sensory Input

Young children think and learn primarily through their senses, not by abstract thought. The more senses used in the learning process, such as through three-dimensional play objects, the more the information is retained.
Safe Environment
In the safe environment of the playroom, there is no evaluation or fear of failure, so the child can ask questions and take risks during the learning process. Children do not learn well if they feel threatened or stressed. A relaxed, enjoyable learning environment is best for learning (Moyles, 1989).

Active Involvement
Children tend to actively explore, become involved, and often get deeply engrossed in the play activities. Active, self-initiated learning experiences are more effective than just passively listening to instruction.

Consolidation of Skills
In addition to learning new things, play allows children to practice behaviors already known over and over again. Thus, play can consolidate skill development through repetitive practice (Piaget, 1951). The pleasure one gets from repeatedly shooting a basketball through a hoop can lead to solidifying that particular skill. In a similar manner, play helps children learn social skills, assertiveness, and anger control skills by frequently rehearsing them (Kelly, 1982). In play, one can practice a skill without fear of consequences for making a mistake.

Learning by Example
Toys such as stuffed animals, dolls, and puppets can be used to demonstrate and model the adaptive behavior the therapist wants the child to learn (Danger, 2003). Modeling to enhance problem-solving or social skills often involves a coping strategy. Thus, toy models initially display less-than-ideal coping skills and then gradually become more proficient (Bandura, 1977).

4. Indirect Teaching
Play therapists often provide guidance to their clients indirectly through the use of stories and metaphors. Storytelling is a universal and enduring way to teach children adaptive behaviors. Stories stir the emotions and arouse one to action. Play therapists tell stories to indirectly teach children life lessons or solutions to their problems in a way that reduces defensiveness by bypassing the censorship of the ego and superego. The therapeutic use of stories allows children to distance themselves from painful themes and deal with them symbolically (Carlson & Arthur, 1999). The process of selecting appropriate therapeutic stories involves finding those that reflect the child's identity and problem situations accurately and result in positive and achievable problem resolution. The use of stories in play therapy allows children to read or hear about others who have overcome problems similar to their own, giving them the opportunity to apply what they have learned from the stories to their own real-life situations. Published stories with therapeutic messages can be used (Pardeck, 1990), or play therapists can create their own individualized stories.

The creative use of metaphors can also fuel learning, foster therapeutic insights, and provide new solutions to problems (Friedberg & Wilt, 2010; Linden, 1985). The metaphor is typically viewed as a verbal form of expression in traditional talk therapies and excludes nonverbal metaphors children use when they express themselves through play (Chesley, Gillett, & Wagner, 2008).
5. Catharsis

Catharsis involves the release of pent-up negative affect, such as anger or sadness. Throughout the history of humanity, catharsis has been considered to have a strong healing effect and has been applied in religion, literature, and drama. It is regarded by many as a major mechanism of change in psychotherapy.

Catharsis is believed to produce therapeutic change by not only discharging deeply felt emotions that have been stored up, but also by increasing one’s conscious awareness and control of those feelings. By deliberately expressing a strong emotion, one is likely to experience power over it. A shift from an external locus to an internal locus of control can then occur. Also, catharsis allows one the satisfaction of completing some or all of a previously restrained or interrupted sequence of self-expression. In the safety of the playroom, one can verbally or physically express that which would have occurred as a natural reaction to some upsetting experience had the expression not been thwarted at the moment (Nichols & Efran, 1985). This termination of “unfinished business” prevents future emotional arousal.

The Role of Play

Play contributes to the effectiveness of catharsis in several ways:

- The playroom provides a safe and supportive environment in which to vent negative affect.
- Symbolic play expression provides sufficient psychological distance from the experience of the painful affect. Physical play activities such as pounding clay allow the release of both physical tension and negative affect.
- The positive feelings aroused in play (power, fun) help to balance the negative emotions released.

6. Abreaction

Abreaction, a psychoanalytic term, can be defined as a mental process in which repressed memories of a traumatic event are brought to consciousness and are reexperienced with an appropriate release of negative emotions. The premise is that we have a basic need to assimilate emotionally significant experiences into a unified, coherent conceptual system. Unassimilated experiences will keep reemerging into consciousness so as to accomplish assimilation.

The Role of Play

The abreaction goals of cognitive assimilation and emotional release are achieved in play therapy through the following mechanisms.

Miniaturization of experiences

The small toys used to re-create the trauma experiences give children a sense of power over the event.

Active control and mastery

Children actively control the playing out of a trauma event that had been experienced passively. They can change the ending of the reexperiencing to one of mastery of the trauma, resulting in a cognitive restructuring of the experience.
Piecemeal assimilation by repetition

Children will typically reenact the trauma over and over again in their play and, if all goes well, this ultimately results in successful processing and resolution. Thus, repetition allows for a slow-paced healing process. Freud termed this process of habituation the repetition compulsion (Freud, 1919).

By playing out the trauma in the form of a story, the child can form a coherent narrative from the often-fragmented memories elicited by the trauma and place these within a larger context, rather than framing the trauma as a personalized attack. The concrete play materials facilitate the recall of vivid sensory details of the trauma, which tend to be stored in right hemisphere of the brain.

Pretend play can allow children enough psychological distance from the reenacted trauma to prevent them from being overwhelmed by the accompanying negative affect. The positive affects resulting from the play can help to balance any negative emotions felt by the child.

Abreaction in the playroom offers an opportunity for a “corrective emotional experience.” According to Alexander and French (1980), after a trauma, children need not only a cathartic release of negative affect but also a corrective emotional experience, which can be obtained from the acceptance and empathic response of a therapist to their painful reexperiencing of it in play therapy.

7. Positive Emotions

People at play experience a number of positive emotions, including joy, mirthfulness, excitement, interest, flow, and delight. Studies have confirmed children at play exhibit more positive affect expressions than those not at play (Moore & Russ, 2008). In addition to contributing to an overall sense of happiness (Lyubomirsky, King, & Diener, 2005), it is believed that positive emotions have healing powers as well. A positive emotional experience can be the healing force that precipitates change in psychotherapy.

Positive feelings provide a balance to the preponderance of negative emotions we experience during stressful times. They produce a feeling of relief and respite from the weight of negative emotions. The filling of your “well-being well” with positive emotional experiences can help one break out of the strait jacket of negativity (Fredrickson, 2001). The most natural way to experience positive emotions is through play.

8. Counterconditioning of Fears

Counterconditioning refers to the reduction or extinction of an undesirable response to a stimulus (e.g., fears/phobias) through the introduction of a more desirable, often incompatible, response (e.g., relaxing, feeding, playing). Counterconditioning is usually combined with Wolpe’s (1958) systematic desensitization procedure by gradually exposing a client to a fear-producing situation while the client experiences a positive emotion incompatible with fear, such as mirth, merriment, or a powerful mental image. In vitro desensitization is used to overcome imagined threats (e.g., monsters), and in vivo desensitization refers to real life threats (e.g., spiders).

The Role of Play

There are numerous reports in the literature of the use of play to help children countercondition and thus overcome both actual and imagined threats. Mikulas, Coffman, Dayton, Frayne, and Maier (1986) trained parents to use game play and a storybook to successfully reduce...
darkness phobias in their children aged 4 to 7 years. Francisco Mendez developed an “emotive performances” (EP) treatment package for use by therapists to treat darkness and other childhood phobias (Mendez & Garcia, 1996; Santacruz, Mendez, and Sanchez-Meca, 2006). The EP consists of in vivo exposure to a phobic stimuli. The treatment is applied as a game in a gradual, brief, and repeated way. The EP is an in vivo alternative to the “emotive imagery” technique. King, Heyne, Gullone, and Molloy (2001) outline clinical strategies for the use of emotive imagery in the treatment of childhood phobias, such as imagining a favorite superhero at one’s side for protection when in a dark room.

Croghan and Musante (1975) used game play to overcome high-building phobia in a 7-year-old boy. Wallick (1979) eliminated an elevator phobia in Sally, a 2-year-old girl, by creating an elevator game. The game was played with a basketball, a 5-foot-high basketball hoop, and an imaginary elevator button. Sally would press the “button” and mimic sounds suggestive of an elevator while the therapist lifted her to the goal. After 4 weeks of elevator play, Sally was able to ride a real elevator with the therapist without difficulty. Nevo and Shapira (1989) described the use of humor by pediatric dentists to counteract dental fears in children. Dentists create a playful and humorous atmosphere by using humorous rhymes, incongruities, absurdities, exaggerations, and puns. Ventiis, Higbee, and Murdock (2001) helped college students conquer their strong fears of spiders through humor desensitization.

Levine and Chedd (2006) developed “replays,” a playful technique in which autistic children use interactive play to practice and master daily upsets, such as tooth-brushing or putting on shoes, for a toddler with heightened sensory sensitivities. Through replays, the adult playfully acts out how the child should handle the situation. During the reenactments, amusing, highly positive affect play is paired with limited but tolerable amounts of the negative emotions triggered by the stressful events. Through this desensitization practice, the child is able to tolerate and master previously aversive, anxiety-provoking experiences. The adaptive doll play technique also uses play reenactments to help children overcome fears and anxieties, such as separation anxiety (Danger, 2003).

9. Stress Inoculation

The stress inoculation power of play is intended to help clients prepare themselves in advance to handle stressful events successfully and with a developmentally appropriate amount of anticipatory anxiety. The use of the term inoculation is based on the idea that a therapist is inoculating or preparing clients so they become resistant to the effects of stressors in a manner similar to how a vaccination works to make patients resistant to the effects of a particular disease (Meichenbaum, 1993).

A basic rationale behind this strategy is the “work of worrying” hypothesis of Janis (1958). When facing an upcoming stressful event (e.g., surgery, separation from a loved one), people may engage in a mental rehearsal of what is likely to take place when they actually experience the event. Such preparatory worry will, according to Janis, minimize reactions to the stressor, strengthen reality-based expectations about how to cope with the danger, and enable the individual to make plans for taking protective actions against the event. Janis concluded that a moderate amount of worry works best.

For over 35 years, Donald Meichenbaum has been involved in the development of stress prevention and reduction procedures under the label of “stress inoculation training” (Meichenbaum, 1985). Clinicians using stress inoculation training help individuals prepare for and prevent maladaptive responses to upcoming stressful events by enabling them to build on the strengths and resiliency they bring to challenging situations.
The Role of Play

How does play-based stress inoculation work? First, the therapist directs the child’s play by presenting toys related to the upcoming stressful event (e.g., medical toys for a planned medical procedure). Then the therapist plays out with the play objects exactly what will happen to the child in real life. If starting school is the upcoming stressor, the therapist would play out the child doll getting on the miniature school bus, greeting the teacher, taking a seat in the pretend classroom, and so forth. Questions asked by the child would be answered honestly. This play rehearsal would be repeated until the experience becomes familiar and predictable. The concrete, multisensory toys and play actions help the child better understand the event. Also, by taking an active role in playing out the stressful event, the child can gain a sense of power over the stressor that is uncontrollable in real life. For example, a child may play the role of the powerful doctor giving the child doll a needed injection.

The elements of the play rehearsal that fortify the child and enable him or her to handle the future stressor are:

- The strange experience becomes familiar and predictable, and thus less scary.
- The child learns and practices coping skills for dealing with the stressor.
- The fun and enjoyment of this play rehearsal act to reduce the activation of negative emotions during the play.

10. Stress Management

Play can be an excellent antidote to children's stress because it allows them to work through the stresses they encounter and emerge with a stronger self-concept and renewed optimism about the future. As Erickson (1976) stated, “to play it out is the most natural self-healing measure childhood offers” (p. 475). Or in the words of an 8-year-old girl describing her play therapy experience: “In here I turn myself inside out and give myself a shake, shake, shake, and finally I get glad all over that I am me” (Axline, 1969, preface).

The Role of Play

The following are among the numerous ways play can serve as a stress-buster for children.

Humor therapy

Fun and laughter are powerful antidotes to stress reactions. In fun play therapy, the therapist acts in a comical way to trigger smiles and laughter in the child. Over the past 40 years, empirical studies on laughter have documented its effectiveness in reducing stress reactions (Borcherdt, 2002; Galloway & Cropley, 1999), including:

- Physical benefits. Laughter lowers blood pressure and boosts our immune system by decreasing stress hormones and increasing both immune cells and infection-fighting antibodies.
- Psychological benefits. Laughter triggers the release of endorphins—the body’s natural “feel good” chemicals. Endorphins elevate our mood and promote an overall sense of well-being. Even when facing threatening situations, humor can help to “distance” oneself from the experiences by taking one’s self or one’s experiences less seriously, thereby reducing emotional reactions to the stressors (Lefcourt, 1995).

A well-known example of humor therapy is the use of clown doctors to alleviate the stress symptoms of children hospitalized for medical procedures (Fernandes & Arriaga, 2010).
Fantasy compensation
A 5-year-old boy, in foster care, after removal from a home where he was malnourished and neglected, played out a scenario in which he had a banquet for just himself with servants bringing him unlimited amounts of food to eat.

Adaptive doll play
This technique involves therapists using doll-play scenarios that replicate real-life difficulties to model adaptive ways to resolve the distress. For example, doll play can be used to model ways a child can handle separation from parents (Danger, 2003), relate to a new baby, start school, or cope with a doctor visit. Pretend play with dolls allows children to enact disturbing situations over and over until they habituate and feel more comfortable (Campbell & Knoetze, 2010).

A study by Barnett (1984) found that after preschoolers who were anxious on the first day of school were allowed to play with family dolls, they were less distressed than anxious children to whom someone simply read a book.

Self-soothing play
Children can self-soothe in times of stress by playing with sensory materials (e.g., water, clay, sand, paints, sensory balls, bean bags) or by cuddling with a security object, such as a teddy bear (Winnicott, 1953).

Fantasy escape
Pretend play and game play can provide a temporary escape from the stresses and pressures of real life.

11. Therapeutic Relationship
The majority of therapists consider the therapeutic relationship to be the most important ingredient in successful therapy (Kazdin, Siegel, & Bass, 1990). Without the establishment of a helping relationship, no technique or strategy is likely to be effective. Meta-analytic studies (Shirk & Karver, 2003) have confirmed that the therapeutic relationship is related to positive outcome across diverse types and models of child treatment. After forming an initial alliance, the task of the therapist is to establish an ongoing relationship that motivates the client to continue to engage in the therapy tasks. The characteristics of the therapist that are frequently listed as desirable to the formation of a therapeutic relationship are: warmth, caring, understanding, acceptance, respect, and trust. These traits reflect the qualities of a good interpersonal relationship in general.

The Role of Play
Several unique qualities of play help build a therapeutic relationship.

• The positive affects triggered by play are conjunctive emotions that connect us with other people. A mutually enjoyable activity like play creates a “pleasure bond” between two people, strengthening the relationship.
• Masselos (2003) found that if play therapists are fun to be with, children view them as more trustworthy, caring, and approachable.
• By smiling and laughing, play therapists signal to the child that they are friendly and safe to be around (Hanline, 1999).
• When children laugh with an adult, they feel they are on a level playing field with the adult—that they are in an egalitarian rather than a hierarchical relationship. Also, a reciprocal model of therapist–child interaction can be fostered in play by turn-taking in game and block play.
• The excitement sparked by play can enliven and energize a relationship.

12. Attachment

Attachment refers to the affectional bond formed between infant and caregiver (Bowlby, 1969). All infants seek to form affective ties with their parents so as to meet their needs for physical and psychological safety (Ainsworth, Blehar, Waters, & Wall, 1978). Attachment enhances the infant’s chances of survival because it keeps the infant in close proximity to a stronger and wiser figure. In both infancy and adulthood, researchers have amply demonstrated that attachment security predicts individual differences in relationship functioning, affect regulation, and psychopathology (Cassidy & Shaver, 1999).

The Role of Play

When infants express their first social smiles, they become more attractive to their parents. Smiles and laughter activate the reward center in the right brain of both parent and child, and bonding is facilitated (Nelson, 2008). Playful interactions between parent and child that produce smiles and laughter are likely to increase feelings of attachment in the child. Indeed, Maccoby (1992) asserted that intense, positive, affectively charged interactions between parent and infant help form the initial basis for bonding.

Examples of Attachment Play

• Peek-a-boo
  A mother plays peek-a-boo with her 1-year-old daughter by hiding her face repeatedly with a towel, and then when mother's face appears each time, the infant smiles broadly and waves her arms excitedly. The roles are then reversed and mother smiles and laughs when her daughter's face reappears.

• Tickle tunnel
  A mother stands and makes a tunnel by spreading her legs apart. The child runs through the tunnel and gets tickled on the way through. The child screams with joy.

• Running hug game
  A father sits on the floor, after a long day, and the child comes running from the other end of the room and crashes into his arms with a big hug, sometimes knocking the father over in the process. Father and child then roll around on the floor laughing.

• Horsey
  Father gets down on his hands and knees and child climbs on his back to enjoy a horseback ride around the room.

No toys are needed for these attachment-oriented play activities. Lawrence Cohen, author of Playful Parenting (2002), observed that from the initial games of peek-a-boo, to hide-and-seek, tickle fights, and rough-housing, there are many ways parents can use these fun interactions as opportunities to connect with their young children.
13. Sense of Self

Everyone is motivated to gain a sense of personal identity, which includes those roles, attributes, behaviors, and associations we consider most important about ourselves. Self psychologists (Kohut, 1971) believe the outcome of healthy development is a cohesive and integrated sense of self. Philosophers from Plato to Sartre (1956) have observed that people are most human, whole, free, and themselves when they play. According to philosopher Erich Fromm (1994), a man's main task in life is to give birth to himself.

The Role of Play

In young children, the sense of self, which is nascent and in flux, is largely developed through play. Free from reality constraints, play provides children with opportunities for self-definition, to reveal what they choose to do and who they choose to be, and to integrate right and left brain functioning and primary and secondary process thinking.

Freedom

The realization of the self is the ultimate goal of child-centered play therapy. This humanistic, nondirective approach gives the children freedom to think for themselves, to make their own decisions, and to solve their own problems. By mirroring responses, the play therapist further promotes the children’s self-awareness. Virginia Axline (1964) described the growth of the self in an autistic child in her famous case illustration of child-centered play therapy entitled Dibs: In Search of Self.

Imagination

In play, children imagine and play out different possible selves. As George Bernard Shaw once said, the imagination is the beginning of self-creation. First one imagines what is desired, then the individual wills what is imagined, and at last the individual creates what is willed.

Primary process thinking

Margaret Lowenfeld (1935/1991) pioneered the use of sandplay therapy to help children become aware of their “forgotten selves.” By creating worlds in the sand, children reestablished communication with their primary process thinking (i.e., concrete, emotion-laden, symbolic, and drive-dominated thought).

14. Empathy

Empathy refers to the ability to take the perspective of others and imagine what they are thinking and feeling. The ability to empathize is an important part of social and emotional development, improving the quality of social relationships, and promoting altruistic behaviors. The effects of a lack of empathy in humans can be seen all around us in wars, crime, inequality, prejudice, and antisocial behavior.

The determinants of empathy include both internal, neurological factors and external, environmental factors. A key to understanding how empathy is fostered neurologically is the action of mirror neurons. Discovered in primates in the 1990s, mirror neurons are a set of neurons in the premotor area of the brain that are activated not only when performing an action oneself, but also while observing someone else performing that action. It is believed mirror neurons increase an individual’s ability to understand the behaviors of others, an important skill in social species.
such as humans (Iacoboni et al., 2005). It has also been observed that children with autism have abnormally low activation in the premotor area of the brain that contains the mirror neuron system while initiating and observing emotions. The lower the activation, the greater the social impairment (Dapretto et al., 2005).

The Role of Play

In regard to external influences on the skill of empathy, play fosters the development of empathy in children in numerous ways, particularly by role-playing and storytelling by adults.

Role-play

Role-play occurs when play therapists transform, during pretend play, into people or objects other than themselves, as indicated by the verbal or motoric enactments of their perceptions of the role. There is evidence that role-playing promotes perspective taking—imagining the thoughts and feelings of others—which, in turn, promotes the development of empathic and altruistic behaviors.

For example, numerous studies have shown that sociodramatic role-playing by preschoolers and early elementary schoolers is related to their development of empathy, cooperation, altruism, and ego resiliency (Connolly & Doyle, 1984; Gottman & Parker, 1986; Iannotti, 1978; Strayer & Roberts, 1989). In a study by Connelly and Doyle (1984), preschoolers who engaged in more pretend play involving role-playing received higher likeability and socialability ratings from peers and teachers. In a study involving female undergraduates, Bohart (1977) discovered role-playing the point of view of a provocateur in a conflict situation was a more effective strategy in reducing anger and conflict than catharsis, intellectual analysis, or no treatment.

Storytelling

Stories facilitate children’s understanding of the thoughts, feelings, and motives of others. Thus, by listening to stories, children develop empathy and compassion for others. According to Manney (2008), it is the imaginative act of the listener/reader translating the words on the page into thoughts and feelings that enables them to see the world through the characters’ eyes and feel their feelings. The recognition that humans share common bonds, goals, and aspirations also facilitates empathy. If play therapists regularly place themselves in the shoes of different characters and experience empathy for them, this recurring behavior cannot but help but to create a more empathic personality in children (Manney, 2008). As with a muscle, empathy gets stronger with regular exercise.

15. Creative Problem Solving

Through the use of play in play therapy, the child is able to use various components of creative problem solving resulting in symptom reduction and general progress in treatment. Through the empirical literature, Russ (2004; Russ & Wallace, 2014) found that play relates to or facilitates divergent thinking ability, flexibility in problem solving, problem solving requiring insight, ability to think of alternative coping strategies in dealing with daily problems, experiencing positive emotions, ability to think about affect themes (positive and negative), ability to understand the emotions of others and take the perspectives of others, and aspects of general adjustment.

The “broaden-and-build” theory of positive emotions (Fredrickson, 1998) posits that when people experience positive emotions, which they often do through play, they widen the array of possible thoughts that come to mind. In this open state of mind, they tend to contemplate new
ideas, develop a number of alternate solutions to problems, reinterpret their situations, and initiate new courses of action to resolve difficulties. This creative thinking aids clients in overcoming the narrow, inflexible mindset that keeps them repeating maladaptive behaviors, and thus helps them find successful therapeutic outcomes (Isen, 1999).

16. Resiliency

Resiliency has emerged as a topic of great interest to scientists and the general public (Masten & Coatsworth, 1998). Resilience (from the Latin resilio, “I bounce back”) can be defined broadly as those skills, attributes, and abilities that enable individuals to adapt successfully to hardships, difficulties, and challenges (Alvord & Grados, 2005). Resilient children have been found to have high self-efficacy, strong interpersonal skills, above average intelligence, and good problem-solving skills (Masten, 2001). Individuals with such attributes are variously referred to not only as resilient but also as invincible, hardy, and invulnerable.

The Role of Play

Play behaviors promote resilience in the following ways.

Creative problem solving

Resiliency requires the ability to think flexibly and creatively rather than rigidly in response to changing situational demands, especially stressful encounters. For at least 50 years, scholars from psychology (Bruner, 1972), philosophy (Carruthers, 2002), and psychotherapy (Jung, 1968) have posited a link between play and creative responses to the environment.

Training for the unexpected

Play has the quality of uncertainty. The course of play cannot be determined in advance, nor can the results be attained beforehand. Thus, play functions to increase the versatility of one’s cognitive and emotional responses to unexpected events in which one experiences a sudden loss of control. To obtain this training for the unexpected, both animals (Spinka, Newberry, & Bekoff, 2001) and humans (Pellegrini, 2007; Sutton-Smith, 1998) actively seek and create unexpected situations in play. These unexpected events often involve danger or risk, such as self-handicapping play (deliberately restricting control over one’s movements, or putting oneself in dangerous situations, e.g., battles with monsters, war, death, and injury) (Spinka et al., 2001). Although these themes are of universal concern to children, many adults avoid talking about them and, in the process, increase the anxiety of children and undermine their resiliency. In the safe environment of play, confronting these dangerous situations gives one the opportunity to experiment with a variety of novel and possible adaptive responses. With practice in play, these responses become more accessible when facing life’s unexpected and dangerous situations. In play, the therapist is able to generate a repertoire of positive behaviors that are adaptive in dealing with stressful events.

Positive emotions

Resiliency is also fostered by the many positive emotions one experiences in play. This builds up an inner well of good feelings that can be drawn upon to cope with the negative emotions triggered by daily life stresses.

Numerous studies (Carlson & Masters, 1986) have shown positive emotions to have a mitigating effect on subsequent negative experiences. Positive emotions seem to build a broad range
of coping responses, allowing individuals greater flexibility in using such responses to cope with stress and adversity (Tugade, Fredrickson, & Barrett, 2004). Research has already documented that people who are particularly adept at self-generating positive emotions are more likely to be resilient (Cohn & Fredrickson, 2010; Tugade & Fredrickson, 2004).

**Humor**

The emotions of mirth and delight aroused by humor are particularly helpful because they are incompatible with feelings of stress. A sense of humor has been identified as one of the attributes of protective factors in resilient youth. Research on resilience indicates that a sense of humor (i.e., cognitive play) helps to stress-proof children in conflict. By introducing a comic element into a stressful situation, one can obtain a temporary relief from tension. Indeed, “gallows humor” is the term used to describe the humorous treatment of a grave or dire situation.

17. Moral Development

“Morality” comes from the Latin word “morals,” meaning “customs, manners, or patterns of behavior that conform to the standards of the group (Alvord & Grados, 2005). At every age, individuals are judged by how closely they conform to the group’s standards, and they are labeled “moral” or “immoral,” accordingly. Thus, moral development is related to the rules people have for their interactions with others.

Jean Piaget (1932/1997) was among the first psychologists whose works remains directly relevant to contemporary theories of moral development. In his studies, he focused specifically on the moral lives of children, studying the way children play games in order to learn about their beliefs regarding right and wrong.

**Game Play**

Piaget (1932/1997) argued that children’s spontaneous rule-making in game play (e.g., in deciding what is fair to all players in a game of marbles) provides a crucially important experience in the development of mature moral judgment. Such peer group experiences help the child to move away from the earlier stages of morality based on authority (rules are seen as external, constraining forces arbitrarily imposed and enforced by powerful adult authority figures), to the concept of a morality based on the principles of mutual cooperation and consent among equals. In a similar vein, Chateau (1967) stated that the invention of game rules by children is the root of the human capacity to develop morality. He believed that children, in accepting to follow a rule developed for the common good, express the human capacity to create civilizations. Also, according to Vygotsky’s (1978) theory, as children follow rules in the context of play, they are developing an understanding of social norms and expectations and learning to act against their egocentric impulses.

In game play, children learn about fairness, equality, justice, creating and following rules, respecting oral contracts, and taking action against wrongdoers—things that help children develop a sense of morality and ethical behavior. One of the most surprising findings from child development research is that children’s basic notions of morality appear to stem less from powerful discipline or lessons taught in Sunday school and more from the social interactions with peers during the course of play.

**Role-Play**

Through role-play (e.g., pretending to be a doctor, teacher, police officer), children are able to develop the capacity for empathy—the ability to see and experience things from another’s perspective. This process enables the player to understand the motivations of others, adopt their
perspective, and consider their needs. All of these insights foster the development of morality, such as an allocentric versus an egocentric orientation (Slote, 2010; Wispe, 1987). The golden rule of most religions, do unto others as you would have them do unto you, asserts that the abilities of perspective taking and empathy are the basis for morality.

18. Accelerated Psychological Development

The power of play is significant in accelerating a child’s psychological development through opportunities to practice and develop a multitude of skills (Drewes & Schaefer, 2010).

Theory

Lev Vygotsky (1978) proposed that children have a “zone of proximal development” or a range of tasks between those the children can handle independently and those they can master with the help of adults or more capable peers. Vygotsky (1978) also proposed:

Play creates the zone of proximal development of the child. In play, a child always behaves beyond his average age, above his daily behavior, in play it is as though he were a head taller than himself. As in the focus of a magnifying glass, play contains all the developmental tendencies in a condensed form and is itself a major source of development. (p. 102)

The Role of Play

Once the play therapist makes accomplishing a developmental task a thing of fun and delight, children are motivated to attend to and persevere at the task.

Research

Fisher (1992) conducted a meta-analysis of 800 studies and concluded there is cogent evidence for the positive impact of play on child development. Play was found to significantly promote cognitive and social aspects of development, and these gains were magnified when adults participated in play with children.

Recent studies (Daunhauer, Coster, & Cermak, 2010; Lindsey & Colwell, 2003) continue to find that play accelerates the cognitive, social, and emotional development of young children.

19. Self-Regulation

Self-regulation, or self-control, refers to the ability to control one’s thoughts, feelings, impulses, and behaviors. Self-control has been found to be positively related to both social and academic competence in children. On the other hand, problems with self-control are linked with the etiology and maintenance of a broad array of psychosocial problems, including crime and drug use (Strayhorn, 2002). Unfortunately, studies have shown children’s ability of to regulate and control their behavior has decreased over the past 40 years.

The Role of Play

Preschoolers who play more often or in more complex ways score higher on various measures of self-regulation (Fantuzzo, Sekino, & Cohen, 2004). Children who attend preschools that emphasize play have also been found to score higher on these measures (Hanline, 1999).

Several types of play behaviors in particular, such as the following, promote the development of self-control.
Pretend play

Pretend play involves the use of make-believe and symbolism. When young children engage in imaginative play, they tend to be less impulsive and aggressive (Singer & Singer, 1990). Pretend play helps children put symbols between their impulses and actions. Rather than acting out their impulses, they can express them symbolically in pretend play. Also, during make-believe play, children engage in private speech. They talk to themselves about what they are doing and how they are feeling. This aids in establishing self-awareness and emotion regulation (Berk, 1986).

Sociodramatic play

This collaborative dramatic play involves sustained, elaborate, imaginary play in which children make a plan, stay in character (doctor, teacher, salesperson), and act out this alternate world for an extended period of time. In sociodramatic play, children have to subordinate themselves to the role they are acting. This often means acting against their own impulses and wishes. Self-control is also strengthened by coordinating one’s role with the role of others to portray a coherent story (Vygotsky, 1967). Social pretend play has proven particularly advantageous for impulsive children who are behind their peers in self-regulatory development.

Game play

Games like “Simon says” (following the leader), “red light/green light” (the leader says red light to stop the children from what they are doing and green light for the children to go ahead and move), and “statue” (children stand still like statues and hold their positions until the leader says go) help children develop control over their impulses and motor responses. Strategy games like chess and checkers strengthen children’s executive functioning (i.e., their ability to stop and think, plan ahead, consider alternate moves, and anticipate the consequences of their moves).

Self-soothing play

The ability to relax is an important way to cope with stress. There are many different types of relaxing play, such as sandplay, water play, clay play, fingerpainting, guided imagery, and the use of soft play objects, such as teddy bears and squishy balls.

Rough-and-tumble play

The research of Jaak Panksepp and colleagues (Panksepp, Burgdorf, Turner, & Gordon, 2003) has found that frequent access to rough-and-tumble play reduces the impulsivity and hyperactivity of rats with frontal lobe damage. Accordingly, he suggests a regimen of social rough-and-tumble play might be one way to help children with ADHD control their impulsivity.

20. Self-Esteem

The term self-esteem is used to describe a person’s overall sense of self-worth or personal value. Self-esteem can involve a variety of beliefs about one’s self, such as an appraisal of one’s capabilities, competence, achievements, and attractiveness to others. Self-esteem has been widely studied for over 30 years because of its broad influence on one’s personality, behaviors, and motivations. Two of the many ways play boosts children’s self-esteem are through the enhancement of their sense of power/control and self-efficacy.
Power/Control

One of the biggest needs children at every stage of development have is the need to have a sense of personal power and control. Living in a world populated by adult giants, most children feel very little power over what happens in their lives. As a result, they may fight for control by engaging in power struggles or by acting out aggressively, or they may resign themselves to roles of dependent helplessness.

The Role of Play

Play is one aspect of their lives where children feel in control. They determine what and how to play, whether it is shaking a rattle, pretending to be a princess, or building a world in the sand. In play, children are the powerful giants towering over the miniature play objects. Free play provides children with opportunities to control body actions, ideas, objects, and relationships, and is limited only by their interests and imagination.

Specific examples of empowerment play are: (a) playing with toys associated with extraordinary strength or abilities (e.g., superheroes, dinosaurs, dragons, fairies, witches, goblins); (b) playing with aggressive play objects, such as swords or guns; (c) rough-and-tumble play; (d) changing the rules in game play; and (e) playing the role of doctor, teacher, or firefighter.

FUTURE DIRECTIONS

Many prominent psychotherapists have called for a shift in psychotherapy training from an emphasis on broad theories of psychotherapy to a focus on therapeutic change mechanisms. A greater understanding of change agents is of vital importance to play therapists and other clinicians for two reasons:

1. It should improve clinical effectiveness by facilitating a more targeted and efficient treatment delivery through “prescriptive matching” (i.e., the matching of curative factors in play to the underlying causes of a disorder) (Shirk & Russell, 1996).

   In this regard, Kazdin (2001) proposed that the first step in treatment planning be the identification of the core cognitive, affective, and behavioral forces involved in the development and maintenance of a particular clinical problem (e.g., insecure attachment). Once the primary origin(s) of a disorder are uncovered through a comprehensive assessment using a solid theoretical frame, specific therapeutic powers can be applied to elicit change in the factors causing and/or maintaining the disorder.

2. It should encourage the development of a broad repertoire of change agents that transcend adherence to a single theoretical model (Garfried & Wolfe, 1998).

It is the authors’ opinion that play therapists need the full arsenal of the therapeutic powers of play to effectively and efficiently overcome the many forces precipitating psychopathology. In addition to expanded instruction and training on the importance and application of the therapeutic powers in play therapy, we need to substantially expand the number of play therapy process research studies in order to further identify and validate the specific therapeutic powers of play. We believe these change mechanisms are the essence, the heart and soul, of play therapy and, as such, deserve much greater attention from play therapists and researchers.
CONCLUSION

According to Kazdin (2009), understanding and promoting effective treatment is best achieved by understanding the mechanisms of action that cumulatively result in positive outcomes for youth and families. Mechanisms are what is “inside the black box” of a treatment such as play therapy. We know play therapy works, but how and why it works have heretofore received little attention. The multiple healing powers of play therapy account for its effectiveness in addressing the problems associated with a broad array of psychological disorders. These play powers appear to constitute or augment the healing process, rather than simply serving as a medium for the application of other treatment modalities that just use play as an adjunct to the protocol. In other words, play powers are the actual change agents, not just an aid in moderating treatment (Bennett, 2000).

The 20 healing powers of play described in this chapter were selected because they have been frequently and widely mentioned in the play therapy literature. Thus, they may be termed the “mega-powers” of play therapy. However, this taxonomy of play powers is tentative and is not meant to be exhaustive or final. It needs to be continually reworked, refined, expanded, and researched.

Much additional process research is needed to fully understand how play therapy leads to therapeutic change. To this end, Rosen and Davison (2003) advocate for focusing future psychotherapy research on identifying and validating “empirically supported principles of change” and not on broad theoretical approaches, such as humanistic or cognitive-behavioral therapy.

REFERENCES

The Therapeutic Powers of Play


Rosen, G. M., & Davison, G. C. (2003). Psychology should list empirically supported principles of change (ESP’s) and not credential trademarked therapies or other treatment packages. Behavior Modification, 27(3), 300–312.


PART 2

Core Theories
Play therapy based on psychoanalytic and analytic theory began in the early 1900s and continues to be important in the treatment of children and adolescents today. For the psychoanalyst (Freudian), “the personality develops out of the need to fulfill the pleasure principle, all the while attempting to negotiate reality demands without incurring superego strictures” (Lee, 1997, p. 46). For the analytical analyst (Jungian), the personality develops when the conscious and unconscious have “a fluid yet regulated” communication with each other (Allan, 1997, p. 101). Regardless of a therapist’s therapeutic identity, when they make use of the symbolic, they are doing analytic work.

Freud and Jung established the foundations of psychoanalytic and analytical psychology and worked together intensely over a 6-year period from 1907 to 1913. While neither Freud nor Jung worked with children, their followers have extended their theories to include some models suited for work with children and adolescents. Object relations theory, ego psychology and self psychology expanded on Freud’s concepts (Abraham, 1979; Blanck & Blanck, 1979, 1994; Kernberg, 1976, 1980; Klein, 1969, 1975; Kohut, 1971, 1977, 1978). The work of Neumann (1969, 1990a, 1990b) and Fordham (1994), as well as sandplay (Kalff, 2003; Ryce-Menuhin, 1992; Weinrib, 1983), are examples of extensions of Jungian theories. These subsequent modifications are generally referred to as psychodynamic psychotherapies. In this chapter, psychodynamic psychotherapy is not regarded as a singular or separate theory, but rather as a way of working with children and adolescents that considers both psychoanalytic and analytic traditions. This view has become even more pronounced with the advent of infant observation and research because the analytical community now tends to view treatment as an attitude not a technique.

THEORY

A discussion of the major psychoanalytic and analytical psychology theories follows with contributions from the followers of Freud and Jung.
Psychoanalytic

In addition to Freud, the major contributors to child psychoanalysis were Hermine Hug-Helmuth, Margaret Lowenfeld, Anna Freud and Melanie Klein. The principal components of their theories will be presented.

**Sigismund Shlomo “Sigmund” Freud**

Psychoanalysis began with Sigmund Freud’s efforts to develop a therapy that allowed people to reveal and resolve their inner turmoil and anguish in a time when those with mental illness were generally treated with scorn, repressive measures, and/or were institutionalized (Glenn, 1992). By observing hypnosis as conducted by Jean-Martin Charcot, Freud witnessed how talking could free symptoms. He used the method of free association as an analytic technique to access unconscious material in order to free patients from their suffering. As he went on to develop his theory of personality and development, childhood, which had previously been thought to play an insignificant role in the lives of adults, became a central source of the roots of adults’ internal conflicts.

Shortly after this, Freud (1909) worked through Hans's father to treat the 5-year-old son who had developed a phobia of horses. Based on his experiences, Freud conceptualized mental illness not as a single traumatic event, but as a condition that developed over time and was linked with the person’s life history. He encouraged the direct observation of children and the application of psychoanalytic findings to child-rearing practices (Glenn, 1992). Children, Freud thought, desired more than just to be taken care of—they also craved love and physical pleasure and had an intense primitive sexuality (Glenn, 1992).

Recent research has expanded on Freud’s early work on the etiology and consequences of childhood trauma (Kalsched, 1996, 2013; Schore, 2003b). Freud postulated that unconscious contents cause anxiety and pressed for discharge in the conscious mind. However, he also postulated there to be two instinctual drives: sexuality and aggression. He believed the expression of these is in opposition to social organization and therefore must be modified to fit social mores. This inner conflict between the need for instinctual gratification and the need to fit in socially form the basis of Freud's theory. Essentially, the basis of behavior is the discharge of internal tension (Freud, 1953). The mind is always under this pressure, and even if it does not result in neurotic symptoms, it may manifest as slips of the tongue or in jokes. Much of the conflict occurs outside one’s awareness and can only be understood by examining a patient’s behavior to determine its unconscious meaning.

Freud spoke of how these unacceptable thoughts and wishes are kept out of our awareness, repressed, and then expressed only symbolically. There is the conscious stratum, which is awareness; the preconscious stratum, which contains repositories of the past and can be brought into one’s awareness; and, lastly, the unconscious stratum, the contents of which are blocked from awareness by an active censor. This division of mind has been called the *topographic hypothesis* (Bemporad, 1980).

Freud eventually revised his theory to include a structural model and the familiar division of id, ego, and superego to account for unconscious processes not in service of instinctual gratification (Bemporad, 1980). The id consists of raw instinctual activity and psychic energy. The ego is the mind’s central organizing agency representing external reality within the psyche, and mediates between the id and the superego. The superego is the intrapsychic structure representing learned cultural standards. The ego was thought to have arisen from the id and the superego to have developed in later childhood as a form of identification with the parents’ moral values. Thus, the ego was seen as the regulator of the expression of the id from which it came and was there to
assist with handling the increasing conflict children encountered in their transactions with the environment.

When the id, ego, and superego are in balance, the individual functions optimally. Where there is conflict, the use of defense mechanisms comes into play in order to allow the individual to continue to function or to defend against perceived threat, whether real or imagined. Various defenses are considered more primitive than others, for example, denial versus projection. Freud used the term neurosis when a conflict between the id and superego occurs and the ego is unable to resolve this conflict or becomes overwhelmed by depression or anxiety. When this happens, a child may regress to an earlier stage of development or become fixated at the stage of development where the conflict/frustration occurred. Optimum development includes the ability to tolerate frustration and cope with conflict.

Freud also postulated a series of different instinctual forces, each of which become active at different stages of development: the oral, anal, phallic, latency, and genital periods. The oral stage occurs from birth to age 2. The primary goal of this stage is survival and the development of a secure attachment. A hallmark of the secure attachment is the stranger anxiety infants display at about 8 months of age, highlighting the importance of the relationship and differentiation of the caregiver from others. During the anal stage (approximately ages 2 to 4), children's focus is on bodily control and growing awareness of the power of the word no. If successful in this stage, children acquire the beginning sense of autonomy. During the phallic stage (approximately ages 4 to 6), children's psychic energy is concentrated in the genital area. It is also the time when the Oedipal conflict occurs. The Oedipal phase is the period of time when boys want the mother all to themselves and girls want the father to themselves. For satisfactory resolution to occur, they must relinquish these desires and identify with the same-sexed parent. All of Freud's theory focuses on this as the important milestone to be achieved and holds that the major components of the personality are developed by the end of the Oedipal period. The next stage is the latency stage, which runs from the resolution of the Oedipal conflict to the onset of adolescence. During latency, there is a quieting down to consolidate the gains achieved to that point, followed by a resurgence of libido in adolescence with the onset of the biological maturation and sexuality. Now the movement is from cognitive to social development and away from psychosexual development. The last stage is the genital stage, occurring from adolescence onward, and the primary task of this stage is the development of an intimate relationship.

The gratification of children's instincts over the course of these developmental periods results in pleasure, and these instinctual pleasures are precursors of the adult sexual experience. If children experience inadequate satisfaction, the result would be an unconscious need for satisfaction later in life. If patients develop an overly strong preference for any one instinct, this could result in perversions. The excessive persistence of childhood instincts was termed fixation and was seen as having the potential to lead to regression in times of stress. In fact, much of adult psychopathology was explained as a regression to a childhood state of gratification (Bemporad, 1980).

While Anna Freud and Melanie Klein are often credited as those who began the profession of child and adolescent psychotherapy, there are both earlier and parallel influences that set the stage for psychoanalytic work with children and adolescents (Lanyado & Horne, 1999).

**Hermine Hug-Hellmuth**

Hermine Hug-Hellmuth has been described as the world's first practicing child psychoanalyst; her work preceded the work of Anna Freud and Melanie Klein by many years (Lanyado & Horne, 1999; McLean, 1986; Plastow, 2011). She was the first to use and interpret children's spontaneous play and to work with the parents as needed to continue to work with the child; this is unlike Anna Freud, who referred parents for their own analysis, or Melanie Klein, who preferred to have
minimal contact with the parents. In fact, Hug-Helmuth used the child's transference in therapy to orient the work with the parents and the child and to help the parents learn what might be best in terms of upbringing, education, or development. Hug-Hellmuth contributed significantly (Hug-Hellmuth, 1921; MacLean & Rappon, 1991), but her death came prematurely and, at her request, no account of her life or work appears in the literature (Plastow, 2011). Both Freud and Klein used concepts developed by Dr. Hug-Hellmuth, but neither gave her credit. Anna Freud used the more educative and child-raising aspects of Hug-Hellmuth's work with her emphasis on the ego and later on defense mechanisms. Melanie Klein used Hug-Hellmuth's conceptualization of the child's transference and the way she made use of the child's play.

**Margaret Lowenfeld**

In the 1920s, Margaret Lowenfeld established the Children's Clinic for the Treatment and Study of Nervous and Delicate Children. Originally a pediatrician, she left her career to begin the psychiatric treatment of children in London using what she later called the *World Technique*. Previous to her work in London, she was a member of medical missions in Eastern Europe and had personally experienced the ravages of war. She knew some children could survive the horrors of war, but she was wary of how to help given the different languages and cultural backgrounds of the families with whom she was working (Lowenfeld, 1979). She discarded the idea of using language as the primary intervention and thought of introducing objects that might help both the child and therapist better understand what the child was going through.

Based on her memory of H. G. Wells's book *Floor Games*, first published in 1911 (Wells, 2004), Dr. Lowenfeld collected small objects, toys, colored sticks and shapes of paper, metal, and clay and kept them in what her young patients called “The Wonder Box.” These objects were later moved into a cabinet, the contents of which came to be called “the world” by children attending the clinic. The children spontaneously created the new technique of making world pictures in small metal trays half filled with sand. The elements of Lowenfeld's World Technique have remained mostly unchanged since her early work in 1929 (Urwin & Hood-Williams, 1988). She described the goal of this method as being “to find a medium which would in itself be instantly attractive to children and which would give them and the observer a ‘language,’ as it were, through which communication could be established” (Lowenfeld, 1979, p. 281). Thus, Lowenfeld was using the sand primarily as a means for children to express themselves.

**Anna Freud**

Anna Freud is considered one of the founders of child psychoanalysis, having engaged in the direct study of children and working in this profession her entire life. She opened the Hampstead Nurseries of the Second World War, which later became The Hampstead Child-Therapy Clinic. The clinic began providing child psychoanalytic training in 1947 (Sandler, Kennedy, & Tyson, 1980).

Anna Freud's theory was based on the psychosexual stages developed by her father, but she elaborated on them to include the gradual evolution of the child's significant attachments to others from birth to adolescence. Moreover, she delineated the relationship between progress along what was considered normal developmental lines and the formation of psychopathology (Freud, 1965). Here she saw blockages in progression of development as the underlying cause of psychopathology and saw the goal of psychotherapy as being the removal of these blockages so natural, healthy development could occur.

Anna Freud thought the cultivation of a positive transference and analysis of resistances took time and needed interpretation only after a positive relationship was developed with the analyst.
She did not think children developed a transference neurosis, a relationship with the analyst that recapitulates early parental relations, because she believed the child was still quite tied to the parents who are real and present as love objects and not just present in fantasy as they are with adult patients (Freud, 1966–1980). Anna Freud also thought it important to keep in close contact with the child’s parents, and she advocated pedagogy to help the child fit the analytic work and its results into life at home and school. She also thought it important to work from a detailed life history of the child patient and to gain an understanding of the child’s daily life experiences. Klein thought all of these things were both unnecessary and an interfered with the analytic work.

**Melanie Klein**

Melanie Klein was a child analyst from Berlin, and she was the analysand and protégée of Karl Abraham. Klein differed from Anna Freud, saying the superego does not develop solely as a result of the dissolution of the Oedipus complex; rather, it develops in part from the deprivation experience of weaning, which (at that time) most often occurred at the end of the first year or the beginning of the second year of life. Klein believed the Oedipus complex peaked at about age 2 1/2 to 3, much earlier than Anna Freud envisioned (Young-Bruehl, 1988). She felt the child’s superego further developed from the child’s own cannibalistic and sadistic impulses, not from any identification with the parents (Young-Bruehl, 1988). Klein thought the Oedipal conflict was experienced as early as age 1 in response to the anxiety resulting from the fear of being devoured and destroyed by the primary caregiver. In this context, as well as in object relations theory, the primary caregiver is referred to as the whole object. The child seeks to destroy the object by biting, and these impulses produce anxiety because of the awareness of Oedipal longings, which cause the child to seek to introject (or internalize) the object, who then becomes someone from whom the child expects punishment. The harshness of this superego can be mediated by experiences of the benevolent internalized object, or good superego. When that does not happen, the intrapsychic conflict that develops between a nonbenevolent object and the child’s unconscious fantasies results in the child’s neurosis. In treating children, Klein felt it was necessary to reactivate and relive this experience to resolve the conflict.

According to Klein, the basis of ego and its formative process can only be understood by way of introjection and projection. To define this further, introjection results when the object is introjected into the ego, which then identifies with some or all of its characteristics. Projective identification is the result of the projection of parts of the self into an object. This may result in the object being perceived as having acquired the characteristics of the projected part of the self, but it can also result in the self becoming identified with the object of its projection (Segal, 1974). Her theory can only be understood if one accepts the existence of early object relationships, namely those between the child and the primary caregiver, as determined by the physical needs, impulses, and fantasies of the child. Thus, the child’s object can be defined by that which is external or internal to its own body. For example, during the period of oral primacy, the introjected fantasy object is experienced as either the “good” or “bad” breast, depending on whether the oral need is gratified or frustrated. The object is treated at the same time as if it were both external and internal.

In describing child development, Klein speaks of “positions” rather than stages representing groups of anxieties or defenses. She described “states” such as the paranoid schizophrenic and the depressive states. Klein accepted and extended Freud’s idea of a life instinct and a death instinct, which exist simultaneously (de Ajuriaguerra, 1980). Klein postulated the death impulse as the primary determinant of anxiety and the struggle between life and death that extends throughout
one's daily life; the anxiety cannot be eliminated and is an aspect of all anxiety-arousing situations.

Klein offered interpretations very early in the analysis due to her belief children establish an immediate transference. Anna Freud thought it important to prepare children for interpretation and to be sensitive to the milieu in which the child resides. Klein thought the success of the analysis came from the delivery of a correct interpretation and not from any preparation or from being sensitive to the child's milieu.

In summary, there were distinct differences between Anna Freud’s and Melanie Klein’s practices of child analysis. Anna Freud’s method involved an initial preparatory phase consolidating the working relationship of the child and the analyst. Following this, the child was treated using careful interpretation of the defenses and later the drives as the repressed became more conscious. Melanie Klein disagreed with this approach and interpreted the child’s behavior from the outset. Her interventions bypassed the defenses and struck directly at the unconscious symbolic meanings of the child’s play during the sessions (Glenn, 1992). For Klein, the main focus was the defenses, whereas for Anna Freud it was the ego. Another difference was the degree of focus on the transference. Anna Freud felt the child’s transference had to be weak because of the strong attachment to the parents, and she thought it required a certain amount of ego development over the course of treatment. Klein, on the other hand, interpreted the child’s transference from the start. Thus, those following Klein’s work would minimize contact with parents and the resultant interference of the transference, whereas Freud’s followers usually see parents on a regular basis to obtain information about the child.

Analytical

In addition to Jung, the major contributors to child analytical psychology were Michael Fordham, Erich Neumann and Dora Kalff. The principal components of their theories will be presented.

Carl Gustav Jung

Jung studied medicine at the University of Basel and became a staff physician at the Burgholzli Mental Hospital in Zürich, where he became preoccupied with the search for the meaning of psychotic behaviors and utterances. He did his research on the psychological aspects of the neuroses by means of the word-association experiment, in which the subject must respond as quickly as possible to a series of 100 stimulus words. These studies led to the discovery of feeling-toned complexes (i.e., autonomous contents of the unconscious), which manifested themselves in the experiment in the form of interference (e.g., delayed response time). Jung published and sent “The Psychology of Dementia Praecox” (1908) to Freud, who later let Jung know that his work had made significant contributions to his own efforts. In 1907, the two met and began their well-known, professional relationship.

In 1912, Jung published “The Psychology of the Unconscious” (Jung, 1917/1926/1943), in which he proposed the existence of an impersonal psychic realm, the collective unconscious, a common substratum transcending all differences in culture and consciousness. Freud saw the unconscious as an appendage of consciousness in which all the individual’s incompatibilities are heaped up; Jung saw the unconscious as a collective psychic disposition that was creative in character. Table 4.1 highlights the differences between the two theories. As a result of these and other disagreements, their relationship ended in 1913.

After the break with Freud, Jung entered a period of uncertainty during which he sought a psychological standpoint of his own. He began his own self-experiment to try to understand the fantasies and other contents surfacing from his unconscious and to come to terms with them. He
Psychoanalytic and Jungian Play Therapy

Table 4.1 Freud and Jung Theoretical Differences

<table>
<thead>
<tr>
<th></th>
<th>Freud</th>
<th>Jung</th>
</tr>
</thead>
<tbody>
<tr>
<td>Center of Theory</td>
<td>Neurosis—sexuality</td>
<td>Individuation—complex</td>
</tr>
<tr>
<td>Cause of Neurosis</td>
<td>Repression of sexual drive—fixation of libido</td>
<td>Imbalance in self-regulation of the psyche</td>
</tr>
<tr>
<td></td>
<td>• Oral depression</td>
<td>• Any complex can be the cause</td>
</tr>
<tr>
<td></td>
<td>• Anal compulsion</td>
<td>• Way of coping with conflict</td>
</tr>
<tr>
<td></td>
<td>• Oedipal hysteria</td>
<td>• Problem of typology</td>
</tr>
<tr>
<td>Libido</td>
<td>Sexual drive</td>
<td>Psychic energy</td>
</tr>
<tr>
<td>Incest</td>
<td>Incest longing mainly during Oedipal phase</td>
<td>Going to psychic depth to be born again (night sea journey)</td>
</tr>
<tr>
<td>Resistance</td>
<td>Important to illuminate repression of drive</td>
<td>To be respected and analyzed</td>
</tr>
<tr>
<td>Transference</td>
<td>Analysis of transference as falling in love with analyst—no involvement from analyst</td>
<td>Projection and analytical relationship—more involvement from analyst</td>
</tr>
<tr>
<td>Unconscious</td>
<td>Place where everything was repressed—as id antagonist to ego and superego</td>
<td>There is a compensating creative side of psyche (to be acknowledged)</td>
</tr>
<tr>
<td>Regression of Libido</td>
<td>Always pathological (mostly fixation of libido along with regression)</td>
<td>Natural rhythm of progression and regression</td>
</tr>
<tr>
<td>Psychological Understanding</td>
<td>Interpret symbols</td>
<td>Hermeneutics</td>
</tr>
</tbody>
</table>

drew and dealt with these images in The Red Book (Jung, 2009). One image important for Jung was the mandala, which in Sanskrit means circle. Jung interpreted the mandala as a symbol of human wholeness or as the self-representation of a psychic process—individuation. Jung sketched a mandala every morning during this period, and later he concluded the mandala was akin to archetypes being revealed in a natural setting as “formation, transformation/the eternal Mind’s eternal recreation” (Jung, 1945/1948, p. 400). This he said is the wholeness of the personality, which if all goes well is harmonious, but which cannot tolerate self-deceptions. The self, Jung formulated, was one’s “… life goal, for it is the completest expression of that fateful combination we call individuality …” (Jung, 1928, ¶404).

On the basis of his own experience during his confrontation with the unconscious, Jung developed the technique of active imagination. This method involves a conscious submerging in the unconscious, whose contents are then observed, pictured, and meditated upon. Jung felt active imagination initiated the cure of a neurosis because it builds bridges between consciousness and previously unacceptable contents of the unconscious.

For Jung, psychotherapy meant dealing with individuals, because only individual understanding will do. Analysis for him was a dialogue demanding two partners who sat facing one another, eye to eye. The main interest of Jung’s work was not the treatment of neuroses, but rather the approach to the numinous—those emotionally meaningful things reflective of the self. For as much as one can attend to the numinous experiences, one is released from the curse of pathology (Jung, 1963). It is central to analytical treatment that human completeness manifests itself in the relationship with another, and the soul can live only in and from human relationships. The transference occurs when a person out of the patient’s childhood is projected onto the therapist. The result of this projection is a vital relationship, and it is important for the person to
rework this relationship with the goal of individuation. Individuation has two principal aspects: it is an internal and subjective process of integration, and it is an equally indispensable process of redefining the objective relationship. Neither can exist without the other.

Whereas Freud identified specific developmental phases, Jung saw the individual's life as consisting of the first half, lasting from birth until the ages of 35 to 40, and the second half, lasting from this time forward until death. For the first half, he used the analogy of the dragon fight; for the second half, he used the analogy of the night-sea journey. In the first half, the ego separates out of the collective unconscious, establishing itself as an independent entity on both the inner and outer levels. Jung saw the night-sea journey as the process of the individual ego going back to the direction of psyche, the totality of all psychic processes, a process he called the neurosis of the second half of life. This is the time when the ego relinquishes its heroic illusions of being master of its own destiny and learns to go with the flow of psyche. He saw life's victories and struggles as part of individuals working toward achieving wholeness, becoming all they can be, and being in touch with their true nature.

For Jungian psychology, the psychic system is engaged in continuous movement, and it is a self-regulating and relatively closed system. When the person is in psychic balance, then energy is free flowing. Often, free-flowing energy is manifested in the form of images from the collective unconscious that appear in dreams, fantasies, visions, and creative art, hence the importance of dreams to Jungian psychology. Jung gives an example of a common dream, in one case dreamt by a young man and in the other dreamt by an old man. In the dream, the dreamer is riding a horse and jumps a ditch full of water, just clearing the hazard. From the history of the young man, the dream signified being able to overcome his hesitance and move forward and succeed. For the old man, an invalid who gave his doctor and nurse a great deal of trouble and who had actually injured himself as a result of his failure to follow medical instructions, the dream was making clear what this man was still doing: His spirit of enterprise was still flickering within him and was his greatest trouble.

Jung talks about the structure of consciousness: the function or activity maintaining the relation of psychic contents with the ego. The ego is a complex of representations at the center of the individual's field of consciousness providing identity and continuity. The main functions of consciousness are sensation, feeling, thinking, and intuition. A person will use these functions to perceive and interact with the world. One will become primary, while the others become auxiliary functions. When people use only one function, they are considered to be one-sided, and the goal of therapy is to enable them to access all functions. How one reacts to inner and outer experience is determined by one's attitude type. The extravert thinks, acts, and feels in relation to the object, what's outside, whereas the introvert thinks, acts, and feels in relation to the subject, what's inside. The persona is the face one shows that it is presentable and acceptable to others. It is the bridge between the ego and the collective consciousness, which is made up of what is expected of us and from which we must individuate. The collective consciousness is about morality and immorality and can be positive or negative and is usually characterized by the spirit of the time.

The unconscious is the totality of all psychic phenomena out of consciousness. Its function is to compensate for and balance consciousness. The personal unconscious was part of the individual's experience that has been subsequently forgotten or repressed. The collective unconscious was never conscious; rather, it comes from the heritage of humanity from society, people, and humankind. Jung conceptualized the collective unconscious as explaining why similar complexes (e.g., the mother, father, puer, senex, and others) happened in many individuals.

The shadow is the thing a person has no wish to be. It is the sum of all the unpleasant qualities one wants to hide, and it develops from parental images of what we should or should not be. This
serves to make us human, and it initially appears as a projection. For example, the minister who has affairs, or the business executive who fraudulently alters the books would be examples of the shadow. Nevertheless, the shadow is not always negative.

There are the contrasexual aspects of personality—syzygy, the images of the feminine in the male and the masculine in the female. The anima is a female inner figure in a male and is the deposit of all female ancestral experiences of humans. It brings forth the creative seeds having the power to fertilize the feminine side of man. The animus is the male inner figure in the female. These inner figures act as a bridge from the unconscious to the ego. The anima and animus are what is experienced as not belonging, that is, what is outside of him- or herself, and these belong to the soul/spirit of the person. They act as psychopomps (guides of the soul) and are necessary links to creative possibilities and are instruments of individuation. They bring the soul into this world and relationships. A man dominated by his anima would be restless, promiscuous, and moody; a woman dominated by her animus would be obstinate, ruthless, and domineering (Jung, von Franz, Henderson, Jacobi, & Jaffe, 1964).

The theory of complexes came from Jung's work with the association experiment. He found some of the responses were disturbed and held together by a feeling tone he called emotional complexes. A complex is a relatively closed system of representations clustered around a core derived from one or more archetypes. Jung called the complex the royal road to the unconscious and the architect of dreams. All complexes have an archetypal core, and there are three kinds: conscious (those autonomous and sufficiently integrated into consciousness), unconscious (once connected to consciousness and then repressed), and never been conscious. A complex is not necessarily pathological, but it can become so when it consumes a person's energy and prohibits the person from interacting freely.

The archetype is a structural element of the unconsciousness. Archetypes are typical modes of apprehension (behavior and images). An archetype has energy, is numinous in that we are usually moved by it, and yet it cannot be experienced directly. Archetypes have a close connection with instincts or typical modes of action. The archetype is an innate capacity in the psyche. It is an unrepresentable, unconscious, preexistent form that seems to be part of the inherited structure of the psyche and can therefore manifest itself spontaneously anywhere at any time. It is a primordial image determined as to its content only when it becomes conscious and filled out with the material of conscious experience. The representations of archetypes are not inherited but the forms are. For example, the mother archetype is inherited but mothering yields a mother image.

The symbol is the best possible description of a relatively unknown fact that is known to exist. When a person is feeling stuck, a symbol may appear providing illumination and possibility. The symbol attracts one's attention to another position, adds to the personality as well as resolving conflict. This third way or other position is known as the transcendent function. Symbols are numinous, individual, and universal.

The self is the psychic totality of the individual (Jung, 1921). The self is not only the center, but also the circumference embracing consciousness and unconsciousness. The self demands to be recognized, integrated, and realized. Jung states, "the self is the principle and archetype of orientation and meaning" (1963, p. 190) and therein lies its healing function. One does not go beyond the center; the center is the goal and everything is directed toward the center.

Synchronicity is the empirical connection between spirit and matter. With this in mind, one knows not everything is due to fate, nor does everything have a cause and effect. It is sometimes important to let things work toward change. These synchronicities are acausal events and are connected through meaning.

Sometimes we become stuck in life. Jung saw these as messages informing us something needs to change; perhaps something new is trying to be born in us. It takes some patience
and understanding to learn what these messages may be. One of the ways to learn more about ourselves is through the use of dreams; the interpretation of dreams helps us to become more conscious of the creative forces within each of us.

In Jungian psychology, the suffering of the mind is seen not so much as a curable disturbance but rather as a necessity and the impulse for psychological development. Problems arise when there are disturbances of the ego–self axis prohibiting the person’s growth and development. Jung did not work directly with children, but he led seminars on the childhood dreams of adult patients (Jung, 2008), and his followers took up the task of working with children.

**Michael Scott Montague Fordham**

Fordham was surprised to find symbols of the self in childhood, and like Jung, he thought “without the self what chance did the individual have to free himself from the determinism of his childhood?” (Astor, 1995, p. 15). Fordham did not agree with Klein’s dual-instinct theory because he thought instincts were in the service of adaptation and survival, not death (Astor, 1995). Fordham’s contributions led to a theory of Jungian ego development in which the interaction between mother and baby is unique to the situation and is reciprocal; this does not exclude the inclusion of archetypal content. Fordham thought the archetypal images of children were based in the body, known to the child, and could be integrated. In this way, Fordham was adding to Jungian theory by placing a greater emphasis on the body than was previously done in the past.

Fordham was working on a theory of the self, extending Jung’s theory to include an original state of integration, giving rise to anxiety followed by the reestablishment of a steady state. The motive forces behind these sequences are called deintegrative and integrative, and as psychic organization proceeds, these sequences become spread out over longer periods of time (Fordham, 1994, p. 75).

What is important in terms of child development is that the self in infancy actively creates the environment within which the child grows, and thus it is an interactive field that brings the child into an adaptive relationship with the environment. This led to the growing field of infant observation (Adamo & Rustin, 2014; Bick, 1964, 1968; Sidoli, 1989, 2000; Sidoli & Davies, 1988).

**Erich Neumann**

Jung stated, “Neumann starts at the place I left off” (Lori, 2005). Central to his theory is the concept of centroversion, defined as the innate tendency of a whole to create unity within its parts and to synthesize their differences in unified systems (Neumann, 1990a). Centroversion expresses itself as a compensatory relation between the conscious and unconscious systems that strives for balance and systematization (Neumann, 1969).

An important goal of childhood development and education is the making of the individual into a useful member of the community; however, this differentiation comes at the cost of wholeness, according to Neumann, going from the unconscious activity of the self to an ego-centered consciousness. The process of differentiation in childhood is the loss and renunciation of all elements of perfection and wholeness, as the person must move into the path of collective usefulness. Libido, previously in the unconscious world, is now employed to build up and extend the conscious system, as marked by the transition from playing to learning.

The persona, anima, animus, and shadow figures are produced by the differentiation processes, occurring during the first half of life. Growth, according to Neumann, is moving from instinct-centeredness to ego-centeredness; failures here bring up various developmental disorders and illnesses. The typical child survives this process and derives an enhanced ability to hold the polarization of the inner tension. As ego consciousness increases, there is a progressive
transference of libido to the world. This transference of libido comes from two sources: the application of conscious interest by the ego and the projection of unconscious contents.

Neumann (1990a) has gone into detail in describing the stages of ego development in *The Child*. The ego becomes configured gradually as the child separates not only physically but also emotionally from the mother. Puberty is characterized by a change of emotional tone, a feeling for life and the world, an activation of the collective unconscious layer. Detachment from the biological parents comes in puberty and is caused by the activation of the archetype of the transpersonal parent (e.g., projection of the father archetype onto a teacher or mentor, or projection of the mother archetype upon one’s country, church, or political movement).

A lasting contribution of Neumann was the importance of understanding symbolism involved in play, and this is very relevant for play therapy today.

**Dora Maria Kalff**

The development of Sandplay therapy by Dora Kalff was a notable contribution of Jungian theory to work with children, even though it was not created exclusively for work with this population. She relied heavily on the work of Erich Neumann.

The basic concepts of sandplay are as follows:

- The psychological development of the individual is archetypally determined and under normal circumstances is similar for everyone.
- The psyche consists of consciousness and the unconscious and the interaction between them, and it is a self-regulatory system. It contains a drive toward wholeness and has a tendency to balance itself through the compensatory function of the unconscious. This drive toward wholeness suggests that under adequate circumstances the psyche, like the body, has a tendency to heal itself (Jung, 1947/1954).
- The self is the totality of the personality and its directing center. It is the central organizing factor of the psyche out of which the ego evolves.
- The primary aim of sandplay therapy is to allow the ego to relinquish its illusory dominance and to reestablish a connection and continuing relationship between consciousness and the unconscious.
- As the mother is the source of physical life, so the unconscious is the source of psychological life. The mother and the unconscious, therefore, can be seen as symbolic feminine equivalents. Under certain circumstances, this drive to return to the mother is seen as regressive; in other circumstances, the regression may be temporary and in service of psychological renewal and symbolic rebirth.
- Psychological healing involves restoration of the capacity to function normally (i.e., with free flowing energy), while ego-consciousness has to do with awareness and choice of what we are doing while we function. Expanded consciousness, while it may contribute to healing, does not ensure it.
- Psychological healing is an emotional, nonrational phenomenon taking place on the matriarchal level of consciousness hypothesized by Erich Neumann. Kalff (2003) refers to this as the preverbal level. Healing at this level enables renewal of the personality and expansion of consciousness.
- Both healing and the expansion of consciousness are desirable ends in psychotherapy. Sandplay encourages a creative regression, enabling healing precisely because of delayed interpretation and the deliberate discouragement of directed thinking. For example, if an image of a bridge connecting two entities appears in a dream, the bridge is a symbol of
connection. However, in sandplay, the patient has actually placed a bridge connecting two separate parts. This physical action may have an effect on the unconscious, and vice versa.

• The natural healing process can be effectively activated by therapeutic play and stimulation of creative impulses via conditions provided by the “free and protected space.” The Jungian view of the function of this symbol is as a healing agent, a reconciling bridge between opposites; it “can be regarded as an attempt of the unconscious to lead regressive libido into a creative act, thus pointing the way to a resolution of the conflict” (Harding, 1961, p. 8).

The key to how sandplay works is the fourfold base of freedom, protection, empathy, and trust. It is unusual to have both freedom and protection. Wild animals are free but not protected; domesticated animals are protected but not free. In sandplay therapy, one is free to do what one wants within the frame of the tray. Engaging with the body utilizes more of the whole person than does talking by itself. The protection in sandplay therapy is from being punished or criticized for what one does, being judged or being told what to do, or being evaluated. Here it is safe to be oneself.

In sandplay, the emphasis is on empathy—to feel with the patient. When patients sense this trust, they in turn trust that what they do in the session will be honored. Through the development of the transference, they can ultimately feel safe to be themselves. As the therapy progresses, there may be more mutuality of empathy and trust. This is not only true for therapy, but also for the evolution of parent–child relationships over the course of European history (De Mause, 1974), in which parents have shown progression toward the capacity for empathic parental responsiveness to the child (Punnett, 2014). Empathy is the most critical aspect of both the parenting and therapeutic relationship. According to Mario Jacoby, Jungian analyst, “I think empathy is the most important therapeutic factor for child psychology” (Punnett, 2011, p. 78).

An appreciation for what the sand scenes are depicting, an empathy for the struggles children encounter, and a rejoicing in their achievements are generally enough to provide the temenos where development will occur. Once the sandplay series has been completed and some time has been allowed to pass, jointly viewing photographs of the trays with the child provides the opportunity to exchange more verbal observations on what has happened. At that time, cognition can beneficially join the feeling experience.

In the Kalffian tradition, the relationship to the miniatures is interpreted largely in relation to the mythological world, and the therapist would make inferences about the state of the child’s relationship to the archetypal figures in his or her unconscious. According to Fordham, this approach emphasizes the collective features of the images and supports defensiveness against the integration of the personal relevance of the imagery. Fordham thought sandplay “encouraged an impersonal aspect to child therapy and he maintained the child needed a more interactive approach with the therapist” (Kirsch, 2000, p. 235).

RESEARCH

Until recently, few studies have cited the benefits of long-term, depth therapies. In fact, they have been considered to be outmoded, not cost effective, and of little benefit. With the publication of Roesler’s (2013) work and the attachment research of Alan Schore (1996, 1997a, 1997b, 2003a, 2003b), there has been renewed interest in long-term therapies. This section briefly reviews these important findings.
Roesler (2013) compiled empirical studies conducted mainly in Switzerland and Germany on the effectiveness of Jungian psychotherapy. These were mainly quasi-experimental, prospective outcome studies and retrospective studies conducted over a 6-year period. While there were no randomized controlled trials, the studies did show the effectiveness of Jungian psychotherapy on symptom reduction, well-being, interpersonal problems, change of personality structure, reduction of health care utilization, and changes in everyday life conduct with stable effects at follow-up and for up to 6 years after termination of therapy in up to 80% of the cases. From a Jungian perspective, these results were understood to mean the patient’s initial complexes were reproduced in the transference relationship, and toward the end of the therapy the ego complex separated from the other complex patterns resulting in ego strengthening.

Another recent study by Jonathan Shedler (2010) provided empirical evidence for the efficacy of psychodynamic therapy, with effect sizes as large as those reported for other therapies that have been demonstrated to be effective. It also showed that “patients who receive psychodynamic therapy maintain therapeutic gains and appear to continue to improve after treatment ends” (Shedler, 2010, p. 98). While psychodynamic therapies are effective, the challenge now is to produce studies with careful attention to scientific methods.

The work of various infant researchers also lends support to aspects of psychodynamic psychotherapy (see Stern 1985, 1995). In early childhood, the development of attachment is a crucial outcome of these interactive processes. Later, early attachment behavior effects what happens in the therapeutic relationship in longer-term therapies. Jung wrote about the importance of relationship and mutual influence as early as the 1920s, stating:

For, twist and turn the matter as we may, the relations between doctor and patient remains a personal one within the impersonal framework of professional treatment. By no device can the treatment be anything but the product of mutual influence, in which the whole being of the doctor as well as that of his patient plays its part. (Jung, 1929, ¶163)

The importance of the therapeutic relationship is stressed by Stern’s investigation of “now moments” and the following: “all the events that regulate the feelings of attachment, physical proximity, and security are mutually created experiences … they cannot exist as a part of known self-experience without an other” (Stern, 1985, p. 102).

The quality of the attachment relationship is important, as illuminated by Ainsworth’s work in Uganda (Ainsworth, 1967). These attachment experiences can be the foundation for later psychological difficulties, as they are markers for the quality of the relationship between the mother/caregiver and the infant. Analysis can help uncover these early experiences, leading to more lasting changes. While Ainsworth focused on the relationship, Bowlby (1960, 1982) challenged her ideas and emphasized the role of environmental factors in the early years as contributing to the development of neurosis, as was previously noted in Spitz’s work (1945, 1965). Bowlby applied ethological ideas to mother–infant behavior and essentially brought together the biology of ethology with Freudian theory, emphasizing maternal care as essential for mental health—a revolutionary concept in its day. This was further delineated by Winnicott (1971), Kohut (1971), and Stern (1985), who described the importance of mother–infant dyads’ communication in the development of a sense of being understood and appreciated. This is a factor in the therapeutic relationship and in play with the child.

Most recently, infant research has moved away from strict behaviorism to scientifically studying internal causes of overt behavior. What seems to emerge again and again in the research is
the interactive nature of development, and this has implications for the psychoanalytic approach of play therapy. A significant body of research (Bowlby, 1982; Emde, 1983, 1988; Schore, 1994, 1996, 1997a, 1997b; Sroufe, 1989; Trevarthen, 1993) indicates that different types of unregulated stresses occurring during the critical period of growth of the orbitofrontal cortex act as a source generator for insecure attachments. Schore (1994, 1996) stated that these events predispose the vulnerable individual to future psychopathology by permanently altering corticolimbic circuits that are implicated in the regulatory failures underlying the pathophysiology of psychiatric disorders (Schore, 1996, 1997a). The significance of this for psychoanalytic and analytic therapies is that the interaction between the therapist/analyst and the patient is critical and that changing corticolimbic circuits takes time. Having face-to-face contact has the potential for rewiring brain patterns previously established at the neurophysiological level. While this provides critical evidence for a developmental approach, one must also be sensitive to the potential unconscious aspects that can arise independently. In addition, through psychotherapy this interactive repair aids in the resilience of the patient to cope with life's ups and downs, just as it had the potential for repair within the caregiver and infant dyad. Sroufe (1989) stated that the core of the self lives in patterns of affect regulation and that this regulatory capacity is responsible for the maintenance of the continuity of self despite changes in development and context. Now there is research evidence to support Anna Freud's concept of the "corrective emotional experience" provided within the therapeutic relationship.

All of this is relevant for the understanding and treatment of children and adolescents from a psychoanalytic and analytic psychology perspective. The thrust of the infant research for analytic psychotherapy is the importance of changing brain patterns, which takes time, and the interactive nature of relationship.

PROCEDURE/TECHNIQUE

With the advent of infant research and neurobiological advances in understanding disturbances in attachment and its sequelae, the ways in which each of these perspectives conceptualizes treatment have moved closer together. The goals of normal childhood processes are: growth and maturation so as to develop age appropriate physical and mental abilities, to free the flow of energy so it is not inhibited by use of defense mechanisms, and to help children develop their unique identities and experiences such that they can adapt in spite of their particular life circumstances and can meet the demands of family, school, and society. The goals of analysis are, essentially, to allow for and support these normal processes. Neubauer (2001) states the goal of analysis is to liberate developmental forces that will allow the ego to work unencumbered, specifically to remove unconscious conflicts, repressions, and fixations. Thus, the therapist is in the position to offer developmental assistance to the ego, to strengthen the ego and to help children accomplish developmental reorganization, to address conflicts and defenses, and to make way for the emergence of the self.

Therapist Qualifications

When it comes to considering the training of analytically oriented play therapists, there are two issues to consider. One is the kind of training one should have in order to be considered a well-trained play therapist who is qualified to incorporate elements of analytic concepts and techniques into his or her play therapy work. The other is the sort of training a play therapist must have to be considered a child analyst.

Many play therapists make use of analytic techniques such as symbolic play, interpretation, and sandtray work. When doing so, the play therapist must first and foremost be a qualified mental
health professional. It is also recommended that the therapist meet the training criteria set forth by the Association for Play Therapy (APT) for becoming a Registered Play Therapist (RPT; see http://www.a4pt.org for the specific educational and clinical training criteria). Having achieved foundational competence in play therapy, the individual should have then received both academic training and clinical supervision in the use of analytic techniques.

Play therapists who want to become child analysts must go on to complete analytical training. This is usually accomplished at an analytic institute after one has completed a graduate degree and requires additional coursework. Thorough training in the following areas is essential to working with children and adolescents within this framework: fundamentals of theory, the psychology of dreams, developmental psychology, comparative theories of neurosis, fundamentals of psychiatry, comparative religion and the influence of religion on upbringing, fundamentals of ethnology and archetypal family structures, the psychology of myths and fairy tales, symbolism of children’s play, psychological understanding of pictures and drawings, and a general knowledge of the literature in the field of psychology and therapy with children and adolescents.

In addition to academic work, prospective analysts must complete their own personal analyses to gain perspectives on their own childhood conflicts so as to be able to tolerate the issues that may be raised by children or parents. Prospective analysts have to have a capacity for introspection and maturity and a willingness to be open. They must also be free of any serious personality flaws that would prohibit this kind of work. They need to be able to play and to be in touch with the inner child that exists in all of us in order to be effective therapists with children and adolescents. This ability to play includes the freedom to be spontaneous, and yet being able to empathize without overidentifying with or being repulsed by the child's behavior.

Frequent case supervision is important in order to understand the dynamics transpiring in the child, in the therapist, and in the transference and countertransference. Training should also include clinical experience working with children in a variety of settings, including outpatient, inpatient, and infant observation. In addition, it is vital to have experience with children and adolescents who do not exhibit problems; for example, volunteering at a summer camp would be a good way to gain this experience. Experiences with emotionally healthy children give the therapist a better sense of the intensity of patients’ symptoms as well as the goals toward which they should be working. Sensitivity to the cultural, ethnic, and gender roles within a wide variety of families is very important in order to establish good working relationships.

**Patient Characteristics**

Traditional psychoanalytic play therapy work requires the child to have fairly well-developed language skills in order to make maximum use of the interpretive process. In the tradition of Melanie Klein, who worked with young children, the focus is not on the reciprocal relationship, but rather on the interpretation of the behavior to make the conflict more conscious so the child will be able to resolve it. Regardless of the school of thought to which one belongs, the primary emphasis is to resolve those conflicts interfering with the child’s optimal growth and development within the contexts of the family, school, and society.

Psychodynamic variants of play therapy included the use of ego-strengthening activities related to the developmental age of the child. Therapeutic techniques involve parallel play, conjoint play, symbolic play, and directed play, whereby the therapist models a strong dependable ego that can encourage and support development. The use of sandplay therapy as an adjunct to play therapy is helpful to provide a holding container to allow the creative energy within the child to unfold and develop solutions. Sandplay is easily embraced by the young child, but often adolescents claim little interest.
Play is a universal language, and thus analytic techniques can be used with all diagnostic categories except perhaps for those with severe mental disabilities. Clients’ physical disabilities may present challenges, but these are not insurmountable and call for creative solutions on the part of the therapist. The goal is to have free-flowing energy between the conscious and the unconscious. While the ability to use the symbolic is characteristic of analytic therapies, one must keep in mind the psychological development of the child. To do so, the work of Erik Erikson (1963, 1980), who developed stages of development from birth to death, can be a useful tool. These stages can be used to help parents understand the normal developmental challenges their children face. Of serious concern is the ability of the parents to have a good working relationship with the therapist such that they do not prematurely terminate the therapy. Often when the child improves, the parents are ready to stop, but the work needs time to consolidate so new patterns are developed in the child or adolescent and the parents. It is often useful to discuss the process of therapy with parents at the beginning of treatment to avoid any later sabotaging or premature termination.

Logistics

Analytically oriented play therapy can occur in virtually any setting, including hospitals, schools, office buildings, and home offices; however, the nature of the space and its contents will vary somewhat depending on the orientation of the therapist and the nature of the work.

In traditional psychoanalytic work, child patients were provided with relatively few toys, each of which had been selected by the analyst based on the degree to which the toy could symbolically represent the child’s intrapsychic conflicts. However, the current thinking is that all play materials may elicit dynamic material, the point being to allow the child or adolescent to select toys while the analyst keeps an open mind regarding the selection to see how the choice leads to further understanding and facilitates interaction. If used, complex board games and intricate construction materials should encourage rather than restrict the child’s free play and imagination, as well as promote verbalizations of fantasy and the expression of affect (Essman, 1983). Games, therefore, do not necessarily need to be played by the rules, or the rules can be changed as needed. Toys that may elicit resistance rather than communication should be avoided.

The room may include many more toys than was traditional while focusing on the potential of each to trigger symbolic play. These toys might include: sandplay miniatures, mythical or superhero figures, and puppets and dollhouses; even standard games can take on symbolic meaning. For sandplay therapy, the basic miniatures from the following categories should be available on open shelves: animals, birds, insects, sea creatures, half-human/half-animals, reptiles and amphibians, monsters, eggs and food, fantasy figures, rocks and shells, fossils, mountains and caves, volcanos, buildings, barriers, vehicles, people, fighting figures, and spiritual and miscellaneous items (e.g., marbles, jewels) (Amatruda & Simpson, 1997). Multiple expressive techniques can be used, including drawing, movement games, music, and dance. If possible, access to an outdoor play space is an advantage.

Treatment frequency ranges from 5 days a week to several times a week, to weekly, biweekly, or monthly, depending on the needs of the child and family. More traditional analytic work will usually continue over a period of years. Some psychodynamic variants allow for a narrower treatment focus and, therefore, treatment may be completed in a shorter period of time.

Assessment and Treatment Planning

In order to formulate the problem and treatment, a thorough case history must be obtained. The history should include the presenting problem, developmental history, mental status, family
history, family of origin issues and dynamics, cultural issues, and genograms, if necessary. Intake sessions should be conducted with the child as well as with the parents. Jung, in particular, felt the child often carried the burden of the parent’s unresolved issues, so assessing the degree to which the parents’ issues are impinging on the child is an important part of the intake process. As far as treatment is concerned, Fordham (1994) took Jung's formulation further, stating children’s needs must be addressed in their own right so they can differentiate their struggles from those of their parents in order to develop their own style and live their destiny.

Beyond the intake, it may be useful to conduct both formal and informal assessments. Formal assessments might include projective tests or drawings. Informal assessment might include observations of the child’s free play or having the child complete a sandtray. When observation of the child’s free play is used in the assessment process, the therapist is specifically looking for clues to the child’s underlying emotional themes. The sandtray often gives useful information as to not only the problem the child is experiencing, but also the potential solution. The assessment is always ongoing, and one waits and listens to what is occurring in the play therapy and in the therapeutic relationship, looking for cues to the child’s unconscious.

**Treatment Stages and Strategies**

The playroom is a protected space for the child, a time away from ordinary time and a place where the emotional work is accomplished. In traditional psychoanalytic therapy, the therapist remains neutral and more objective, whereas in Jungian analytic psychotherapy, the encounter is existential and both parties are changed by it. Thus, the therapist is an observer and also a participant, while maintaining the ability to think analytically about what is transpiring in the interaction and in the room, including what is happening verbally, nonverbally, and symbolically in the play (Allan, 1997).

Psychanalytically oriented play therapists use the analytic work they did in their personal analyses to understand their own internal processes in the play therapy sessions. This helps guide them in delivering appropriate interventions based on the transference and countertransference. The therapist uses his or her own ego to assess feeling states, emotions, and fantasies from within, to analyze the play, and then to make appropriate interventions using these insights to understand the unconscious processes in the child. At any given point in time, the therapist will consider an intervention based on these factors and make a decision to: (a) observe, (b) reflect on feelings and thoughts, (c) ask for clarifications or amplification of the symbol, or (d) use interpretation to link feelings and thoughts to the past or present, to help an issue become clearer or more understandable, or to assist in resolving a current relationship problem (Allan, 1997).

Because children’s egos are in the process of expanding and their consciousness is still developing, it is important for the analytic play therapist to ensure the free flow of psychic energy in an analytic play therapy session. The therapist is in a central position to facilitate the child’s developmental needs and support the child’s ego development and mastery of conflicts (Chethik, 1989). In analytical treatment, Jung thought the psyche is always evolving toward wholeness and the direction comes from the archetype of the self. Analytic play therapy is not simply about the uncovering and analysis of the wound. If one follows the internal productions of these images and symbols, one then understands the core psychological issues and wounds, usually by assisting in the production of symbol making. In treatment, the child’s ego becomes stronger and more flexible, and in turn the family also becomes more understanding and flexible.

The treatment stages are the initial phase, the working phase, and the end phase. The initial phase is the introduction and orientation to therapy with the intake and setting of treatment goals with the parents and the children knowing they will be coming to a place where they have the freedom and trust to explore themselves. Any work with the child should include the school as
necessary for follow-up with behavioral interventions and to increase support for the child’s challenges as needed. This can be accomplished either by direct contact with the teacher or school counselor as well as by empowering the parents to follow through with acquiring appropriate services for their child. During the initial phase, child patients are told why they are coming, the schedule, and perhaps are provided with some education about feeling states and emotions in order to give them the language needed to discuss what they may be feeling. During this time, rapport is established and the therapeutic alliance is built.

The working phase includes chaos, struggle, reparation, and resolution. This is the phase where children’s negative thoughts, feelings, and struggles are experienced often as projections onto the therapist, and a new working through of these feelings can be attained. Frequently the child will test the limits. The therapist addresses such testing in a manner specific to the therapeutic context and the larger context of the child’s family or social life. At this time, specific traumas may be divulged and toys may be used to symbolically elucidate the child’s traumas and wounds. Children often disclose their fantasies and fears and worries, and the goal is to transform these affects in such a way as to serve the child. Progress in therapy is often cyclical. There can be regression, then progression, followed by regression, and so on until the child has acquired sufficient ego strength to maintain the gains.

The end phase is when the termination of the treatment occurs, and this needs to be processed and discussed well before it finally happens. Usually it is the play therapist who determines when the child has made sufficient gains to warrant bringing therapy to a close. However, children will announce they are finished and, if the therapist is in agreement, this can provide an excellent opening for discussing termination with the child and parents. To make sure the gains the child has made will hold over time, the frequency of the sessions may gradually be reduced until termination is fully accomplished. This also allows children to feel they have some control over the termination and to prepare for, and work through, the feelings that come with having to say goodbye. Successful termination results in child patients who are equipped with new sets of skills and are ready to find their place in the world.

Illustrative Analytical Psychology Case

To illustrate the analytic approach in working with children, the following case, which was first published in the *Journal of Sandplay Therapy* (Punnett, 2009) is presented here. The work with “Danny” included the amplification of miniatures as symbolic expressions of his symptoms and their archetypal roots through the use of sandplay and play therapy. From an analytic perspective, treatment was fairly short: 26 sessions over a 6-month period—3 sessions with the parents and 23 sessions with the child, during which he completed 10 sandtrays.

Case Example

Danny a 5-year, 3-month-old boy, was referred by his pediatrician because he was exhibiting “nervous habits” that had not gone away despite the behavioral interventions the parents had tried. The tics consisted of twisting his ears and yawning. From the mother’s report, he did not do well with changes in his daily routine. Temperamentally slow to adapt, Danny tended to worry.

The first time these tics appeared was 2 years prior to the therapy when Danny made throat sounds and rubbed his nose while yawning. The onset was approximately six months after the birth of his sister. This coincided with the time the parents also realized there was something wrong with her. Preschool had now ended, and Danny had begun a new school for kindergarten. His behavior was characterized as increasingly argumentative.
The parents had been married for 10 years at the time of the consultation. They were genuine in their concern, although both admitted to being perfectionistic and prone to anxiety. Danny's developmental milestones had occurred within normal limits, but he was somewhat immature in self-help skills. He had other anxiety-based behaviors: sleeping with a night-light, having many “bed buddies” (stuffed animals), and verbal rituals at bedtime.

Danny's sister was diagnosed with profound hearing loss at 7.5 months, when Danny was 3 years, 2 months old. The hearing loss was due to a recessive genetic disorder. When the sister was 18 months old (Danny was 4), she received a cochlear implant. Danny's parents were present for the surgery as well as for multiple appointments thereafter, while Danny remained with his grandparents. He never complained about the separations.

Danny was seen for two evaluation sessions. He did not talk spontaneously, but he answered questions appropriately. When asked if he had any problems, he said, “Was wondering about my yawns.” When I asked him more about his tics, he stated, “Worry when do habits”; he then yawned and demonstrated what he did with his ears, a twisting motion “to get wax out.” I asked if he wanted to stop this habit and he seemed ambivalent, saying at first he didn’t want to stop and then said he wanted to “a little bit.” I asked him about his sister's implant and he said, “God forgot to put one little part in her.” Danny told me a “really scary dream” in which people with flashlights were looking for Thomas the train (from the Thomas the Tank Engine children's books, Awdry, 1998) in a dark tunnel, “like a ghost tunnel.” During the evaluation, Danny completed a House-Tree-Person Drawing and a Kinetic Family Drawing. The family drawing featured him as the largest figure. There were also two cats behind him that were fighting for food.

My impression was that Danny manifested a Tic Disorder, Not Otherwise Specified. He had single or multiple motor and vocal tics, and there had been periods when he was tic free for more than 3 consecutive months. These tics appeared to be anxiety based and appeared related to the sister's birth defect and resultant necessary medical interventions to facilitate hearing. Moreover, he experienced the emotional loss of his mother as she attended to the needs of his sister. The dream highlighted his need to be found; the drawings highlighted his need to be seen and valued in the family. The latest ear tic was directly related to the sister's diagnosis.

According to de Vries (1974), the ear is a symbol for inquisitiveness and the seat of the memory is in the lobe. Danny's symptom overtly suggested he needed more attention, but more profoundly, there was for him a painful memory that had not been addressed. These were conscientious parents who had to focus on their daughter, but the son felt emotionally abandoned by them and resorted to a psychological defense of overcontrol of his emotions, which was modeled for him at home.

**Ego Development**

In terms of the development of the ego, it is possible to hypothesize what Danny may have experienced. Neumann's work may enrich our understanding of child behavior and shows “how the development of the child’s ego consciousness recapitulates the same archetypal stages and symbolic images that appear in ancient mythologies” (1990a, p. vi). For Neumann, “the primal relationship of mother and child is the basis for all successful normal development” (1990a, p. 2). According to Neumann, the magical stages of ego development begin at about 16 months to age 4. Danny was in this “magic-phallic stage” of ego development when his sister was born and diagnosed. In this stage, the ego no longer revolved around the mother like a satellite, but showed greater independence of the body-self and the thou. For Danny, this was a time of incubation.
meant to serve the eventual achievement of his greater independence, but there was interference. During this phase, the intentions and ritual actions of the magical ego were still partially unconscious and emotionally toned; it was through this charge of feeling and emotion that the world became significant. During this phase, we note in children that their magical killing of animals portrayed in play is identical with the killing of the real animal; the figures viewed on television are real to them. “The magical thinking of the magical ego makes possible the establishment of an ego-center at the core of consciousness and the liberation of ego-consciousness from the total domination of the unconscious within and the world without” (Neumann, 1990a, p. 154).

It was during the magical ego time that Danny’s outside world could not sustain him; specifically, he needed to be contained by his mother. So it seems the tics developed to contain his feelings. In the beginning, the tics were rather random coughing and head movements, and then eventually they transformed into yawning and ear tics. It appears that the tic—as symbol—was progressively metamorphosing into a more accurate expression of his experience.

At age 5, Danny was having difficulty with the “magical-warlike” ego stage of development (Neumann, 1990a). In this phase, the ego not only began to oppose the mother archetype, but also gained consciousness of masculinity. This strengthening of the male ego began with the increased force with which it resisted the feminine principle. The male child must separate from the maternal world and join the patriarchal world. It is only the heroically fighting ego that “is capable of overcoming the feminine-maternal which, when it impedes the ego and the masculine principle of consciousness in their development toward independence, becomes Terrible Mother, dragon and witch, a source of anxiety” (Neumann, 1990a, p. 168). For Danny this was expressed in the hero’s fight to progress to the next stage and not succumb to a regression. Wherever, in its transition from one archetypal phase to the next, the ego is forced to abandon its previous position, it is assailed by fear. The tics were a symptom of this fear. To progress further in his development, Danny would take a hero’s journey and complete a fight with the dragon, as was seen in his sandtrays. From the analytic perspective, the fear is a sign of development when it does not overpower the ego. The function of anxiety is to acquaint the ego with what is to be feared. This process makes a new orientation possible. Regardless, the mother will become a negative power from which the ego must turn away.

**Beginning of Therapy (Sessions 1 Through 4)**

After the assessment sessions, we began psychotherapy. The parents were instructed to spend special time with Danny and to increase his independent behaviors. The parents and I worked on increasing the flexibility of his play and increasing his ability to express his feeling states by increasing his feeling-word vocabulary. The mother became aware she often did not accept what he said. For example, he would say he did not like his sister and her response was, “That’s not nice.” Once she realized this, she became more accepting of his feelings. During this beginning phase of therapy, the parents noted a decrease in tics, but there was an increase in Danny’s defiance, aggression, and neediness, although he was expressing anger more appropriately. The mother also noted that the tics increased when she did not spend individual time with Danny.

In the beginning of therapy, Danny focused on lining up planes with no particular theme to his play. He said he would not like another sibling because his mother would have to spend more time with “her.” In a game of tag he chased me, caught me, put me in jail, and then hid the key. It seems he acted out the anger at his mother with me, as well as the need to separate from the mother, but also the need to contain the mother and have control over her location. The tics increased when the mother announced she would be out of town with his sister. When he expressed worries about them, I encouraged him to focus on what he and the father would do
in their absence. I encouraged the mother to help him express his worries and ignore the tics. I began to introduce the possibility of his being angry at his sister and the attention she received. He said he would not like to have what she had because he would have “to get a hole in his head” for the hearing device. He was sharing more in therapy and cried when his mother had to reschedule an appointment because he thought he would not be coming any more.

At the second session, Danny made two sandtrays: a tray followed by floor play, and then a second tray. In the first tray (wet) he used the periphery and had two boats racing, possibly suggesting too much competition. He said, “These boats have cobwebs and are sinking. The white one is going back and forth. The pirate ship goes back and forth.” The two boats in the upper right suggested there was a dangerous entanglement and they were stuck. The river he constructed did not flow freely. The other boats could only go back and forth. The path of the boats suggested that the psychic energy had stopped flowing. There were five boats in total, three in the upper left and two that were near. It is the two plus the three.

The number 2 can represent symmetry, polarity, and discrimination. The 2 is also related to the reality in which we live, and the pirate ship and the boat both were “just going back and forth” without direction, much like Danny felt. The pirate ship, risky and dangerous, was very near to him. The number 3 introduced a directional element and the possibility for development to take place, and it was connected to an inner determination (Abt, 2005). As a union of opposites, the 3 appeared as the new creation, but in this scene the energy was blocked. The number 5 related to the body with five fingers, five toes, five extremities, five sense organs, and five reflex zones. Interestingly, Danny was having difficulty controlling his body movements.

In the second tray (dry), Danny said, “This is a steamship” and it had its own power. He had two boats in the tray. It seemed to me the boats were less stuck than in the first tray. During the floor play, he lined up the airplanes on the floor; he introduced Captain Hook and then threw him in the “ocean” in the second tray. Hook had a somewhat double-sided nature: a ruthless pirate captain who had moments of compassion. Danny had these qualities himself, at times compassionate toward his sister and other times ruthless with her. It was the negative parts that he wanted to drown in the ocean. But this was where the learning needed to come for him—in the anger that he held. The number 2 in the tray suggested the tension he experienced. One of the boats was under the power of the wind, and the other boat had its “own power.” Danny tried to go under his own steam, but it had been difficult for him.

At the third session, Danny engaged in floor play. He got out all the airplanes and precisely lined them up on the floor along with the cars. I added a few planes and intentionally did not line them up perfectly. He wanted to be chased; he sped with his planes; he crashed but survived repeatedly. There were attempts to take him to jail for speeding, but he always escaped. He seemed freer to be himself.

In session 4 he constructed a jail in the dry sand; there were also two keys and two cars, which he rendered immobile. I introduced a karate Smurf figure to look for the keys, but they were not to be found. In traditional sandplay, the therapist does not introduce elements into the sand, but in his case it felt right to temporarily shift away from sandplay to SWAM, a term used by Bradway (2006, p. 9) for non-sandplay therapy uses of sand, water, and miniatures. He needed help to strengthen his resolve to separate from the mother. Danny needed to distance himself from her and to activate some of the power within him for this separation. He played out good and bad.

After the original unity of the one, there needs to be an awakening with the number 2, a sense of being different from one’s surroundings and awareness of gender and of good and evil (i.e., the development of consciousness). Interestingly, there was a fence on the sand he used as a walkway that pointed to where I was sitting. I viewed this as his connection to me, a more
Middle of Therapy (Sessions 5 Through 16)

In the following phase, the S was activated and Danny, as ego, began the hero’s journey. (Note the use of the upper case ’S’ refers to the archetype). He demonstrated aggressive behavior and aggression toward the “sister” dinosaur in his fourth sand tray. I noted increased tics when he talked about his sister. There were nightmares with the theme of him being in the clutches of his parents and struggling for freedom. While there was continued aggression toward the sister, he also demonstrated caring toward her. When the mother left town with the sister, he complained of stomachaches and clung to her. He was being more expressive. The parents were utilizing logical consequences to address his misbehavior.

In session number 6, the mother noted the tics increased after she told him she would again have to be out of town with his sister. He told me he worried about his mother. During this session, he made two sandtrays devoid of figures. In the first (his fifth sand tray), he made two circles. This scene appeared to be an amplification of the 2—the doubling of the circles. According to Eastwood, some of the most important characteristics of the number 2 “are separation, conflict, the birthing of new material from the unconscious to the conscious, and the initial experience of ego and Eros, yet also many strong feelings of overwhelm, despair, and struggle” (Eastwood, 2002, p. 62). In this tray was the Enso, the Zen circle of emptiness/opportunity. This image came when he found out his mother would be away. Nevertheless, it was an awakening of the wound he experienced with all of her absences. Hayao Kawai (1996, p. 100) points out that “emptiness” in the Dharmic world of principle is pregnant with the dual meaning of nothingness and presence. The empty circle can be seen as depicting the manifested activity of Buddha-nature, or the Self, which is also a form of dying, disappearing into oneness. All is empty, but fully held and supported by the divine. It is a state in which the death–rebirth experience activates more extensive dimensions of our own being. Danny’s experience was one of invisibility; his needs were not seen by his mother, hence the state of emptiness. There was no knowledge of what would come next.

And yet the psyche seemed to know to go to an inner place of wisdom, a place filled with the potential for something new to come.

Danny added water to his next tray (his sixth) and he drew a square and a circle in the dry sand. The number 4 was represented in this sand-only tray: There were four sides to this shape. The number 4 helps the ego consciousness with orientation (e.g., four weeks make up a full moon cycle, four seasons make the full cycle of the year, the four directions of the compass, the four elements). According to Abt, “with the number four we reach a definite limit beyond which something new begins” (2005, p. 128). He continued to say that the fourfold structures form the unconscious connection to the archetype of the Self (2005). Four has been correlated to the earth and the feminine, and therefore to the mother goddesses (Gimbutas, 1989) and feminine energy (Eastwood, 2002). Danny had to go to the archetypal mother because the personal mother had failed him. It is important to say that all successful personal mothers fail their children in some way because metaphorically we all must leave paradise—the child must grow and develop. Failure has been described as an aspect of the good-enough mother (Winnicott, 1965/1991).

Danny would have to move from taking things personally to discriminating and learning more objectivity. Danny made this four-sided shape using the tray in a vertical orientation, signifying a spiritual quality.

His mother reported to me that he had a nightmare. In the night he called out for her and told her it was about “Mom [who] had him and he needs to get away.” Another part of the dream was about him needing a square. She soothed him and he returned to sleep. In the morning, he
did not recall the dream. It appeared that he experienced the negative mother and turned to the archetypal mother. The square was another rendition of the rectangle in the sandtray. He needed to go to the quaternity, a representation of the Self. This necessity might have been due to feeling confined by rules and structures at the moment and feeling hurt by a perceived lack of sensitivity on the part of the mother.

In session 10, the mother reported that Danny was worried he might miss our session because he was not feeling well. He made sandtray number 7 with dinosaurs. In the center, he constructed a cage and hid the key. The figure he used was the Triceratops on the edge of the tray. He introduced the mother and father “shark” that he repeatedly killed; he resurrected the father shark from time to time, but not the mother, which was developmentally appropriate. In the upper left corner was a mountain that had been “killed.” He also killed the Brontosaurus, which was outside of the cage. In the cage was a two-headed dragon-serpent.

Danny was now going on the hero’s journey to fight the dragon. This was the fight for increased awareness, and he was now developmentally trying to gain his masculinity; this meant separating from the feminine. This was quite pronounced by his “killing” the mountain, a symbol for the feminine. He used helpers, the fire-breathing (creative energy) and the winged dragons. He wanted me to choose a dinosaur, and because he had labeled a mother and father (the sharks), I said this could be the sister, Brontosaurus. He immediately began to twitch his ears and soon “killed” her and threw her out. He battled the two-headed dragon and “locked” it in the cage.

Danny used the dinosaurs and dragons as his companions in this battle; they were his helpers to bring more light or consciousness. The mother and father shark and the two-headed dragon were all contained within the cage. He was trying to contain the energy of the battle—the battle of separating from the mother and identifying with the father—within this container. This circle may also symbolize the magic circle in which the ego sets itself apart from the world and concentrates on itself. This was his task.

At a later session (session 12), the mother reported that she was not spending as much individual time with Danny. She reported he was also more aggressive toward her and his sister, but few tics were present. In the sand he set up the cage and directed me to take some dinosaurs; he took the Triceratops, the fire-breathing dragon, and the winged dragon. He directed me to use the two-headed dragon, the Brontosaurus, and the mechanical battery-operated dragon in the eighth sand tray. He took the gun and shot my dinosaurs. He added the sword and keys, which unlocked the cage. In this tray, the parent dinosaur figures were absent, and he more fully expressed his feelings toward the dinosaur that represented the sister. She was caged and the keys were hidden. It seemed that there was an empathic stance toward the sister—the dinosaur that represented her lived, albeit caged. He was learning to deal with this young anima energy, which he experienced before as inimical. Interestingly, when the mother came to take him home, he hid behind a chair and took the gun from the tray and playfully shot her.

In session number 13, he became clingy and did not want the mother to leave the therapy room. He soon agreed she could leave, but he cried after her departure. This was a pivotal analytic moment. I gave voice to his heretofore unspoken feelings, saying that he wanted his mother now and there was a time when he could not have her because, when the sister was born, things changed. He sobbed for 20 minutes. This was a difficult time. In my countertransference I wanted to hold and nurture him, but I knew this would not be helpful; he needed to express grief for the loss of his mother that had been unexpressed. After the crying, he was willing to play a board game he enjoyed. There was no clinging behavior when the mother returned and he left and played with the sister while I debriefed with the mother.

Prior to the next session, he told his mother he did not want to return, but his behavior over the week was improved. In the transference he wanted to avoid me, but he had a corrective
emotional experience where I (as mother figure) could be present and witnessing and not merely withholding or abandoning. When he came to the session, he asked me to take his coat off and I told him he knew how to do this and he readily took it off. He was expressing more feelings; for example, he could now tell his mother he missed her when she and the sister went to her medical appointments. He experienced stomachaches when the mother was gone, but they were no longer debilitating. I worked with him to problem solve what he could do when he could not go with his mother. For example, he could do fun activities with his father or grandparents. He focused on winning the board game, but when I won, I invited him to join me in the thrill. My goal was to help him increase his compassion and cooperativeness. He now wanted to go outside more and initiated games of soccer and showing off how well he could run.

The mother reported that she yelled at him and he said, “Are you angry with me?” Mother said, “No,” and he replied, “Makes me feel like [I am] not doing a good job when you yell at me.” The mother expressed guilt over problems her son had, and I said that his experiences might eventually become a source of strength for him. Then she told me he stood up for his sister when another child was yelling at her to move and she could not hear him.

**End of Therapy (Sessions 17 Through 23)**

Danny continued to improve at school and at home. While he continued to spend time with the father, he also had time with his mother without the sister. He was more freely expressing that he missed his mother. He was playing games in the session and was not so caught up in the winning. He was now also going outside to play soccer. When his mother was going to medical visits with his sister, he and the father planned special things to do. He engaged in play with the airplanes and took “trips to Monster Island” and there were no monsters there. He engaged in a fight with his sister and received natural and logical consequences. I talked with him about termination and he told me how many more visits he would like to have. I reviewed his progress with him and what he had learned in therapy; I explained that he expressed himself better and how this made things better in his family. We talked about the feelings associated with saying goodbye. He said he would be sad, and I, too, because of the special times we had shared. The last session was scheduled to be after the sister’s second surgery.

I met with the parents 4 weeks before the last session. The sister would be going for her second cochlear implant; we talked about the importance of him being able to go on this trip. Previously he was not allowed to accompany them. Though the decision had been made for very good practical reasons, it had been emotionally difficult for him. This would now be a family trip for his sister’s surgery. The mother noted that on occasion he complained of a stomachache, but this quickly resolved after they talked about his feelings. The mother realized she had to check in with him, because it was easy to think he was doing all right when actually there were feelings he needed to discuss. The mother and father’s progress was reviewed. Communication was much improved; feelings were more openly discussed and not dismissed.

Over the last 2.5 months of therapy, Danny played outside more; for him, this was another way of constellating the archetypal mother and activating his identification with the masculine.

At his penultimate session (session 22), the mother informed me that the sister’s surgery was delayed by 2 weeks. Danny did not want to change the date of our last session. We talked about saying goodbye, the importance of our work, and all his growth. After he played in the garden, he made his ninth tray. He used the wet sand tray in the vertical orientation. He said there was a battle and the keys to the cage were hidden, as were a sword and a gun. He assigned two dinosaurs to me. These were attacked, captured, and caged by his two dinosaurs. He took the blue Triceratops out of the cage and said, “This is the son… like the father [Triceratops].” He was making
sure to literally cage this aggressive/hostile energy. Six small trees surrounded the cage; four of one kind and two of another. He then put a large tree upside down, the branches down on top of the captured animals.

Most prominent in this tray was the upside down tree. The Baobab tree, found in Africa, Madagascar, and Australia, is often referred to as the “upside down tree” because when bare of leaves its branches look like roots sticking up in the air (http://en.wikipedia.org/wiki/Baobab). In addition, it is often called “tree of life” or “mother” by the native people who greatly respect the Baobab because mature trees not only support an ecosystem, but also yield food, shade, and so forth.

In alchemy, for change to happen, the dragon-lord of fire must be called upon, because the dragon with the prima materia needed the washing of a substance not with water, but with fire. The aim of this operation was to transmute the leaden body of the dragon into gold within the hermetic vessel and obtain the elixir of life (Huxley, 1979). This was the case with Danny in his struggle to separate from the mother and unite the father and son.

Two weeks later, Danny returned for the last session. The mother reported he had made very good gains and she noted very few tics. There were some complaints of stomachaches, but once talked about, they resolved. Discipline incorporated both children and now Danny suffered logical consequences for his actions, which were not dependent on his sister’s disability. He talked about looking forward to his participation in the sister’s surgery.

He made the last tray in the wet sandtray. The circular cage held Brontosaurus, a flying dragon, and a small dragon inside with keys; another key was just outside the cage. To the right of this were the crocodile and the two-headed dragon. Salisbury Cathedral, a large castle, and a small castle were to the left. The father and son Triceratops, the fire-breathing dragon, and a pink dinosaur (Spinosaurus) were near to the buildings. He told me this was a battle between his dinosaurs and mine (the ones in the cage). Initially he identified his as bad and mine as good, and then later he said his were good and mine were bad. The keys to the “jail” were hidden. He also buried a clay sword and the gun. At the end of the play, he used the clay sword to kill the bad guys and then put the sword away. He moved the little castle away from the rest to the upper tray so his animals were nestled between the castles. He said, “The bad guys are in the jail.” Then he added, “That’s the end.”

Danny moved his animals closer to all the castles, which were representative of his newfound self in its more secure home. The bad guys were killed and now he literally put away the sword as if he had done the work he needed to do. It seems there were still dangers in the world, the crocodile and the two-headed dragon, but he did not seem threatened by them.

This was the first time he had put buildings in the tray. There were two castles and Salisbury Cathedral, also known as St. Mary's Cathedral. He placed this holy building closest to him. It seemed he was more secure in the archetypal feminine. The castles, in contrast to the more feminine cathedral, were masculine images. The image of the castle was doubled, emphasizing that he also now felt more secure in the masculine world.

Aft (2005) refers to the number 10 as a symbol of the self that contains centers and regulates the many different archetypes. There were 10 figures in the tray, and the number 10 signified the reappearance of the number 1, the uniting of all numbers. As such, it represented for Danny the coming together of the whole creation, including human consciousness. In this scene Danny, destroyed the “bad” aspects of himself and yet realized there would be other dangers. As there was greater connection to the self, he would be in the world in a more secure position. After he finished this tray, he went outside and we played soccer; a wonderful metaphor for his newfound ability to be out in the world.
Final Remarks on the Case

As previously mentioned, De Vries (1974) described the ear as inquisitiveness with the seat of the memory in the lobe. This child's symptom related to a problem with his sister and overtly suggested he needed more attention, but viewing this more symbolically, one can see there was for him a painful memory that had not been addressed. Danny's feeling of being displaced and the lack of emotional attunement by his parents at the time of his sister's diagnosis of congenital deafness were major factors in the development of the anxiety disorder. These were conscientious parents who had to focus attention on the daughter, but the son felt abandoned by them and resorted to the defense of overcontrol of his emotions with resultant anxiety. The mother thought he was well adapted because he did not complain. However, when faced with beginning kindergarten, a developmentally normal separation from mother, it became clear Danny was not emotionally equipped as he became symptomatic. On follow-up many years later, Danny remained symptom free with no return of the tics.

CONCLUSION

The 20th century marked the beginnings of play therapy based on psychoanalytic and analytical theories. Now, in the beginnings of the 21st century, we are at a place where play therapy and work with children are of the upmost importance given the complexities of everyday living. Based on more recent infant research, the psychopathology of the child is thought to reside within the inter- and intrasubjective relationships of the parents/caregivers and is enriched by the intergenerational transmission of conflicts, that is, by the history of the parents and grandparents (Fraiberg, 1959). This research has validated the use of long-term therapies, psychoanalytic and analytic psychotherapy, to effect change. Psychoanalytic and analytical play therapy as treatments for children are important because play therapists are interacting in a multimodal approach that encompasses visual, tactile, auditory, and sensory modalities, and over time this can affect brain patterns, especially as these relate to emotions.

The historical beginnings of psychoanalytic theory were discussed in the works of Hermine Hug-Hellmuth and Margaret Lowenfeld. The major psychoanalytic theories of Sigmund Freud, Anna Freud, and Melanie Klein, and the analytical theory, C. G. Jung, Michael Fordham, Erich Neumann, and Dora Kalff, were discussed. While neither Freud nor Jung worked with children, their theories were presented as foundational for the work that was to follow with children. These theories provide a basic framework that informs emerging ego consciousness. The Freudians and post-Freudians developed a model of a primary nurturing relationship, and it is this nurturing relationship that sets the context for the integration of new experiential material with the internal archetypal structure of the self (Perry, 2002).

The goal of analytic child play therapy, and adult treatment for that matter, is to recover mental health—to reestablish a balance of the psyche that has been disturbed by impressions both known and unknown. There are a number of strategies to be used, including play in all its forms and the use of symbolic material that arises from this, which constitutes the psychodynamic approach. In analytical play therapy, the therapist is aware of providing this nurturing relationship and simultaneously is aware of the emerging unconscious archetypal material that is unfolding as the patient expands and broadens consciousness. The idea is not so much that analysis can prevent neurosis, but to facilitate the individual strengths of this growing person and to assist the child in coping with all life has to offer.

Procedures and techniques for psychoanalytic and analytic play therapy were discussed. In general, the goal for growth and maturation is to develop and to keep pace with chronological and
mental abilities, to free the flow of energy so it is not inhibited by the use of defense mechanisms, and to help children develop their unique identities and experiences such that they can adapt in spite of particular life circumstances to meet the demands of family, school, and society.

REFERENCES


Child-centered play therapy is both a basic philosophy of the innate human capacity of the child to strive toward growth and maturity and an attitude of deep and abiding belief in the child’s ability to be constructively self-directing” (Landreth, 2012, p. 60). Child-centered play therapy (CCPT) trusts children are capable of positive and healthy growth when the proper conditions are provided. The therapist aims to create a comfortable, welcoming, caring, warm, and accepting environment. In this environment, children will be able to express and play through any of their issues or concerns in a therapeutic manner that allows them to overcome those issues. Children direct the play session in almost any way they desire.

CCPT focuses on relating to the child in ways that will release the child’s inner-directional, constructive, forward-moving, creative, and self-healing powers in the play session (Landreth, 2012). CCPT is an approach to play therapy that focuses on the life of the individual through a relationship between the client and therapist. This approach to therapy avoids the use of techniques in the play therapy process. Rather than relying on techniques, the relationship between the therapist and the child facilitates development of the child’s constructive attitudes and behaviors. Axline (1964) stated her responsibility as a therapist was to communicate as effectively as she could, through her attitudes and personal philosophy, that an individual’s private, personal world belonged to the individual. It is the individual who decides if and when to share any part of that world. In order to relate to the child in a therapeutic way, the therapist must meet the child where the child is with warmth, care, and acceptance.

THEORY

“An understanding of and adherence to a system of theoretical personality constructs provides consistency to the therapist’s approach to children and enhances the therapist’s sensitivity to the child’s internal world of experiencing” (Landreth, 2012, p. 54). CCPT is based on the principles of Carl Rogers’ initial theory of nondirective therapy and was adapted for children by Virginia Axline (1974). It was Rogers’ (1961) belief that individuals have within themselves the capacity...
to grow in a positive and healthy direction when the proper conditions are provided. “Whether one calls it a growth tendency, a drive toward self-actualization, or a forward-moving directional tendency, it is the mainspring of life” (Rogers, 1961, p. 36).

**Personality**

The child-centered theory of personality is based on three concepts: the person, the phenomenal field, and the self (Landreth, 2012). An individual’s personality grows and develops as a result of experiences, relationships, thoughts, and emotions. Individuals interact with the world and the people in their world as they pursue the main life goal of all individuals, the realization of the self. This is also referred to as self-actualization. The healthy personality results when an individual develops sufficient self-confidence to pursue self-actualization (Guerney, 2001).

**Person**

The person is the child’s thoughts, feelings, behaviors, and physical being. Children are always reacting to the changes in their world. As the child changes in one part of the self, the other parts also change. According to Rogers (1951), an individual “exists in a continually changing world of experience of which he is the center” (p. 483).

Although “a counseling theory is an inclusive theory of development that explains personality development and behavior across all ages” (Landreth, 2012, p. 55), CCPT is particularly sensitive to the early stages of human development applicable to young children between the ages of 2 and 10. At these stages, the person is a work in progress, and play is an essential avenue for growth. Children are in the process of increasing their vocabulary and language proficiency. Neither cognitive functioning nor social skills are fully developed. CCPT is supported by the general framework of mental processes and child development principles put forward by Jean Piaget, Erik Erikson, and Lev Vygotsky.

Piaget (1983) described the preoperational (ages 2–7) and concrete (ages 7–11) stages of cognitive development as periods when children move from an inability to fully understand concrete logic and mentally manipulate information to being able to think logically about concrete events, but still having difficulty understanding abstract or hypothetical concepts. They are moving from egocentricity to seeing the world from a more socialized perspective. Piaget (1983) saw play interactions as providing children with opportunities to develop social competence through ongoing interactions. Assimilation and accommodation are both included in the give and take in play and the imitation that unites the individual child with the environment and the child’s reality.

Dougherty and Ray (2007) statistically analyzed the archival treatment data of children who were seen at a university counseling clinic and received weekly individual CCPT. Children were assigned to two data groups according to age (preoperational and concrete operational) as the independent variable and parent–child relationship stress as the dependent variable. Although children in the concrete operations group experienced more change as a result of intervention than did children in the preoperational group, both groups experienced significant decreases in parent–child relationship stress.

Erikson (1963) maintained make-believe play permits children to learn about their social worlds and to try out new social skills. He believed the world of play offers children a safe place to work through conflicts in their lives. During the psychosocial stage of autonomy versus shame (ages 3–5), play provides a safe world where the consequences are not too strong or the limits too
rigid. The child can be the authority. Play puts the child in charge. During the stage of initiative versus guilt (ages 5–11), Erikson (1963) promoted an environment that provides materials, equipment, space, time, and understanding adults to allow children to organize their ideas, feelings, and fantasies into a plan for play. Play affords the exploration and manipulation of ideas and relationships without too much doubt, shame, or guilt even though the child is yet unskilled.

Vygotsky (as cited in Frost, Wortham, & Reifel, 2008), in his sociocultural theory approach, proposed make-believe play in the preschool years is vital for the acquisition of social and cognitive competence. He believed children learn to live within self-imposed rules during their fantasy play. According to Vygotsky, play allows children to practice self-regulation, helps them choose between courses of action, and provides a vehicle for children to behave more maturely than at other times. In fantasy play, children can work at the top of their zone of proximal development.

**Phenomenal Field**

A child's phenomenal field is everything the child experiences internally and externally (Landreth, 2012). The experiences of a child provide a frame of reference in which the child views the world. For children, their phenomenal field is their reality as they perceive it. It is how children perceive the world around them. In therapy, it is important to understand the child’s frame of reference and reality. The child’s behavior is only understood by looking through the child’s eyes at his or her world of reality. Life is constantly changing, and children are continually experiencing a reorganization of thoughts, feelings, attitudes, and behaviors. At times their perceptions become distorted. Children’s perceptions of reality must be accepted by the therapist without challenge, and the children’s communicated words or symbols should not be interpreted or questioned. To foster change, the therapist must be empathetic to their feelings, thoughts, wishes, and goals. The therapist relies on the strength of the relationship and its safety to facilitate psychological growth.

**Self**

The self is the child’s perception of “me” in relation to the environment (Landreth, 2012). The child can only develop self through interactions with others. The self grows and changes as the child’s phenomenal field changes. A child’s behavior is consistent with the child’s sense of self. According to this approach, the main life goal of all individuals is for self-realization. It is believed children modify their behavior in an effort to match external behavior to the internal self. Rogers (1963) asserted that a lack of an internally directed self often develops in childhood through the parent–child interactions in an environment full of conditions of worth. If this childhood environment could be altered, allowing a more natural, positive growth experience, the child would have a better chance of growing into a self-directed, congruent, healthy individual. Children’s structure of self is formed through interactions with the environment and evaluating interactions with others (Landreth, 2012). The perception of the self is made up of an existing awareness of the self in relationships. Positive and negative values are associated with past, present, and future relationship qualities.

Distortions of the self within children occur if there is a lack of love, support, or belonging, or if there are negative forces in the home or school (Rogers, 1963). To allow for children to change, the therapist places importance on creating a warm, accepting, and empathetic relationship. The therapist’s acceptance and understanding during free play reawakens children’s abilities to self-evaluate and eventually self-direct. This process allows for therapeutic change.
to occur. The healthy self in childhood is characterized by the achievement of developmental and emotional milestones, healthy social development, and effective coping skills, such that children can have a positive quality of life and function well at home, in school, and in their communities.

PROCEDURE

According to Landreth (2012), “child-centered play therapy is a complete therapeutic system, not just the application of a few rapport-building techniques, and is based on a deep and abiding belief in the capacity and resiliency of children to be constructively self-directing” (p. 53). Unlike more behaviorally oriented therapies, CCPT is not directed toward specific problems or populations, but is generic in nature. That is, it aims at improving self-esteem and the feelings underlying inappropriate behaviors. Feelings such as frustration, anger, performance anxiety, separation anxiety, fear of abandonment, or concerns about personal safety that manifest in inappropriate and maladaptive behaviors can be addressed by allowing a child to play them out in the safe, interpersonal atmosphere of a play therapy session in the presence of a warm, caring adult (Guerney, 1983).

CCPT is based on the principles of Rogers's theory of nondirective therapy which is characterized by three core conditions: (1) congruence between the therapist and the client, (2) unconditional positive regard toward the client, and (3) empathy with the client. “The first element could be called genuineness, realness, or congruence. The more the therapist is himself or herself in the relationship, putting up no professional front or personal facade, the greater is the likelihood that the client will change and grow in a constructive manner” (Rogers, 1980, p. 115). “The second attitude of importance in creating a climate for change is acceptance, or caring, or prizing” (Rogers, 1980, p. 115). Rogers referred to this as unconditional positive regard and believed that when the therapist is experiencing a positive, acceptant attitude toward whatever the client is at that moment, therapeutic movement or change is more likely to occur. The therapist prizes the client in an unconditional way. “The third facilitative aspect of the relationship is empathic understanding. This means that the therapist senses accurately the feelings and personal meanings that the client is experiencing and communicates this understanding to the client” (Rogers, 1980, p. 116).

In developing nondirective play therapy, Axline (1974) incorporated Rogers' core conditions into eight basic principles for practice. These principles emphasize the development of trusting relationships between therapists and children and an acceptance of children exactly as they are. The therapist creates an atmosphere of permissiveness and recognizes and reflects the feelings children express. Children are trusted to choose the direction of sessions and, when necessary, therapeutic limits are set within the therapeutic relationship.

The eight basic principles of nondirective play therapy as set forth by Axline (1974) provide the foundation for child-centered play therapy as it is practiced today.

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist accepts the child exactly as he or she is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his/her feelings completely.
4. The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back in such a manner that he/she gains insight into his or her behavior.
5. The therapist maintains a deep respect for the child's ability to solve his/her problems if given the opportunity to do so. The responsibility to make choices and institute change is the child's.

6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.

7. The therapist does not attempt to hurry the therapy along. It is a gradual process, recognized as such by the therapist.

8. The therapist establishes only those limitations necessary to anchor the therapy to the world of reality and to make the child aware of his or her responsibility in the relationship (1974, pp. 73–74).

**Therapist Training and Qualifications**

For those individuals who feel a calling to work with children in a therapeutic modality, both generalized training as a helping professional and specialized training in play therapy are essential. Currently, most play therapists come from the mental health fields of psychology, social work, and counseling, which license professionals in all 50 U.S. states. A basic licensure requirement is a minimum of a master's degree in one of these helping fields or a related area. This ensures a foundation in theories of counseling and psychotherapy, clinical counseling skills, group counseling, multicultural counseling, and ethical practice. All play therapy models, including CCPT, share an expectation that play therapists are knowledgeable in the area of child development. In addition, Landreth (2012) suggests a minimum of 90 hours of instruction in play therapy content, observation, and analysis of children from the normal population as well as maladjusted children, observation of experienced play therapists, and supervised experience by a professional who has experience in play therapy.

Content specific to CCPT would include awareness of the theory, history, and background of child-centered play therapy as presented by Rogers and Axline. Guerney (2001) and Landreth (2012) provide the foundation and details for contemporary practice. CCPT is not a set of techniques or principles that can be employed at the discretion of the therapist. It is a system in the true sense in that every procedure applied is necessary to the others. “Deviations from the system make the therapy something else, not CCPT” (Guerney, 2001, pp. 18–19).

CCPT is a process, not a technique. There is respect for children's individual growth and trust that they will play out what is of concern to them. CCPT requires a deep commitment to the belief that children, with the full therapeutic support of the play therapist, will grow toward health.

With this belief and commitment to the process established, child-centered play therapists should also possess knowledge of the stages of play therapy, recognize play themes, be able to identify progress, and effectively manage the termination process (Guerney, 2001; Landreth, 2012). They should have a rationale for toy selection and the arrangement of the play space. Child-centered play therapists should be able to apply child development information in the play therapy session and when communicating and working with caregivers. They should have an understanding of how to apply CCPT to special populations.

Skills that enhance the relationship and support CCPT include the ability to convey understanding through tracking behavior, reflecting feelings, and reflecting content; build self-esteem; enlarge the meaning of the play; free the child; facilitate decision making and responsibility; facilitate spontaneity and creativity; and set therapeutic limits. Therapists practice being succinct in their verbalizations while continuing to be verbally active. They learn to recognize and match
the pace of the child, maintaining congruence of facial expression and voice tone with the child's affect and the therapist's message. The skills practiced in CCPT create an atmosphere of respect and caring that children feel and respond to.

**Therapist Characteristics**

The relationship between the therapist and the child is the foundation of CCPT. To facilitate this relationship, the therapist must be able to provide the three core conditions for change as outlined by Rogers (1980): genuineness, non possessive warmth, and empathy. It is through the play therapy experience that a relationship is established that makes it possible for children to share their real selves with the therapist. Certain therapist characteristics make this process successful.

The child-centered play therapist is authentic in the therapy session so the child experiences the genuineness of the therapist in the relationship. The child is aware of the therapist as a person and can sense when the therapist is not being honest. Being honest and objective with children requires courage. When trust is established, children may share their darkest fears, pains, anxieties, and uncertainties. The play therapist must have courage and the capacity to face these issues with the children who experience them.

CCPT asserts positive change results because therapists accept children as they are and respond to children in ways that show they are accepted (Landreth, 2012). Children are not expected to behave a certain way and are allowed to be who they are and play the way they wish to play. Acceptance by the therapist shows children they are valuable and worthwhile. This includes having a high tolerance for ambiguity and the ability to accept information that may be vague, fragmented, inconsistent, contradictory, or unclear without discomfort. Therapists are open-minded and accept children's actions and behaviors as unique and specific to each child and that child's sense of self. Wilson and Ryan (2006) suggest that when none of the child's play activities or behaviors is evaluated, it removes the opportunity for a child to attempt to seek out acceptance or rewards.

Child-centered play therapists are never simply observers. They are actively engaged as emotional and verbal participants, and they have the ability and willingness to enter the child's world. The intent of therapists is to see, hear, feel and experience with the child in a nonevaluative manner. They do not question the child's thoughts or expressions, as they believe it would interfere with the child's experience of responsibility for leading the relationship. Therapists are sensitive and understanding of the child and the child's frame of reference of the world. “Children are not free to explore, to test boundaries, to share frightening parts of their lives, or to change until they experience a relationship in which their subjective experiential world is understood and accepted” (Landreth, 2012, p. 70).

In addition to these characteristics, child-centered play therapists hold certain beliefs about children and the process of play therapy. They maintain children are capable of self-determination and allow them to be self-directive. They mirror children's typical developmental stance of being oriented in the present. The relationship between the therapist and the child is not that of playmates (Landreth, 2012). The child is the director of the play session. The therapist is nondirective, but responds to the child in a manner that the child feels the therapist is a part of whatever the child is engaged in, even though the therapist may not be physically participating. The therapist does not assume a role in the therapy session but instead is present for the child. The therapist is a willing participant when invited by the child. For example, role-playing often involves the therapist being assigned a role by the child and following the directions of the child. The therapist's participation in the child's play is always done with the intention of being accepting, warm, welcoming, and therapeutic. Since change is believed to be the result of the child's ability to play freely, the therapist is often seen as just another tool for the child to animate through the child's play in the session.
Axline's eight basic principles are a guide for therapist behaviors that support children in their quest for self-growth; however, they also require considerable self-constraint from the therapist. One final characteristic of child-centered play therapists is patience. Moustakas (1981) suggests the challenge of therapy is to serve, to wait with interest and concern for the child to activate the will and to choose to act, to dare to pursue what is present in the way of interest and desire. This calls for unusual patience and an unshakable belief in the child’s capacity to find the way, to come to terms with the restraints and tensions of living, a belief in the child’s powers to listen inwardly and to make choices that are self-enhancing. (p. 18)

Client Characteristics

A powerful force exists within every child that strives continually for self-actualization (Landreth, 2012). This inherent striving is toward independence, maturity, and self-direction. The child's mind or conscious thoughts are not what direct the behaviors to areas of emotional need, but rather it is the natural striving toward inner balance that takes the child to where the child needs to be. CCPT focuses on the child and not on the child's problems. Consequently, client characteristics are best explained by several of Rogers' (1951) propositions regarding personality and behavior. Children are the best determiners of their own personal reality. They behave as an organized whole with a desire to enhance the self. Children are goal-directed as they pursue satisfying their perceived needs. They are interested in maintaining a positive self-concept and behave in ways consistent with their self-concept. Children disown behavior that is inconsistent with the self and respond to threats by becoming behaviorally rigid. However, they can admit into awareness experiences that are inconsistent with the self if the self is free from threat. Children do not self-select therapy; they are referred to therapy by caregivers or other concerned adults. Whatever the circumstance, CCPT contends it is the child and not the child's behavior that should be the therapist's focus. To achieve this objective, Landreth (2012) offers a set of tenets that provide context for relating to children.

- Children are not miniature adults, and the therapist does not respond to them as if they were.
- Children are people. They are capable of experiencing deep emotional pain and joy.
- Children are unique and worthy of respect. The therapist prizes the uniqueness of each child and respects the person each child is.
- Children are resilient. Children possess a tremendous capacity to overcome obstacles and circumstances in their lives.
- Children have an inherent tendency toward growth and maturity. They possess an inner intuitive wisdom.
- Children are capable of positive self-direction. They are capable of dealing with their world in creative ways.
- Children's natural language is play, and this is the medium of self-expression with which they are most comfortable.
- Children have a right to remain silent. The therapist respects a child’s decision not to talk.
- Children will take the therapeutic experience to where they need to be. The therapist does not attempt to determine when or how a child should play.
- Children's growth cannot be speeded up. The therapist recognizes this and is patient with the child's developmental process (p. 46).
Indications/Contraindications

The Centers for Disease Control and Prevention (CDC) issued their first comprehensive report on children’s mental health in the United States of America in 2013. Data was collected from a variety of data sources between the years 2005–2011. “Attention-deficit/hyperactivity disorder (6.8%) was the most prevalent parent-reported current diagnosis among children aged 3–17 years, followed by behavioral or conduct problems (3.5%), anxiety (3.0%), depression (2.1%), autism spectrum disorders (1.1%), and Tourette syndrome (0.2% among children aged 6–17 years)” (CDC, 2013, p. 1). CCPT has been shown to be effective in treating many of these conditions. This is supported by research from a number of controlled-outcome studies published from 1998 to 2013 with interventions that followed CCPT methodology and used standardized psychometrics to measure change.

CCPT is credited with moderate to significant decreases in internalizing behavior problems such as somatic complaints, anxious/depressed behavior, and withdrawn behavior (Brandt, 2001; Packman & Bratton, 2003; Ray,Schottelkorb, & Tsai, 2007;Tyndall-Lind, Landreth, & Giordano, 2001). Significant increases in self-concept were measured in studies by Kot, Landreth, and Giordano (1998) and Tyndall-Lind et al. (2001).

CCPT has resulted in significant decreases in externalizing behavior problems such as aggressive or delinquent behaviors (Bratton et al., 2013;Garza & Bratton, 2005;Kot et al., 1998; Rennie, 2003; Tyndall-Lind et al., 2001). Moderate to significant treatment effects have been measured in children with ADHD symptoms (Bratton et al., 2013; Ray et al., 2007).

In addition to emotional and behavior problems, CCPT has been found to have a significant positive impact on academic achievement (Blanco & Ray, 2011) and moderate to large treatment effect on second graders’ reading achievement scores (Swanson, 2008) and 4- to 6-year-olds’ receptive and expressive language skills (Danger & Landreth, 2005). Children who participated in CCPT also showed significant improvement in social skills (Watson, 2007).

Guerney (2001) suggests that “only those with severe autism or active schizophrenia would be considered to be unlikely to respond positively to the approach” (p. 13). This is supported by Rogers (Rogers & Stevens, 1967/2002), “who never claimed that his therapy was effective with those with serious mental disorders” (p. 99). Through his work with schizophrenic adults, Rogers found that the more disturbed the client, the less that client was able to perceive the values of genuineness, empathy or unconditional positive regard which are necessary for the therapy to be effective. Although more and more children are being diagnosed with severe disorders that were once reserved for the adult population, this is still a small percentage of those children who are referred to and receive therapy of any kind, including CCPT.

Logistics

In CCPT no formal structure is brought into the session (Landreth, 2012). The only structure is related to the therapist’s goals of creating an environment that is welcoming, accepting, warm, and comfortable for the child to express and explore whatever the child feels is necessary. Children are given the freedom to take control and guide the session in many of the ways they see fit. Although children are able to guide and direct the session in almost any way they choose, the therapist will step in to set limits. Limits on the child’s play are set very carefully. Limits are set in order to ensure the therapist is able to devote full attention to the child as well as be accepting and warm in the session. The therapist will likely set a limit anytime the child requests or engages in an activity that prevents the therapist from being able to provide the necessary therapeutic environment. While the session is considered unstructured and permissive, limit setting may be appropriate. Limits should not be set for children until they are needed, to ensure that the session remains a learning experience (Landreth, 2012). It is believed that
providing limits before they are needed may establish a negative atmosphere that may impede on the therapeutic relationship. If limit setting is needed, limits should be communicated in a manner that enables children to make choices about what will happen next during the play session. This allows children to experience the feelings of self-responsibility and self-control which contributes to their psychological growth.

In child-centered play therapy, the child is ultimately the director of the play within the session (Landreth, 2012). Because of this, the therapist’s participation in the play session varies by what the child desires. The therapist, therefore, is sometimes a physical participant and is always an emotional participant. This emotional participation is described as “being with.” The participation of the therapist in the child’s play is always at the child’s invitation and is directed by the child. In CCPT, it is important for the therapist to allow children to maintain the direction of their play in order to ensure it is the children’s emotions, thoughts, or beliefs being acted out in the play. The therapist is also likely to set limits on their participation because this is an area where there may be a fine line between how the therapist’s participation is therapeutic and what will not allow the therapist to be accepting and attentive in the session. For example, a child might say to the therapist, “close your eyes.” The therapist would set a limit and provide an alternative, stating, “I know you would like me to close my eyes, but I choose not to close both of my eyes. I will close one eye.”

**Playroom**

Careful consideration is employed in creating a supportive and therapeutic play space. Toys and materials for exploration, expression, and practice of a variety of emotions and behaviors are provided; however, “nothing can take the place of the emotional climate that develops as a result of the therapist’s attitude, use of his or her own personality, and the spontaneous interactions between the therapist and child” (Landreth, 2012, p. 160). Children recognize the playroom is a special place. “Another day brings me back to the magic room where I do whatever it is I have to do” (Dibs, as cited in Axline, 1964, p. 150). Another child echoes this response when he enters the playroom and declares, “In here, I am free.”

The CCPT playroom is designed to reflect a developmentally appropriate and familiar space with a caring therapist where children feel safe and welcome. Toys that support the playing out of aggressive, regressive, independence, and mastery issues make a statement to the child that a great range of behaviors are permitted. There are usually materials for creative expression, blocks with which to build, a housekeeping area in which to enact real-life situations, puppets, vehicles, dolls, dinosaurs, and balls. The general categories help the therapist organize the play therapy space and include: real-life toys for role-playing and reenacting real-life situations; acting-out, aggressive-release toys to express anger, hostility, and frustration; and toys and materials for creative expression and emotional release.

Landreth (2012) identified several essential characteristics of the toys and materials that facilitate children’s expression of feelings and reactions during play therapy. Toys and materials should facilitate a wide range of both creative and emotional expression. They should be engaging to children and facilitate expressive and exploratory play. Toys and materials should allow exploration and expression without verbalization. They should allow success without a prescribed structure as well as allow noncommittal play. Finally, toys and materials should have sturdy construction for active use.

Landreth (2012) stressed the toys and materials in the playroom should be selected and not simply collected because play is children’s language and toys are their words. Most, if not all, of the toys in the playroom should be accessible to children of all ages. Children should not spend time struggling with toys that are unfamiliar or complicated. Continuing with the metaphor that
play is the language of children and the toys are their words, just as in speaking and reading, fluency in play is important. Toys should be somewhat generic and nonmechanical to allow children freedom of choice in what they want the toys to represent. For example, a Batman figure could restrict a child’s play to themes from cartoons or movies the child has seen. A talking cash register may reduce the child’s opportunity to be in control of how the money is manipulated, counted, and distributed. An additional issue occurs with battery-operated toys in that there is an interruption in play when batteries wear out and the toy no longer operates in the way the child expects. Although some situations may be prohibitive, sand and water are among the most effective therapeutic mediums of all playroom materials, and therapists are encouraged to find ways to incorporate them into the playroom space.

Culturally inclusive space

It is the therapist who has control over the play therapy environment (Glover, 2001). In CCPT, a variety of toys and materials are provided for children to choose from in order to work through the issues that may be significant to them. Sensitivity to the images available in the playroom is paramount. Ideally, every playroom would be fully equipped with a variety of materials that would reflect the multitude of cultures existing in the United States of America. This is a noble goal, but may not be feasible for most play therapists. The alternative is to be fully aware of the particular groups the therapist encounters and create a playroom that reflects this diversity.

In therapy, the actual play behaviors of children from nondominant cultures are not dissimilar to those of children from the dominant culture. Both girls and boys enjoy using art materials, easel painting, role-playing (e.g., playing store), and creating scenes in the sandbox or sandtray. Many girls are attracted to doll play and caring for babies. Many boys are attracted to aggressive play with action figures. Some children talk while they play, and others do not. Verbal processing of difficult concepts may be slower for those children who do not speak English as a first language, but processing does occur in the play. In therapy with children from nondominant cultures, the therapist must be on guard not to assume that simply because a child plays happily with the toys provided the playroom is culturally appropriate. Toys and materials that reflect the child’s culture permit the child to bring culture into the play.

The following is a list of recommended toys and materials for the playroom.

Real-Life Toys

- Doll families (ethnically diverse, multigenerational)
- Dollhouse
- Puppets (animals, characters, ethnically diverse people)
- Baby dolls (ethnically diverse)
- Doll clothes, blankets, bottles, traditional baby carriers
- Pretend food, dishes, pots/pan (ethnically diverse foods and cooking utensils)
- Pretend kitchen
- Fashion dolls (both genders, variety of skin colors, not too physically disproportionate)
- Car, truck, boat
- Cash register and money
- Chalkboard and chalk

Acting-Out/Aggression-Release

- Toy soldiers
- Alligator, dinosaurs, shark
• Birds
• Farm animals
• Wild animals (jungle and forest animals)
• Guns (not realistic looking)
• Handcuffs
• Rubber knife
• Length of rope
• Punching bag

Emotional Release

• Sand
• Water
• Play-Doh/clay
• Blocks

Creative Expression

• Easel paper/newsprint
• Easel, paint (include black and brown), paint cups, brushes
• Glue
• Scotch-type tape
• Pipe cleaners, popsicle sticks
• Construction paper
• Origami paper
• Feathers and beads
• Crayons (include a variety of browns for skin colors)
• Markers
• Colored pencils
• Scissors

Furnishings

• Sandbox
• Small table for art
• Shelves for toys
• Child-sized chairs (at least two)

Treatment Frequency and Duration

The course of treatment in CCPT varies for children and is dependent upon a number of factors. These factors include the severity and duration of the event/issue that disrupted the child's natural course of development, whether the event/issue is ongoing (i.e., foster care), and the child's support systems outside of therapy. A single traumatic event may be examined, assessed, and assimilated through play in a short period of time with the support of a trained and caring therapist. On the other hand, the continued impermanent nature of foster care may necessitate access to therapy for the duration of placement. In either case, having caregivers in the home who are able to provide the core conditions of congruence, unconditional positive regard, and empathy can mitigate the time in CCPT.
CCPT is practiced in a variety of settings under a range of conditions. To evaluate typical frequency and duration of treatment, the traditional practice of weekly sessions in a clinic environment provides the best comparison. Guerney (2001) sought to reassure those unfamiliar with CCPT who think the process takes months to complete that goals are much more likely to be attained in 12 sessions or fewer.

Bratton, Ray, Rhine, and Jones (2005) conducted a meta-analysis of 93 treatment-control comparison play therapy studies from 1953 to 2000. The effect of parental involvement and the number of sessions were shown to strengthen play therapy outcomes. Results suggested that although play therapy interventions have shown large effects with lower numbers of sessions, the benefits of play therapy increase with the length of treatment up to approximately 35 sessions then appear to level off and begin to decline. These 93 play therapy studies were not exclusive to CCPT; however, a later meta-analysis specific to CCPT showed results supporting same trends (Tsai & Ray, 2011).

In Ray’s (2008) meta-analysis of archival data on 202 children ages 2 to 13, CCPT appeared to have little to no statistical or practical effect on the parent characteristics of the parent–child relationship. Data analysis (Ray, 2008) revealed upon completion of three to seven sessions of play therapy, it was likely that the parent–child relationship worsened due to child behavior, but not at a statistically significant level. Demonstrative beneficial effects began from 8 to 10 sessions, with statistically significant results present from 11 sessions and beyond.

Assessment and Treatment Planning

Rogers (1957) questioned the value of diagnosis as a precondition to psychotherapy. However, in this age of accountability and third-party payers, identifying behavioral issues and articulating a plan with intended outcomes are standard practices in behavioral health treatment. Children (especially those under the age of 11) are assessed primarily using information provided by parents, caregivers, and teachers. The outcomes are generally those sought by adults as opposed to the children themselves.

Child-centered play therapists know children differ from adults in that they experience many physical, mental, and emotional changes as they progress through their natural growth and development. Children are in the process of learning how to cope, adapt, and relate to others and the world around them. Furthermore, children mature at their own pace, and what is considered “normal” in children falls within a wide range of behaviors and abilities. Any diagnosis of a mental disorder must consider how well a child functions at home, within the family, at school, and with peers, as well as the child's age and symptoms.

The most common problems in childhood are anxiety, attention deficit and hyperactive behaviors, and depression (CDC, 2013). Additional problems appear as disruptive or oppositional behavior; pervasive developmental issues; unusual behaviors associated with weight and/or food; enuresis or encopresis; problems storing and processing information, as well as relating thoughts and ideas; and tics (repeated, sudden, involuntary, and often meaningless movements and sounds). In teens more frequently than in younger children, addictions, unusual mood changes with up-and-down episodes of mania and depression, and (less often) early onset schizophrenia may manifest. Understanding the cluster of behaviors that is typical with each of these problems can help the play therapist communicate with caregivers, teachers, and other professionals as they work with a child. In addition, the American Psychological Association’s (2013) Diagnostic and Statistical Manual V assigns these clusters of behaviors a title and a code to facilitate communication with third-party payers.
Whether a play therapist works in a setting that requires a diagnostic label or not, the initial assessment of problematic behaviors leads to a course of treatment. The treatment plan articulates the particular negative behaviors the referring adult or adults would like to see reduced or extinguished and the particular positive behaviors they would like to see developed or increased. It is not required, or even expected, that these specific changes in behavior will be manifested in the presence of the child-centered play therapist. Indeed, the reported behaviors of concern may only be symptoms. From a CCPT perspective, the presenting issues displayed by children are the impetus for therapy; however, the goal of therapy is the same for all children. By experiencing the power of self-direction in a safe situation, without being judged, the child is able to develop an inner sense of control, relying less on negative behaviors to meet the need for attention (Landreth, 2012). Given the opportunity to express themselves freely, children will reach solutions and resolve their own emotional difficulties themselves, using play experiences and their relationships with therapists to do so.

CCPT focuses on the person of the child rather than on the child's problem. The emphasis is on facilitating the child's efforts to become more adequate, as a person, in coping with current and future problems that may affect the child's life. The broad therapeutic objectives of CCPT are to help the child:

- Develop a more positive self-concept.
- Assume greater self-responsibility.
- Become more self-directing.
- Become more self-accepting.
- Become more self-reliant.
- Engage in self-determined decision making.
- Experience a feeling of control.
- Become sensitive to the process of coping.
- Develop an internal source of evaluation.
- Become more trusting of self (Landreth, 2012, pp. 84–85).

Treatment Stages

Hendricks (1971) and Withee (1975) completed two major studies that illustrate patterns in the process of CCPT (as cited in Landreth, 2012). The initial phase of therapy, during the first few sessions, is distinguished by higher levels of anxiety, exploratory play, and relationship building between the child and play therapist. “The therapist begins where the child actually is and deals directly and immediately with the child's feelings rather than with his symptoms or problems” (Moustakas, 1959, p. 4). The second phase, during the next four to six sessions, is often highlighted with increased aggressive play. As aggressive play decreases, relationship play increases along with creative play. During this third phase, the expression of happiness is predominant and the child begins to share more personal information about self and family. A fourth phase can often be characterized by the child's sharing of a broader range of specific emotions, both positive and negative. Relationship play remains common. During the final phase of treatment, the focus shifts away from problems and onto the process of saying goodbye.

Nordling and Guerney (1999) named four typical stages in the child-centered play therapy process which are similar, but not identical, to the phases described by Hendricks (1971) and Withee (1975): warm-up, aggressive, regression, and mastery. In the first stage, they noted the formation of a therapeutic working relationship, an understanding of the child's and therapist's
roles, and a feeling of safety and security. Both the aggressive and regression stages were described as part of a working period of therapy. During the aggressive stage, children tend to exert control over others, but also accept limits placed on them. Play includes the expression of aggressive tendencies or thoughts through characters or actions. The regression stage includes behaviors related to attachment and nurturance, and children often regress to play from an earlier developmental level. During the fourth mastery stage, children often choose competence and self-mastery play activities. According to Nordling and Guerney (1999), this provides an opportunity to integrate the gains of earlier stages into their personality structures.

In CCPT, just as the child directs the play throughout treatment, the play therapist looks to the child for signs of change as a basis for timing the discontinuation of play therapy (Landreth, 2012). Rogers (1961) described the healthy, well-functioning person as having a more realistic view of self and valuing self more highly. The person is self-confident, self-directing, and better able to cope with the problems of life. The characteristics described by Rogers can be seen in the following behaviors of children in play therapy:

- Child is less dependent.
- Child is less confused.
- Child expresses needs openly.
- Child is able to focus on self.
- Child accepts responsibility for his own actions and feelings.
- Child limits her own behavior appropriately.
- Child is more inner-directed.
- Child is more flexible.
- Child is more tolerant of happenings.
- Child initiates activities with assurance.
- Child is cooperative but not conforming.
- Child expresses anger appropriately.
- Child has moved from negative/sad affect to happy/pleased.
- Child is more accepting of self.
- Child is able to play out story sequences; play has direction (Landreth, 2012, pp. 358–359).

Treatment Strategies

Giving children the freedom and right to choose and respecting their decisions does not mean play therapists are passive observers in therapy sessions. Creating a climate in which children are able to work things out and helping them to discover the capacity to do so involves the active participation and intense involvement of therapists throughout sessions (Wilson & Ryan, 2006). A critical component of CCPT is that it is nondirective. Children choose the focus of the play, the materials they wish to use, and the way they wish to use them. The therapist develops a close and trusting relationship through reflection of the actions of the play, the feelings presented, and the verbalizations, if any. These reflections “do not include praise, interpretation of underlying motives, problem-solving or challenging children’s mental defenses” (Wilson & Ryan, 2006, p. 22). The therapist displays unconditional positive regard for the children in the playroom. Although this caring may be unconditional, therapeutic limits are set which help to provide both physical and emotional safety for children and therapists.

Identifying treatment strategies for each child is inconsistent with the theory and objectives of CCPT. The focus of CCPT is on building a relationship with the child, and there are specific
therapeutic skills that contribute to this objective: tracking, reflection of content, reflection of feelings, and limit setting. These same skills are employed in group CCPT and are taught to caregivers through child–parent relationship therapy (CPRT).

**Tracking**

Tracking follows the path of the child. To do this, the therapist will verbally describe what the child is doing out loud (the actions of the child) and repeat the words used by the child. Repeating words is usually referred to as reflecting the child. This may seem awkward and intrusive; however, for young children who tend to be egocentric, the attention is truly a gift. Tracking lets the child know the therapist is completely involved in the play and is watching everything the child is doing and hearing everything the child is saying. The child does not have to interrupt the play to check to see if the therapist is still paying attention. It gives the child the message the therapist understands the purpose and direction of the play. If the therapist says something wrong, the child will most likely point it out.

**Reflection of Content**

While tracking assures the child that the therapist is present and sees and hears the child, reflecting verbalized content communicates the therapist's acceptance and understanding. The play therapist summarizes or paraphrases and reflects back the child's verbal interactions during the play session. “Reflecting content validates children's perception of their experience and helps to clarify children's understanding of themselves” (Landreth, 2012, p. 218).

**Reflection of Feelings**

The ability to recognize and properly reflect feelings is essential in helping children to be able to accept the full range of emotions that may arise during play therapy. As children's feelings are verbally acknowledged and accepted, they can be more open in expressing them. Reflecting a child's feelings validates the child and facilitates self-trust (Landreth, 2012). Although reflecting feelings may appear simple, it can be quite difficult to implement. The therapist may become distracted by the child's play and forget to look at the child's face and read the frustration, anger, happiness, or pride. The therapist may find the child's expression of feelings to be painful or excessive and attempt to dissuade the child from feeling that way. This gives the child the message that the child's feelings are unacceptable or possibly wrong. The therapeutic relationship is strengthened when the therapist communicates acceptance and understanding. “The child can begin to recognize their inner value when the play therapist responds sensitively to the inner emotional part of their person by accepting and reflecting feelings, whether verbally or nonverbally expressed” (Landreth, 2012, p. 221).

**Limit Setting**

Children need limits to feel safe. In any group situation, it is important for children to understand the boundaries and know the therapist will keep them safe, not only from each other, but from themselves. Rules should be kept to a minimum for that reason. Let children be children while helping them to learn appropriate self-regulation. Guerney (2001) describes therapeutic limit-setting as “the pairing of limit-setting statements with empathic statements about the child's desire to break the limits” (p. 21).
The combination of the acceptance of the child’s wish to break one of the few playroom rules, along with the therapist’s firm communication of the limit, is an effective therapeutic tool.

Landreth and Sweeney (1997) summarized the following in regard to limit-setting in general and how limits define the boundaries of the therapeutic relationship:

- Limits provide security and safety for the child, both physically and emotionally.
- Limits demonstrate the therapist’s intent to provide safety for the child.
- Limits anchor the session to reality.
- Limits allow the therapist to maintain a positive and accepting attitude toward the child.
- Limits allow the child to express negative feeling without causing harm and without the subsequent fear of retaliation.
- Limits offer stability and consistency.
- Limits promote and enhance the child’s sense of self-responsibility and self-control.
- Limits protect the play therapy room.
- Limits provide for the maintenance of legal, ethical, and professional standards (p. 24).

When a child becomes frustrated, too excited, or wants something that has been placed off-limits, the emotion can be overwhelming. Part of setting appropriate limits for a child is to help the child understand the impact of emotions on decision making. Therapeutic limit-setting takes this into consideration by providing clear direction about the unacceptable behavior and by giving the child an opportunity to make a choice.

Landreth (2012) suggests three specific steps when limit-setting is needed, and the acronym ACT serves as a simple reminder of these steps.

A: Acknowledge the child’s feelings, wishes, and wants.
C: Communicate the limit.

**Group CCPT**

Child-centered group play therapy facilitates the establishment of a therapeutic relationship, the expression of emotions, and the development of insight. It provides opportunities for reality testing and for expressing feelings and needs in more acceptable ways (Sweeney & Homeyer, 1999). The process of child-centered group play therapy is similar to that of CCPT; however, the group therapist must have a high tolerance for messiness and noise and must be able to handle frequent chaos. In many ways, it resembles simultaneous individual sessions as group members are free to choose to participate in solitary, parallel, or shared play. Therapeutic responses are not intrusive and generally include the child’s name so that the group members know to whom the response is directed. The therapist keeps responses balanced between group members and avoids placing the focus on any particular child.

The opportunity for children to connect with each other in reciprocal ways leads to an increased capacity to redirect behavior into a more self-enhancing and interpersonally appropriate manner. Through playing with peers, children develop skills for seeing something from another person’s point of view, cooperating, helping, and sharing, as well as for solving problems (Sawyers & Rogers, 1988). They develop leading and following behaviors, both of which are needed to get along well as adults. Such experiences help children think about their social world and gain an understanding of themselves.
Limits and limit-setting are unique in the therapeutic group as group members experience limits set not only by the therapist but also by the other group members (Sweeney & Homeyer, 1999). The group therapist maintains minimal, yet appropriate, limits without taking control of the session. As long as physical and emotional safety concerns are addressed, the group therapist allows children to work conflicts out for themselves.

The addition of multicultural issues to group counseling can complicate the situation. If the group itself is diverse, the therapist needs to be especially sensitive to the reactions, needs, and differences each child brings to the group (Glover, 1999). Not only will the therapist need to be accepting of differences as strengths, but some education may be required for other group members. Opportunities to set limits on inappropriate behavior between children because of misunderstanding due to cultural differences can only be taken advantage of if the therapist is aware of the impact. If the opportunity exists for a group to be formed that consists of members from a single culture which is different than the therapist’s, the therapist has the chance to learn from the group members.

**Working With Parents**

Children do not come to therapy in isolation. A parent or caregiver of some type who is intimately involved with the child accompanies the child. It is highly likely the child would not have chosen to come to therapy had an adult not brought the child. Therefore, the therapist must interact on some level with the adults in the lives of their child clients. Therapy can be an intimidating concept for caregivers. It is the therapist’s job to explain this process in a way they can understand. It is also helpful for caregivers to know the developmental needs of children and how therapy can be a positive intervention when development is not progressing in a typical fashion.

The caregiver’s role in therapy includes being supportive of the therapeutic process by bringing the child to all scheduled appointments on time and also by maintaining open and clear communication with the therapist. Trust in therapy will develop if the caregiver is made aware of and understands the therapeutic process and is kept informed of progress or lack of progress by the therapist. In turn, the caregiver is generally the best source for information regarding any changes outside the therapy sessions.

It is difficult to measure true progress in this “artificial” play therapy situation. The real test is the child’s behaviors in the real-world environments of home and school. The caregiver is able to provide feedback regarding progress or lack of progress. Sometimes, a behavior that has become inconvenient was inadvertently supported by the caregiver. Consultation provides an opportunity for the therapist to present new strategies for the caregiver to use with the child at home to remediate the behavior.

Consultation time also provides an opportunity for the therapist to convey the importance of play to caregivers and other adults who care for children as an essential aspect of the therapeutic process. For young children 18 months to 10 years of age, play therapy is the developmentally appropriate modality; however, using play to facilitate positive change in children can be controversial for the caregivers. They may not necessarily see the value of play or its role in achieving healthy behaviors and emotions. It appears to be too much fun.

The play therapist can help caregivers understand how young children do not typically have the cognitive capacity to talk about things that are interfering with their lives. Landreth (2012) pointed out on many occasions, “toys are used like words by children, and play is their language.”
Providing this play experience for a child in the presence of a trained, caring, and accepting play therapist allows children to express things they are not capable of expressing in words:

Play is the child's symbolic language of self-expression and can reveal (a) what the child has experienced; (b) reaction to what was experienced; (c) feelings about what was experienced; (d) what the child wishes, wants, or needs; and (e) the child's perception of self. (Landreth, 2012, p. 14)

In addition, Sawyers and Rogers (1988) shared several arguments for the importance of play that can be shared with parents to help them understand and be supportive of this modality.

Play provides the opportunity for children to practice new cognitive, social-emotional, and physical skills. As they master these skills, they can use them in other situations. It offers numerous opportunities for children to act on objects and experience events. Each experience builds understanding about the world. Play enables children to use their real experiences to organize concepts of how the world operates. Play reduces the tension that often comes with having to achieve or need to learn. In play, adults do not interfere. Children relax. Play challenges yet does not punish for mistakes. Children express and work out emotional aspects of everyday experiences as well as frightening events, especially through dramatic play. (pp. 3–5)

Caregivers can also participate directly as therapeutic agents for their children using basic CCPT skills through an approach called Filial Therapy. Filial Therapy was developed in the 1960s by Drs. Bernard and Louise Guerney as an alternative method for treating young children with behavioral and emotional problems that would assist caregivers in creating a stronger, more therapeutic relationship with their children (Guerney, 1964). By utilizing the emotional bond that naturally exists between the parent and child, professionals can further empower parents by teaching them basic psychotherapeutic techniques (Authier, Gustafson, Guerney, & Kasdorf, 1975). Combining a support group format with didactic instruction provides a dynamic process that sets Filial Therapy training apart from other parent training programs (Ginsberg, 1976). Through the Filial Therapy training sessions, caregivers learn to become constructive forces for change in their children's behaviors and attitudes by using basic child-centered play therapy principles in special weekly play sessions with their children (Guerney, 1982). Filial Therapy training focuses on the parent–child relationship by attending to the parent side of the relationship (Landreth, 2012).

Building on the Guerney's model, Landreth (2012) developed a more condensed, 10-session parent training format. The refined and formalized model is referred to as Child–Parent Relationship Therapy (CPRT) (Landreth & Bratton, 2006), but retains the same underlying philosophy and group training format as the Filial Therapy training originally presented by the Guernys. Caregivers receive 10 sessions of training in basic child-centered play therapy principles and skills. Once caregivers have completed the initial training period of three sessions, they conduct regularly scheduled special play sessions in their homes with their children while receiving supervision from a therapist and support through group meetings (Landreth, 2012).

“CPRT is a well-researched modality with more than 40 controlled-outcome research studies involving over 1,000 paraprofessionals (primarily parents)” (Landreth, 2012, p. 375). CPRT has consistently shown significant improvement in parent–child relationships as measured by higher levels of parental empathic responses, higher levels of parental acceptance, and lower levels of parental stress. In addition, caregivers who participated in CPRT often reported significant positive changes in their children’s behavior. These findings resulted from research done
with a variety of issues and across diverse cultures, including single parents (Bratton & Landreth, 1995), nonoffending parents of children who have been sexually abused (Costas & Landreth, 1999), incarcerated parents (Harris & Landreth, 1997; Landreth & Lobaugh, 1998), adoptive parents (Holt, 2011), parents of children experiencing learning difficulties (Kale & Landreth, 1999), child witnesses of domestic violence (Kot et al., 1998; Smith & Landreth, 2003), parents of chronically ill children (Tew, Landreth, Joiner & Solt, 2002), Chinese parents (Chau & Landreth, 1997; Yuen, Landreth, & Baggerly, 2002), Korean parents (Jang, 2000; Lee & Landreth, 2003), German parents (Grskovic & Goetze, 2008), Israeli parents (Kidron & Landreth, 2010), Native American parents (Glover & Landreth, 2000), African American parents (Sheely-Moore & Bratton, 2010), and Hispanic parents (Villarreal, 2008; Ceballos & Bratton, 2010).

Case Example

William, an 8 year-old boy of average to above-average intelligence, was referred to therapy because of aggressive and defiant behavior toward adults, especially his mother. When he did not get his way with his mother, he would threaten to hurt himself and engaged in risky behavior. This was graphically illustrated at the end of William’s first session when, after a limit was set about not taking toys from the playroom, he ran out and up the stairs and hung over the railing screaming that his mom didn’t love him and that she’d better pray for him not to go to hell when his skull crushed on the pavement.

William’s parents were divorced. He lived primarily with his mother and stayed with his father every other weekend and some holidays. He had already been diagnosed with ADHD for impulsivity and inattentiveness, and was taking Ritalin. A number of different stimulant and antidepressant medications had also been tried. All of the medications except Ritalin were discontinued due to inadequate positive effects or negative side effects. Eventually, after about five months of therapy, when William was moved to a home-school situation, the Ritalin was also discontinued.

William was referred for play therapy by the school social worker. It was felt that individual CCPT would provide a space for him to explore negative and aggressive feelings. He would have the opportunity to develop self-control in a safe relationship and generalize the resulting self-confidence to his classroom environment. The overall measurable goals for this client were that he would be able to participate in social events and educational activities without angry and defiant outbursts. He would also eliminate using risky behavior as a means of getting attention from and/or punishing his mother.

Soon after beginning CCPT, a psychological and academic assessment was conducted to determine the best placement for William for the following school year. This assessment concluded that William had difficulty translating auditory input into both motor and verbal output. He had difficulty following directions and instructions, especially when the instructions were complex or multistep. He displayed impaired response inhibition/delay capacity and had difficulty modulating emotional displays and tolerating routine frustration. The parents decided that a home-school situation with only one other child would be the best option for William.

During the initial sessions of CCPT, William used most of his time to create battles in the sandbox with the knights, army figures, and various animals. In one session, the knights, army figures, and dinosaurs all wanted the treasure that was hidden under the sand near a tree trunk and coffin. Play during these sessions was aggressive, but thoughtfully planned. The therapist maintained an atmosphere of acceptance, reflecting William’s feelings and
actions and setting only those limits that were necessary for the safety of the therapist and William. At one point, William remarked that the therapist could read his mind. William was able to comply with limits during sessions; however, he struggled at the end of every session when it was time to leave, often hiding under a table or grabbing a toy as he left the playroom.

During the next few sessions, William began to include different activities in his play. He would touch the punching bag, but not actually hit it. He used the dart gun to shoot at targets and crashed the cars into the walls. The therapist continued to accept this play and set safety limits, and she also reflected to William that he wanted to see how far he could push things before they broke. These responses were shared when William used the drum sticks with unnecessary force, tried to remove parts from toys that were not meant to be removed, or smashed toys into each other or the walls. Each time, William denied this intent. William continued to struggle with the ending time of sessions. Sometimes he would ask how much time other children had in the playroom.

As the therapy progressed, William’s behavior in the playroom changed. He continued to be very high energy, but was much more controlled. He began to watch the therapist for facial cues. He included more mastery play, such as bowling and hitting a ball with the bat. When he hit a ball close to the paint cups, he asked the therapist if he would get into trouble if the paint spilled. The therapist reflected his concern. William took responsibility for his own behavior and chose to hit the ball in a different direction. At one point, he threatened the therapist with the dart gun, but did not shoot. At the 5-minute warning at the end of sessions, William would often respond that he would not leave, but then left without resisting.

After about six months of therapy, William began to include water with his sandplay, which allowed him to construct more elaborate scenes in the sand. He also began to create scenarios that had nothing to do with battles. Sessions always included some type of aggressive play and mastery play. During one session, William began using the bat and ball, and then shifted to using the baby dolls for balls and hit them across the room with the bat. Fantasy play broadened beyond battles. For example, rather than a battle, the knights came for a tournament and there were prizes for the winners. At the end of one session, William stated that he would be back to save the world next week. William began to verbalize his anger about the time limit on sessions. This anger was expressed when the therapist gave a 5-minute warning at the end of the session. William would declare “I hate you,” “You’re stupid,” and “You’re not my boss.” The therapist reflected these angry feelings and William’s desire to have more time in the playroom. Each time, when the session was over, William left without incident.

Another shift occurred a few sessions later when William accidentally shot the therapist with the dart gun and apologized immediately. On another occasion, William became upset when he came to a session and found the dart gun had been broken. He stated that the therapist should not let children play with it if they were going to break it. The therapist reflected his frustration and commented that toys do get broken. William said that when he broke a toy, it could be fixed. The therapist took that as a sign of some acknowledgment of responsibility, although William did not fully accept that his behavior might have irreversible consequences.

In the final session, William was very angry at the therapist because the therapist had told his father it would be better for William if movies were restricted and to avoid R-rated violent movies and video games altogether. William said it was none of the therapist’s business. The therapist responded that she could see that William was very angry about that, but William’s parents would still be making those kinds of choices for him for a while.
William’s mother did not have effective limit-setting skills. She was not very structured herself, and she often made William wait as she talked about his misbehaviors with the therapist while he was present. Rather than take on the responsibility for setting appropriate limits, William’s mother solicited help from other adults in William’s life. She had requested on several occasions that the therapist meet with her and William to tell him to stop hurting her, behave better, and cooperate. The therapist continually returned that responsibility to William’s mother and encouraged her to use positive reinforcement and structure, which seemed to work better with William than punishment or guilt. This tactic unfortunately did not work with the home-school instructor, resulting in the instructor becoming more punitive with William and disciplining him for transgressions reported by the mother along with any inappropriate behaviors in school. This undermined the positive relationship William had developed with the instructor and resulted in him saying he disliked school and becoming more uncooperative with the home-school instructor. He also made a suicidal gesture of putting a cord around his own neck.

During consultations with William’s mother, the therapist suggested the mother drop him off at school and not go in to talk with the instructor. The therapist also supported William’s mother in not using the home-school instructor to set limits on William’s behavior with her.

The mother’s inability to set appropriate limits resulted in discussion and eventual change in William’s living arrangement. At the end of therapy, William had begun to live primarily with his father, staying with his mother every other weekend. William was sad about this new arrangement because his dad was more strict and because he would miss his mom. He concluded by saying he would be okay with the change.

Although William continued to have difficulties with aggression and lack of self-control, he had made excellent progress in CCPT. He continued to have episodes of violent and aggressive outbursts, but they were much less frequent. He was able to participate in social events and educational activities without angry and defiant outbursts. He did continue to get into difficult power struggles with his mother. This resulted in William spending more time with his father, who could provide the consistent structure William seemed to need. It was hoped that spending less time with his mother would make the time more precious to William and he would have the ability to maintain his behavior for a shorter period of time. In addition, it was hoped that William’s mother would have a greater capacity to set firm limits over the shorter period of time as well.

William had some major difficulties to face in his life that likely stemmed from a biological cause and were further aggravated by his mother’s inability to provide consistent structure and set firm limits. CCPT gave William a safe space where he could push against limits both physically and verbally and where he could be with a caring adult who gave him the opportunity to make his own choices. Within the playroom, anger, vulgarity, meanness, and hatred could be displayed without repercussion. As William experienced acceptance and understanding, his need to overpower others with uncontrolled aggression diminished.

**RESEARCH**

Child-centered play therapy is the most thoroughly researched theoretical model in the field of play therapy, and the results are unequivocal in demonstrating the effectiveness of this approach with a wide variety of children’s problems and in time-limited settings involving intensive and short-term play therapy (Landreth, 2012). Child-centered play therapy has and will continue to focus on the process of being and becoming.
The largest published research study of CCPT to date is from Ray (2008). She statistically analyzed archival data on 202 children ages 2 to 13, who had been referred over a 9-year period to a university counseling clinic. These children had participated in weekly individual CCPT. Children were assigned to data groups according to presenting problem and length of therapy as the independent variable, and parent–child relationship stress as the dependent variable. CCPT demonstrated statistically significant effects for externalizing problems, combined externalizing/internalizing problems, and nonclinical problems (parent relationship). Results also indicated that CCPT effects increased with number of sessions, specifically reaching statistical significance at 11 to 18 sessions with large effect sizes.

LeBlanc and Ritchie (2001) conducted a meta-analysis of 42 controlled play therapy studies from 1950 to 1996, 20 of which utilized child-centered play therapy without caregiver involvement. These studies were found to have an overall average effect size of 0.43, which is considered a moderate treatment effect.

Lin (2011, as cited in Landreth, 2012) conducted a meta-analytic study focused exclusively on CCPT’s effectiveness. He reviewed 52 controlled-outcome studies conducted from 1995 to 2010 that met the following criteria: use of CCPT methodology, use of control or comparisons repeated measure design, use of standardized psychometric assessment, and clear reporting of effect size or sufficient information to conduct an effect size calculation. Hierarchical linear models (HLM) provide statistically sophisticated ways for dealing with analyses in which data are obtained from multiple levels. Using HLM, Lin estimated a statistically significant overall effect size of 0.47 for the 52 collected studies ($p < 0.001$).

This result indicated that children who received CCPT interventions improved from pretreatment to post treatment by approximately one half standard deviation more than children who did not receive CCPT treatment. CCPT had a moderate positive effect for caregiver/child relationship stress (ES = 0.60), self-efficacy (ES = 0.53), and total behavior problem types (ES = 0.53), and a small positive effect for internalizing (ES = 0.37) and externalizing problems (ES = 0.334). Lin concluded that CCPT should be considered to be an effective mental health intervention for children. It had the greatest impact on broad spectrum behavioral problems, child self-esteem, and caregiver/child relationship stress. (as cited in Landreth, 2012, p. 383)

In the same study, Lin (as cited in Landreth, 2012) found that child ethnicity was a factor in treatment outcome. In 15 of the selected studies, the majority of children were non-Caucasian, and 16 of the studies were mixed groups. In the remaining 15 studies, the majority of children were Caucasian. Non-Caucasian children demonstrated substantially greater improvement as a result of CCPT than Caucasian children. Lin concluded that this finding strongly suggests that practitioners can confidently consider CCPT to be a culturally responsive intervention.

Numerous other research studies have shown CCPT to be effective across diverse cultures: school-based CCPT with Hispanic children (Garza & Bratton, 2005), short-term CCPT training with Israeli school counselors and teachers (Kagan & Landreth, 2009), group play therapy with Chinese earthquake victims (Shen, 2002), group play therapy with Puerto Rican children (Trostle, 1988), brief CCPT with African American children (Post, 1999), brief CCPT with Japanese children (Ogawa, 2006), brief CCPT training for professionals working with vulnerable children in Kenya (Hunt, 2006), and CCPT with Iranian children with internalized problems (Bayat, 2008).
CONCLUSION

CCPT has been widely researched as an effective and developmentally appropriate method for working with children dealing with a variety of concerns. The most famous case of child-centered play therapy is still the one shared by Virginia Axline (1964) in her story of 5-year-old Dibs, the boy in search of self. This story has inspired countless people to become play therapists. Dibs presented himself as nonfunctioning, hostile, and rejecting of others. It was his extreme unhappiness and glimpses of marked intelligence that touched the hearts of his preschool teachers, and they called upon Virginia Axline to unravel the mystery. It is through Dibs’ story that Axline has shared her most compelling arguments about the importance of trust, respect, and patience in a therapeutic relationship. “I wanted him to take the initiative in building up this relationship” (p. 29). “Every child needs time to explore his world in his own way” (p. 42). Once the relationship had been established and Dibs felt completely safe in the playroom, he began to express his anger at his parents. In the following example, he played out that anger and was also able to express some resolution.

“I used to be afraid of Papa,” he said. “He used to be very mean to me.”
“You used to be afraid of him?” I said.
“He isn’t mean to me anymore,” Dibs said. “But I am going to punish him anyhow!”
“Even though he isn’t mean to you now, you still want to punish him?” I said.

Dibs proceeded to build a prison into which he placed the father doll and buried both in the sand. Later, he had the boy doll rescue the father doll and he had the father doll say he was sorry for everything he had done. This was followed by Dibs saying with a little smile, “I talked to Papa today” (Axline, 1964, p. 181). In the end, a little boy who had the opportunity to express himself through his play, in the presence of an accepting and caring play therapist, emerged as a happy, capable child.

REFERENCES


CHAPTER 6

Cognitive-Behavioral Play Therapy

SUSAN M. KNELL

THEORY

Cognitive-behavioral therapy (CBT) is based on the cognitive model of emotional disorders, which involves the interplay among cognition, emotion, behavior, and physiology (Beck & Emery, 1985). According to this model, behavior is mediated through verbal processes, and disturbances in emotions and behavior are conceptualized as expressions of irrational thinking. It is assumed that a person's emotions and behaviors are determined largely by the way one thinks about the world (Beck, 1967, 1972, 1976). The perception of events, not the events themselves, determines how an individual understands life circumstances. CBT, developed for adults, helps an individual identify and modify negative thinking that causes negative emotions and maladaptive behaviors. CBT has been shown to be effective for a variety of disorders with older children, adolescents, and adults.

Three major premises of CBT are: (1) thoughts influence an individual's emotions and behaviors in response to events; (2) perceptions and interpretations of events are shaped by an individual's beliefs and assumptions; and (3) errors in logic or cognitive distortions are prevalent in individuals who experience psychological difficulties (Beck, 1976). For children, the errors in logic are often more accurately thought of as maladaptive, rather than irrational or distorted. This is particularly true for young children, whose thinking is by definition illogical, egocentric, and concrete.

CBT is made up of a set of treatment techniques that aim to relieve symptoms of psychological distress through the “direct modification of the dysfunctional ideation that accompanies them” (Bedrosian & Beck, 1980, p. 128). The CBT therapist works to identify, find patterns for, and change dysfunctional thinking. With adults, these thoughts are revealed through focused questions and careful introspection. By identifying and modifying maladaptive thoughts associated

---

1I am indebted to Dr. Meena Dasari for her continuing engagement with CBPT. Her outstanding skills as researcher, clinician, and writer have broadened and deepened my own understanding of and appreciation for CBPT.
with symptoms and dysfunctional behaviors, the therapist helps the individual reduce symptoms and modify beliefs, expectations, and attitudes (Bedrosian & Beck, 1980).

It is a given that CBT cannot be used as originally conceptualized with younger children. Therefore, cognitive-behavioral play therapy (CBPT) is an adaptation of CBT designed to be developmentally appropriate for preschool and early school-age children. Children are active in the change process by being included in the therapy, which builds on both CBT and play therapy.

PROCEDURE/TECHNIQUE

Before implementing CBPT, consideration should be given to the competencies and characteristics of the therapist, appropriate clients, and indications that CBPT is the appropriate treatment.

Therapist Qualifications, Training, and Characteristics

CBPT therapists should have appropriate coursework, clinical training, and degrees in a relevant discipline (e.g., psychology, social work, psychiatry). They should be licensed in their field (or supervised by a licensed therapist). Coursework taken during their degree program should include child development, psychopathology, assessment, psychotherapy, and family systems.

Therapists who have attained competencies in working with older children and adolescents will need specific training and supervision in play therapy and working with younger children. Competency in cognitive-behavior theory and practice is important. CBPT therapists will also need to be comfortable adapting CBT for use with children and have a thorough understanding of the CBPT literature. Supervised experience should include live or videotaped observations of sessions, if possible. CBPT clinicians should stay current with the growing body of literature on CBPT. Resources should include, but not be limited to, graduate programs, national conventions, play therapy associations (e.g., Association for Play Therapy) and continuing education programs.

Client Characteristics

Case studies using CBPT have included a wide range of populations of young children (ages 3–8 years). To date, there are published reports treating children diagnosed with anxiety (Knell & Dasari, 2006, 2009), enuresis (Knell, 1993a; Knell & Moore, 1990), phobias (Dasari & Knell, 2015; Knell, 1993a; Knell & Dasari, 2006), selective mutism (Knell, 1993a, 1993b), separation anxiety (Knell, 1998), and children who have experienced traumatic life events (Knell, 2011; Knell & Ruma, 1996; Ruma, 1993). See Knell and Dasari (2011) for the 20 published case studies of CBPT extant at that time. Several other case studies are in the process of being published (e.g., Dasari & Knell, 2015; Knell & Dasari, in press). These studies have shed light on the children who might benefit from CBPT. However, at this time, there is no specific research to support use of CBPT with certain populations and not with others.

During the preschool years, children begin to learn more about cause–effect relationships and how they can gain control over aspects of their environments. Many of the case studies to date involve children experiencing issues of control (e.g., toileting). CBPT may be appropriate for these children because it provides alternative, more adaptive ways for them to gain some control of their environment. CBPT is also helpful for anxious, depressed, and fearful children and children who have experienced a traumatic life event. From a CBT perspective, many of these children might have maladaptive thoughts related to their difficulties (e.g., the fearful child who feels unable to face her fear, the maltreated child who feels that it was “his fault”
that he was abused). Because CBPT uses psychoeducational techniques to teach more adaptive coping skills, the intervention makes sense for any child with behavior/emotional difficulties, particularly where maladaptive thoughts might be involved. Understandably, it is often quite difficult to ascertain these thoughts. In addition, the child might be experiencing a lack of positive self-statements, not necessarily negative or maladaptive ones.

There are no specific studies to support the use of CBPT with children with cognitive, developmental, emotional, or social delays/deficits. Despite this lack of empirical support, CBPT may still be an appropriate intervention for these children. For example, a CBPT therapist working with a child with deficits in expressive language could use more nonverbal means of communication. Appropriateness for CBPT is determined on an individual basis; CBPT therapists should be flexible in terms of individualizing treatment for each child.

Although not specifically CBPT, some promising empirical work exists with young children who have experienced trauma. Trauma-focused cognitive-behavior therapy (TF-CBT; Cohen, Mannarino, Berliner, & Deblinger, 2000) has been adapted by Cavett and Drewes (2012) in an intervention that integrated TF-CBT with play. They cite promising results with a 5-year-old who was traumatized by a disaster/flood and a 7-year-old who had been a victim of sexual abuse (Cavett & Drewes, 2012).

**Indications/Contraindications**

CBPT is contraindicated when there are clear issues between caregiver and child that appear to be linked to problematic parenting, particularly when related to child noncompliance. For example, if the child's behavior seems to be a result of parenting which is reinforcing negative behaviors, then every effort should be made to treat the parenting issues first before considering CBPT with the child as the main treatment modality. At times, CBPT is no longer necessary if therapy with the caregiver results in a positive change in the child's behavior. If there is significant psychopathology in the family, CBPT may still be indicated, but often with the addition of individual parent therapy, marital therapy, or family therapy.

**Logistics**

The physical space for CBPT, as well as the logistics of treatment frequency, duration, initial assessment, and treatment planning are important considerations in preparation for treating a child.

**Playroom Setup, Toys, and Materials**

CBPT is typically conducted in a playroom setting, although other venues can be used. The playroom should be stocked with toys, art supplies, puppets, dolls, cars, blocks, and other play materials. Numerous play therapists have written about the setup of a play therapy room and the types of toys that should be there (e.g., Axline, 1947; Giorano, Landreth, & Jones, 2005; Landreth, 2002; O'Connor, 1991). Because CBPT is goal oriented and directive, there are times when a specific toy/play material is indicated for a child. For example, some children with encopresis can use plastic container and pretend it is a toilet, whereas others might do better with a toy toilet that looks like a real one. The appendix at the end of this chapter lists recommended play materials.

In the CBPT playroom, the toys should be (a) visible and easily accessible to the child and (b) kept in a consistent place so the child knows where to find things from one session to the next. Each child should have a safe, consistent place to keep personal projects between sessions.
A locked drawer/area is recommended so children know their confidentiality is being respected. Often children want confirmation other children will not see or play with their projects.

The child’s confidentiality is respected in many ways. Projects that are very personal (e.g., books the child creates, pictures) should be protected and not touched by other children who come to the play room. Sometimes it isn’t clear what falls in this category. For example, if the child is working on an individualized project, these should be considered personal and not accessible to other children. However, often the child will create a family scenario in a toy house, or set up puppets/people in a certain way, or build something with blocks. The child might ask it not be touched until the next session, but the therapist cannot necessarily comply with that request. The therapist might say something like, “I know you would really like it if we kept the play house furniture and people exactly as they are, so you would find them this way next week when we meet. However, as you know, other children use the playroom and it is only fair they would be able to play with these things, too. What if we make a diagram of where everything is so we can use it next week?” One could also take a digital photo for the child’s use.

Puppets are commonly found in the playroom. There is literature spanning the last 70 years (e.g., Bender & Woltmann, 1936) relating to the use of puppets in play therapy. Puppets provide a nonthreatening means of expressing conflicts and feelings. Often the child feels it is the puppet, not the child, who is expressing these thoughts and behaviors. Irwin (1991, p. 620) stated, “Young children often present their conflicts with startling clarity and lack of disguise, thus helping illuminate the diagnostic picture.” In CBPT, stuffed animals/puppets are used in assessment (Knell & Beck, 2000) and treatment (Knell, 1993a, 1993b, 1994, 1997, 1998, 1999, 2000, 2009a, 2009b; Knell & Dasari, 2006, 2009, 2011, in press; Knell & Moore, 1990; Knell & Ruma, 1996, 2003). In most instances, stuffed animals/puppets are used as a means of delivering specific cognitive and behavioral interventions through modeling and/or role-playing (Knell, 2009).

Although play therapy is usually conducted in a playroom, there are situations in which this is not possible or not ideal. For example, a therapist without a playroom might have an office that has a section equipped with play materials. An example in which a play therapy room might not be indicated is with an anxious or fearful child who might best be treated in vivo or in a setting that more closely resembles the situation that the child fears or is anxious about. Examples include the child who is refusing to go to school who might be treated in/around the school building; a child fearful of sitting on the toilet who might be treated in an actual bathroom; or a child who is afraid of dogs who might be treated in a setting where calm (possibly therapy) dogs are present.

**Treatment Frequency and Duration**

Children are typically seen in CBPT on a weekly basis, although there is much flexibility related to the frequency of meetings. When circumstances are such that more frequent sessions might be beneficial, it is useful for the CBPT therapist to consider that possibility, especially during a particularly stressful or problematic time for the child or family. Less frequent sessions (e.g., every other week or monthly) are not ideal at the beginning of therapy, as young children often benefit from the consistency and predictability of weekly sessions. Toward the end of therapy, it is more common to meet less frequently as termination approaches so that there is still contact but a tapering of the therapeutic interaction.

The duration of therapy is case specific. Though CBPT is conceptualized as a short-term treatment, this can mean different things for different children. The length of treatment should be determined by the progress the child is making toward reaching treatment goals.
Pretreatment Intake and/or Assessment and Treatment Planning

There are a number of ways in which assessment and treatment planning take place. The first step is typically an interview with the caregivers, without the child present. At this interview, the therapist gathers a history and background information. Information included should be about the child's developmental level of cognitive, emotional, social, and problem-solving skills, as well as a history of the presenting problem(s). Often, caregivers are given behavioral rating scales and caregiver monitoring forms as part of the assessment.

Behavioral observation and play assessment frequently supplement more standardized measures. This often involves assessment of play skills with young children, as research has shown that play therapy is more effective with children with good pretend play skills (Russ, 2004). The quality of a child's pretend play is thought to be determined by (a) cognitive skills, such as organization, divergent thinking, and symbolism; (b) emotional skills, such as emotional expression, comfort/enjoyment of play, and emotional regulation; (c) interpersonal/social skills, such as empathy and communication; and (d) problem-solving skills, such as approach to problems and conflict resolution ability. Such assessment is typically informal, occurring during the sessions and even in the waiting room before and after CBPT. Information from other settings (e.g., behavioral observation at school, day care) can be valuable. Kaugars (2011) provides a comprehensive review of evidence-based play assessments. Although there are many promising measures, no one instrument has consistently emerged with strong empirical support.

In general, most child assessment techniques have been validated for use with school-age children. Therefore, they are not used as frequently with preschool age children. This would also apply to child-completed self-monitoring forms, which would be beyond the abilities of most preschool age children. Caregivers can either complete (related to their perceptions of the child) or help the child complete simple tracking measures, such as a fear thermometer. With the fear thermometer (0 = no fear, 10 = extreme fear), a child can quantify her fears in a concrete, understandable format; this is a concrete, visual guideline for the child. Use of the fear thermometer is cited extensively in reference to use with children with anxiety, phobias, and OCD (e.g., March & Mulle, 1998), although it is thought to have been used first with adults over 50 years ago (Walk, 1956).

The assessment data should be used to understand the presenting problem(s), diagnostic issues, and to develop a treatment plan. The caregiver report is supplemented by the child's self-report and play, therapist behavioral observations, and any school/provider reports. In general, a multimethod assessment approach is recommended in order to obtain a comprehensive picture of symptoms across several contexts (e.g., Velting, Stezer, & Albano, 2004).

Treatment Stages and Strategies

CBPT treatment takes place over the following stages: introductory/orientation, assessment, middle, and termination.

Introductory/Orientation

The child is introduced to play therapy in several ways. Typically caregivers are educated regarding the best ways of explaining CBPT to their child. This takes place at the end of the intake session, which is usually conducted without the child present. The caregivers might use words such as, “We are concerned about how you’ve been feeling. We know you worry about a lot of things. We went to talk to someone who helps kids when they are worried. She is nice and has a playroom. Next time you will go with us to talk and play with her.” They also might read the child
a book about therapy (e.g., *The Child’s First Book About Play Therapy*, Nemiroff & Annunziato, 1990) as a means to help explain psychotherapy. There is some orientation that occurs at the beginning of the first session with children as well. This includes talking with them about why they are coming to therapy and how play therapy might be helpful.

**Assessment**

During the assessment (discussed previously) the CBPT therapist works to better understand the presenting problems, clarify any diagnostic issues, and develop a treatment plan. There is no set time frame for assessment, and in many ways assessment is an ongoing process, which can occur at any point during the treatment. Something may develop during therapy that indicates further assessment is necessary, or the therapist may achieve further clarification regarding an ongoing issue through assessment during the course of CBPT.

**Middle**

At this point in treatment, the therapist is considering the treatment plan as the roadmap for therapy. Using the information gathered in the Assessment phase, the therapist begins to work with the child on attaining the established goals. During the middle stage of treatment, the focus is on increasing the child’s self-control, promoting a sense of accomplishment, and teaching more adaptive responses to specific situations. Depending on the child’s presenting problems, there will be a range of cognitive and behavioral interventions that can be used.

**Intervention methods**

Research suggests combining cognitive and behavioral interventions is most effective in helping children cope with difficult events and emotions (Compton et al., 2004; Velting et al., 2004). Cognitive techniques include:

- **Psychoeducation**: Teaching the child about a specific disorder, normalizing various emotional states, and explaining CBPT. Psychoeducation can offer the child, as well as the family, accurate developmental and clinical information. It can also help caregivers understand how CBPT may alleviate the child’s symptoms.

- **Cognitive restructuring**: Identifying, challenging, and modifying maladaptive thoughts (often referred to as *cognitive distortions* with adults) that lead to negative emotions and behavior. Adaptations (e.g., having the child be a “thought detective” to find unhelpful thoughts) help to make this intervention more developmentally appropriate.

- **Positive self-statements**: Teaching clear, self-affirming statements to replace maladaptive thoughts. Positive self-statements help teach coping skills through active control (e.g., “I can walk past the dog, and I will be fine”), reducing aversive feelings (e.g., “I will feel happier when I walk by the dog”), reinforcing statements (e.g., “I am brave”), and reality testing (e.g., “The dog is friendly; he will be gentle with me”).

- **Problem solving**: Teaching systematic, active ways of coping. Problem solving usually involves identifying the problem, generating a goal, brainstorming ideas, evaluating possible outcomes, and selecting the best strategy.

Behavioral techniques include:

- **Modeling**: Providing a model who demonstrates more adaptive behavior and thinking. Modeling is a critical component in CBPT and is used to demonstrate other
Cognitive-Behavioral Play Therapy

Interventions. Although there are many forms of modeling, in CBPT it often takes place through toy/puppet models and bibliotherapy (models in books).

- Relaxation training: Teaching strategies to calm the body’s reactions (i.e., physiological sensations) such as deep breathing, imagery, or muscle relaxation. Pincus (2012) offers excellent resources for child-friendly relaxation scripts.
- Contingency management: Behaviors are modified by implementing consequences (e.g., positively reinforcing a behavior to increase the likelihood it will recur) with the reinforcer being social (e.g., praise) or material (e.g., stickers, small prizes).
- Shaping: Helping a child get progressively closer to a goal. Positive reinforcement of smaller steps is used as the child meets closer and closer approximations of the goal.
- Systematic desensitization: Negative emotions and maladaptive behaviors are systematically replaced with more adaptive emotions/behaviors. When the connection between a stimulus and a typical reaction (e.g., fear/anxiety) is broken, more adaptive behaviors/emotions are possible.
- Exposure: Teaching the child to gradually and systematically confront objects or situations. This is usually done with a fear hierarchy, and used in combination with response prevention, which provides the child with positive alternatives.

See Tables 6.1 and 6.2 for interventions and examples of how these can be integrated into play.

**Method of delivering therapy**

Modeling is the primary method of delivering CBPT. The verbally oriented basis of traditional CBT, as used with adolescents and adults, would not be appropriate for young children. Research

<table>
<thead>
<tr>
<th>Technique</th>
<th>Example With Sample Script</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psycho-education</td>
<td>Child is shown feeling flashcards and therapist says “kids and grown ups have different feelings that come up at different times. We are going to look at each feeling face together and act out times when the feeling might come up. I will go first and then you can go after me.”</td>
</tr>
<tr>
<td>Cognitive restructuring</td>
<td>Child who is anxious is shown a puppet with picture of a thought bubble above his head and therapist says “when kids get worried they often have thoughts inside their head. My puppet, X is afraid of dogs. Here is picture of a ‘thought cloud’ above X’s head. Let’s try to figure out some worry thoughts for X who sees a dog. I can go first, ‘The dog will bite me.’ Now, your turn.”</td>
</tr>
<tr>
<td>Positive Self-Statements</td>
<td>For a child whose parents are divorcing, puppet says “I feel sad about my parents divorce because my dad moved his stuff out today. I am going to say my helpful thoughts. ‘I know both my parents love me’ and ‘It will take time but I can have two happy homes.’ I feel better when I say helpful things.”</td>
</tr>
<tr>
<td>Problem Solving</td>
<td>Puppet says, “I am going to use my steps to work through this. First, what is the problem? I feel worried when I have to go to my babysitter. What can I do to make this easier? I can remember I will see Mom when she is done with work. I can tell my babysitter when I am worried so we can play a game together. What else can I do? Let’s take turns thinking of ideas. Can you think of one?”</td>
</tr>
</tbody>
</table>

*Source: Knell and Dasari (in press). Reprinted with permission.*
Table 6.2 Cognitive Behavioral Play Therapy: Behavioral Techniques

<table>
<thead>
<tr>
<th>Technique</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contingency Management</td>
<td>For a puppet who is anxious about reading in front of class, therapist sets up a play situation with 2 puppets, a developmentally appropriate book, and a sticker chart. The therapist's puppet reads aloud and stops after each sentence so the child or therapist can put a sticker on the chart. Cognitive restructuring may be added here (e.g., Puppet saying, “This is hard, but I feel good getting through it and getting a sticker”).</td>
</tr>
<tr>
<td>Shaping</td>
<td>For puppet who is anxious about talking to new people, therapist sets up a play situation with a chart including a few steps that gradually increase expectations for talking (e.g., saying one word, saying a short sentence, asking a question, starting a conversation). Puppet gets a sticker for each step.</td>
</tr>
<tr>
<td>Exposure</td>
<td>For puppet who is fearful of dogs, therapist creates a visual “fear ladder” consisting of the least to most anxiety-producing task (e.g., looking at pictures of dogs to petting a dog in the therapy room). Each session, the task is selected and puppet is placed in the situation while giving “worry” ratings of small, medium, or big. Puppet reports a decrease of anxiety over time from big to small worry.</td>
</tr>
<tr>
<td>Systematic Desensitization</td>
<td>For a puppet with selective mutism who is anxious about talking at school, therapist sets up a school-like setting with toys and activities. Puppet whispers while doing an alternative activity (i.e., playing with selected toy, drawing) to increase comfort and tolerance for anxiety.</td>
</tr>
<tr>
<td>Relaxation training</td>
<td>Therapist introduces deep breathing by having a puppet do it first. Child and therapist practice it together by placing puppets on stomachs, counting aloud while breathing in and out, and watching as the object rises and falls.</td>
</tr>
</tbody>
</table>

Source: Knell and Dasari (in press). Reprinted with permission.

over many years has documented that modeling is an effective way to acquire, strengthen, and weaken behaviors (e.g., Bandura, 1977; Ollendick & King, 1998). As used in CBPT, modeling exposes a child to someone or something (often a puppet or toy) that demonstrates a behavior to be learned. The model need not directly interact with the child; it could be presented through a book, movie, or another indirect means. It is useful if the child can relate positively to the model (Knell & Dasari, 2009).

The therapist uses a coping model to present the more verbal components of therapy in a child-friendly way (Bandura, 1969; Meichenbaum, 1971). The model may verbalize problem-solving skills, by talking through each step out loud, and use self-instruction, allowing time to stop and think before responding (Meichenbaum & Goodman, 1971). The model might be reinforced for efforts along the way (shaping), and it should struggle and falter, problem solve, and eventually learning better coping skills, as coping models are more effective than mastery models (Bandura, 1969; Meichenbaum, 1971).

Another method of delivering CBPT is done through role-playing, where the child practices the skills with the therapist and receives ongoing feedback. This often takes the form of the child and therapist (or caregiver) taking turns being different individuals (“Your mom will pretend to be you, and you will pretend to be the kid who makes fun of you. Your mom will use her skills to tell you to stop. Then we can practice with your mom pretending to be that kid and you being you!”). When delivered through modeling, the model role-plays situations and the child observes.
and learns from watching (e.g., the therapist has a puppet model the coping skills with another puppet, showing the child how the puppet [representing the child] can talk to the child who is bothering her).

**Structured versus unstructured play**

CBPT is usually delivered in a play therapy room, and the process of change is believed to take place in both the structured and unstructured components of the play (Knell, 1993a, 1999). During unstructured play, observations of the child may help the therapist clarify the child's thoughts and perceptions. The structured, goal-directed activities provide the opportunity to work directly with problem solving and teach more adaptive behaviors. The balance between structured and unstructured play is critical and often highly individualized to meet the needs of each child (Knell & Dasari, 2009).

**Caregiver involvement**

Including caregivers in the child's treatment is an important issue and should be determined on a case-by-case basis. In most cases, the initial intake is done alone with the caregivers. The treatment plan may primarily involve CBPT with the child, work with the caregivers, or a combination of CBPT and caregiver work. Critical questions to help determine how much caregiver involvement is indicated include: Will caregivers need help modifying interactions with the child, particularly around the identified problem(s)? Will the child need assistance in implementing a treatment program outside of therapy? Even if the primary work is with the child, it is important to meet with the caregivers periodically. Caregiver involvement usually includes ongoing assessment (caregiver observations and concerns, treatment progress as monitored by child behaviors outside therapy), monitoring the caregiver/child interaction (if this has been of concern), providing psychoeducation (e.g., about the child, the child’s difficulties, and general child development and psychopathology), and assisting in setting up behavior management programs if needed.

For example, skill-building with caregivers of an anxious child would involve teaching them:

- Effectively communicating empathy to the child
- Rewarding positive coping and “brave” behavior
- Prompting the child’s use of coping strategies and problem-solving skills
- Modeling brave and positive coping behaviors (Rapee, Wignal, Spence, Cobham, & Lyneham, 2008)

**Generalization and response prevention**

An important goal in CBPT is to help the child maintain adaptive behaviors after treatment has ended and to teach the child how to generalize these behaviors to the natural environment. Promoting and facilitating generalization and relapse prevention is a critical, integral part of CBPT. As children progress in therapy, it is important for them to generalize more adaptive behaviors to their natural environments (generalization) and to maintain these behaviors after treatment has ended (relapse prevention). Braswell and Kendall (1988) identified the concern regarding children making gains in CBT but who do not generalize and maintain these gains when therapy is completed. It is important to incorporate these skills into therapy, particularly during the middle and end of treatment. Using real-life situations in modeling and role-playing, teaching
self-management skills, involving significant adults in the treatment, and continuing with therapy past the initial acquisition of skills are all important components that facilitate adequate learning, generalization, and likelihood relapse will not occur.

In an effort to help the child and family prevent relapse, high-risk situations should be identified. The child and caregivers can be prepared to handle such potential disruptive situations, rather than being “taken by surprise” without adequate coping skills. Thus, the child is inoculated against failure (Marlatt & Gordon, 1985; Meichenbaum, 1985). In addition to helping caregivers know how to handle such future events, play scenarios similar to what the child might be facing, integrated with coping skills and positive behaviors, can be worked into the play and be part of the therapy (Meichenbaum, 1977). Caregivers may serve as the child’s “coach” outside of sessions by prompting the use of coping skills when the child is exhibiting more maladaptive behaviors.

**Termination**

Therapy termination should ideally occur over a period of time, so the child can gradually prepare for the end of treatment. It can be helpful to provide concrete referents for the end of treatment (e.g., “You will be coming in for X more sessions and then we will say goodbye”). It is important to discuss the feelings that might be associated with the termination. These can be discussed directly (e.g., “You seem a little sad that we won’t be meeting anymore”) or indirectly (e.g., “Some kids tell me they feel a little sad about not coming to therapy anymore”). Some children benefit from the therapist labeling an appropriate emotion for the child (e.g., “I will miss seeing you, but I am really happy that you are doing so well”).

Concrete representation of the end of treatment can be helpful (e.g., a calendar, making a construction chain with one link for each session remaining). Other children might prefer a “transitional” object (e.g., the therapist’s business card) or a picture that the child has drawn for the therapist displayed in a special place in the therapist’s office.

It is best for children to understand the end of therapy as a positive event; they should be praised for their accomplishments in therapy (e.g., working hard, talking about difficult feelings, being brave). If children feel that acting out or problems will prompt a return to therapy, this could influence their behavior in a negative way. Normalizing the experience of saying goodbye can be helpful (e.g., “Remember when you said goodbye to your friends at camp, or your teacher at the end of the year?”) Suggestions for staying in touch can be useful, even if not used (e.g., “Your parents know how to get in touch with me, and can call me if you want to talk to me” or “If you want to send me a picture or leave me a message that would be great!”). Finally, it is best to have an open-door policy, so the child and family understand that they can return at any time and can even come in to tell the therapist about positive accomplishments and brave behaviors.

An end of therapy party or celebration, scheduled for the last session, can provide a link between therapy and termination. Framing this as a celebration, with others invited (e.g., the puppets from the playroom, or caregivers, if the child choses) can be helpful. The emphasis should be on the child’s accomplishments and mastery.

**RESEARCH**

Research has demonstrated that CBT with older children and adolescents is an efficacious treatment for a variety of psychological diagnoses (e.g., Compton et al., 2004; Weisz & Kazdin, 2010). Less is known about the effectiveness of CBT with young children (under 8 years old). Kingery et al. (2006) thought manualized treatments can be modified for younger children, with several case studies supporting this theory (e.g., Hirshfeld-Becker et al., 2008, with children with
an anxiety disorder diagnosis). Case reports have described effective adaptations of CBT with PTSD (Scheeringa et al., 2007) and phobias (Miller & Feeny, 2003). There is preliminary evidence CBT protocols will work with young children, although most of these studies have not included a play component.

A recent meta-analysis reviewed studies to determine if CBT was effective for young children (Reynolds, Wilson, Austin, & Hooper, 2012). Their findings indicate that children aged 4 to 8 who received CBT displayed better outcomes than either no intervention or wait-list controls. However, when compared with children aged 9 to 18, the effectiveness of CBT in the younger group was not as robust. Hirshfeld-Becker et al. (2010) adopted a CBT protocol for children aged 4 to 7 years and compared them with a wait-list control group. They found that the children who received CBT displayed a significant reduction in anxiety and an increase in coping (as rated by caregivers). In a study with children diagnosed with PTSD, Scheeringa, Weems, Cohen, Amaya-Jackson, and Guthrie (2011) showed that a treatment group receiving an adapted CBT protocol showed significant decreases in trauma symptoms as assessed by caregiver ratings on a standardized clinical interview. Most of these studies did not include a play component, though it seems likely a CBPT would increase the effectiveness of CBT for young children.

In more general, non-CBT literature, play therapy has been shown to be effective in treating children's internalizing and externalizing symptoms (Bratton & Ray, 2000; Bratton, Ray, Rhine, & Jones, 2005; Davenport & Bourgeouis, 2008; LeBlanc & Ritchie, 2001). Bratton et al. (2005) conducted a meta-analysis of 93 outcome studies. The children had an average age of 7 years. A large effect size (0.80) for play interventions indicated that children who received the CBT intervention reported better outcomes than children who did not.

Introducing more developmentally appropriate interventions, particularly those that are play based, should increase the effectiveness of current CBT protocols, as used with older children. One very promising intervention is Trauma Focused Cognitive Behavioral Therapy (TF-CBT), an empirically supported treatment for PTSD. It is adapted from adult-based CBT (Cohen et al., 2000) for use with children aged 3 to 18 years. However, the majority of studies have used TF-CBT with school-age children. Cavett and Drewes (2012) developed a CBT intervention that integrated TF-CBT with play for young children that demonstrated promising results, as described in several case studies.

Finally, a school-based study for preschoolers compared a three-session cognitive behavior play intervention, which incorporated CBPT techniques (Pearson, 2007). Children in this group were compared with a control group, with results showing that teachers reported significantly fewer anxiety/withdrawal symptoms in the intervention group. Although the study involved a nonclinical sample and used play with CBPT techniques (vs. CBPT), it represents one of the first to empirically support CBPT interventions.

Given the current support for CBT with children (ages 9 years and older), support of play therapy (ages 3–8 years), and case studies of CBPT, an empirical foundation exists that CBPT may increase the effectiveness of CBT with young children. Future research should be designed to determine the effectiveness of CBPT. A CBPT manual could be used as a foundation for conducting randomized clinical intervention studies to establish effectiveness.

**CONCLUSION**

CBPT was developed by adapting empirically supported techniques for use in a play setting with young children. Designed specifically for 3 to 8 year old children, CBPT emphasizes the child's involvement in the therapy process. The child is an active participant in the change process, as
CBPT interventions are incorporated into play to make them most accessible to the child. A wide range of behavioral and cognitive intervention methods can be included in the treatment. The treatment is both structured and unstructured, and treatment planning includes efforts to help the child generalize learned adaptive behaviors to other settings, and incorporate relapse prevention efforts. An empirical foundation for CBPT includes work with older children and case studies with young, preschool age children. However, more research is needed to support the effectiveness of CBPT with the preschool-age population.

**APPENDIX: PLAY MATERIALS**

CBPT is usually conducted in a playroom or office equipped with appropriate play materials. To some extent, such materials can be chosen by the individual cognitive-behavioral play therapist. Ideally, the room has a variety of toys, art supplies, puppets, dolls, and other materials, such as the following suggested items:

- Puppets: dog (for children with dog phobias), alligator or shark (for use with children who bite or have issues with the expression of aggression), turtle (for children who are shy or have social anxieties)
- Construction paper of different colors
- Markers/crayons
- Dollhouse, including toilet (for children with toileting issues) and bed (for those with sleep problems)
- Family set of figures: mother, father, male sibling, female sibling, baby; different ethnic/racial groups should be represented
- Books on many different topics, including those related to moods/feelings, anxiety/fear, divorce, going to a new school, and so forth
- Toy cars
- Games to build therapeutic alliance: checkers, Candy Land, Connect Four
- Therapeutic games: Talking, Feeling, and Doing Game; Ungame
- Clay or Play-Doh
- Legos or other building supplies
- Feeling faces, posters, and feeling blocks
- Stickers, particularly ones that tie in with therapy themes (e.g., sign language “I love you stickers” from *The Kissing Hand*, trains from *The Little Engine That Could*, positive reinforcement themes)
- Dry-erase board
- Worksheets with pictures of people or animals with thought bubbles above their heads

(Adapted from Knell & Dasari, 2009. Reprinted with permission.)

**REFERENCES**


Cognitive-Behavioral Play Therapy 133


Pthomegroup
Fifty years have passed between the appearance of the first article about Filial Therapy in a professional journal (L. Guerney, 1964) and the writing of this chapter. In that time, Filial Therapy has been shown, clinically and empirically, to be a powerfully effective and adaptable family intervention. This chapter covers the theory, research, procedures, and broad applications of this very beneficial approach to resolving problems and building strong family relationships. Although the word parent is primarily used throughout this chapter, Filial Therapy is intended for use with any caregiver, such as foster parents or relatives assuming the primary parenting role.

**THEORY**

Filial Therapy (FT) is a form of family therapy that uses parent–child play as one of the key mechanisms for change. VanFleet (2014) describes it as a “theoretically integrative form of therapy in which practitioners train and supervise parents (or other caregivers) as they conduct special nondirective play sessions with their own children” (p. 2). Therapists provide feedback to parents after observing the parent–child play sessions, ensuring skill development and helping parents understand their children’s play themes. As parents become more skillful and understanding, they are in a better position to create the types of changes needed in their families. After a series of directly supervised parent–child play sessions in which parents develop their competence and confidence, the play sessions move to the home setting. The therapist continues to meet with the parents to discuss the home play sessions and other family matters and helps parents generalize the skills to everyday use.

FT is based on a psychoeducational model of intervention and prevention. A psychoeducational model views most individual and family problems as arising from a lack of skill or experience rather than from some inherent flaw or weakness of the client. Such approaches attempt to resolve problems by helping clients develop the necessary knowledge, skills, and abilities and to apply them to their own challenges and lives. In contrast to expert models in which therapists provide suggestions for clients to implement, FT operates as a collaborative model in which
parents are viewed as partners in the therapeutic process and are encouraged to take an active part in their own learning. The therapist is considered an expert in the knowledge and skills being taught, and the parents are considered to be the experts on their own children, families, and lifestyles. They combine their respective areas of expertise to identify the best ways to meet the children's and family's needs.

Theoretical Integration

FT represents a true integration of several theories (Cavedo & Guerney, 1999; Ginsberg, 2003; L. Guerney, 1997, 2003; L. Guerney & Ryan, 2013, VanFleet, 2011a, 2011b, 2011c, 2014). As Bernard Guerney developed his thinking about what eventually became FT, he drew from what he considered to be the most useful aspects of several theories of psychology and human development (personal communication, June 2, 1980). These are discussed briefly here and are covered in more detail in VanFleet (2014).

Psychodynamic Theory

FT incorporates the ideas of the unconscious, symbolism, and defense mechanisms, as well as Adlerian ideas of goals, mastery, and social interest. Children's play is viewed as often symbolic, and parents' reactions to play sessions reflect their own intrapersonal and interpersonal dynamics. FT allows for the expression and working through of these dynamics for the children in the parent–child play sessions and for the parents in the postsession discussions with the therapist.

Humanistic Theory

FT uses the principles and skills from Rogerian theory throughout the treatment process. Therapists offer empathy, acceptance, and positive regard to parents, just as parents learn to offer these to their children. The play sessions parents hold with their children remain nondirective, or child-centered (VanFleet, Sywulak, & Sniscak, 2010). The empathy offered to parents, and subsequently to children, is not perfunctory. All effort is made to understand and accept the deepest levels of feelings, intentions, motivations, and wishes. Both empathic listening and child-centered imaginary play skills help parents convey acceptance and understanding to their children.

Behavioral Theory

FT also uses principles and strategies from learning theory. Therapists employ ample positive reinforcement, shaping, and observational learning as they teach parents to conduct the special play sessions, as well as modeling, role-plays, and behavioral rehearsal. Parents learn to use structuring and limit-setting effectively during the play sessions to help children succeed behaviorally, and they learn positive reinforcement and appropriate consequences in daily life.

Interpersonal Theory

FT incorporates the importance of reciprocity in relationships and the idea that individual behavior is heavily influenced by interpersonal interactions. It essentially alters the problematic action–reaction patterns by helping parents recognize and change them. When the parent changes, so does the child. The FT process helps both parents and children take responsibility for their contributions to the change process. Parents begin to see themselves and their family through the eyes of their child via the play enactments, and motivation to make their own changes and adjustments increases.
Cognitive Theory

FT recognizes play sessions usually change the way children think about themselves, their parents, and situations in their lives, and those thoughts influence their feelings. FT uses cognitive restructuring to help parents understand children’s play themes and their own emotional reactions to them, and this process changes the way parents think about their children, themselves, and their relationships.

Developmental/Attachment Theory

FT allows for children’s developmental processes to be expressed during the play sessions and helps parents understand the developmental implications of the play. FT offers parents and children an opportunity to develop healthier, more secure attachments, and parents’ own attachment-related difficulties can be treated (Bifulco & Thomas, 2012). Therapists establish a safe environment in which all family members can work toward healthier attachment relationships.

Family Systems

In FT, the client is the relationship, not the individual child or parent. When one member of the family changes, so does the entire family system. Because everyone in the family is involved in the process whenever possible, FT helps strengthen the various dyadic relationships within the family (including the marital relationship as the couple learns to parent more collaboratively), as well as of the family as a whole.

Louise Guerney (1997) has described the dynamic and didactic elements of FT as:

the dual commitment to the forthright teaching of play sessions and simultaneous focus on the parents’ feelings as players and on parents as parents . . . . In involving parents in this process, one is entering the potentially emotionally threatening world of the parent-child relationship—a world of feelings and attitudes and family dynamics that would require the same respect and understanding that parents were asked to provide for their children. It should be understood, however, that the task of working with the children is always given top priority and the parents’ feelings and personal concerns never dominate. Filial Therapy is not a circuitous route to providing child-centered personal or parental therapy to parents. The perspectives of parents are critical and require acceptance and understanding on the way to learning how to develop the competence to conduct an appropriate child-centered play session for the benefit of their children and their relationships with their children. (pp. 131–132)

Essential Features of FT

FT is grounded in the values of genuineness, respect, transparency, understanding, empowerment, collaboration, relationship, and family strength. All family members are encouraged to express their feelings and needs in various ways throughout the process, and the therapist embodies humility, recognizing clients have much to offer for the resolution of their own problems and the right to make decisions about their own family life.

Based upon the theories integrated fully into the FT process and the values on which it is based, several features are considered essential to the method. These features distinguish FT as a unique approach to family therapy and differentiate between FT and other parent–child interventions,
as well as between FT and some variations that have been derived from or inspired by FT. These essential features of FT follow and are described in depth in VanFleet (2014).

- The importance of play in child development is highlighted, and play is seen as the primary avenue for gaining greater understanding of children.
- Parents are empowered as the change agents for their own children.
- The client is the relationship, not the individual.
- Empathy is essential for growth and change.
- The entire family is involved whenever possible.
- A psychoeducational training model is used with parents.
- Tangible support and continued learning are provided through live supervision of parents’ early play sessions with their children.
- The process is truly collaborative.

**EMPIRICAL SUPPORT FOR FT**

When FT was first conceived and developed, family therapy and play therapy were in their infancy. In the 50 years since, therapists have gradually embraced family interventions, and they have increased their awareness of and appreciation for what FT offers their client families. FT is now practiced in many countries and cultures throughout the world by therapists enthusiastic about the results they see. Research in many areas relevant to FT has also increased dramatically, including numerous topics related to family, play, parenting practices, play therapy, child socialization, attachment, and other family interventions. FT has also been studied since its inception, along with its variations and adaptations. This section discusses the research that informs and supports the practice of FT, as well as that which has established FT as an effective form of therapy to address child and family problems.

**Importance of Parent-Child Play**

The important role of play in optimal child physical, social, emotional, and cognitive development has been well established (see Ginsburg, 2007, for a review). Parent–child play has been shown to deepen, extend, and add to many of these benefits. In parent–child play, parents are given the unique opportunity to become the audience to their child’s internal world, to show interest in and acceptance of the child’s inner experience, and to help their child understand and value self in meaningful ways. Parent–child play is associated with increased positive child emotion (Stern 1993), increased parent affective congruence and attunement (Stern, 1985), advancements in child language development (Tamis-LeMonda, Bornstein, & Baumwell, 2001), lower levels of child conduct problems (Gardner, Ward, Burton, & Wilson, 2003), higher child IQ scores (Levenstein & O’Hara, 1993), increases in emotion knowledge (Lindsey, 1998), and increased peer competence and popularity (Vandell, Ramanan, & Lederberg, 1991).

Parents’ supportive involvement allows children to perform beyond their independent capacity. For example, in parent–child play, children show increases in sustained attention, greater complexity, and improved problem solving in play and an emerging sense of mastery and self-efficacy (Grolnick, Frodi, & Bridges, 1984). Perhaps the most important outcome of supportive parent–child play is that children learn they are loved and important (Power, 2009). In a review of the research associated with the benefits of child play, Ginsburg (2007) concluded that child resilience and healthy development are founded in the connection that develops when parents engage in child-led play (Ginsburg, 2007). These benefits of parent–child play are maximized as parents learn and use the play session skills of FT.
FT Targets Key Parenting Practices and Attitudes

FT implements what Cavell and Elledge (2004) refer to as a socialization-as-intervention approach to treatment. Rather than focusing exclusively on the reduction of child behavior problems, as in the case of intervention-as-intervention approaches, FT also concentrates on the broader relationship issues key to healthy child socialization. In addition to addressing immediate needs, FT assists families through fostering and improving the patterns of parent–child interaction that are most predictive of secure attachment and strong child behavioral and emotional regulation. Furthermore, FT helps parents increase their reflective functioning, a competency central to parents’ ability to foster each of the three child outcomes discussed next.

The first key child outcome is attachment security. Attachment security is predictive of a host of positive outcomes for children, including increased levels of positive affect, more frequent compliance with parent requests, greater social competence, higher self-esteem, greater empathy, and better emotional health (see Thompson, 2009, for a review). Parent sensitivity, accessibility, and responsiveness are the foundation for secure attachment (Ainsworth, Blehar, Waters, & Wall, 1978). Parental sensitivity, in particular, is one of the most influential parenting practices in promoting positive child outcomes (Sroufe, 1988). Sensitive parents are attuned to, accepting of, and responsive to their children's feelings and needs. Attunement is defined as attending to, accurately perceiving, and following the child (Stern, 1985), whereas misattunement is defined as misreading a child, making inaccurate attributions, or simply being tuned out (Powell, Cooper, Hoffman, & Marvin, 2014). Sensitive and attuned parenting promotes secure attachment for children and allows them to freely explore their physical and psychological worlds with confidence that the parent will act as the secure base to which they can return in times of distress or uncertainty. In contrast, parenting that is insensitive and misattuned is linked to social withdrawal, aggression, and attention deficit disorder (see Cummings and Cummings, 2002, for a review).

The second key child outcome is behavioral regulation. One of the primary goals of socialization is for children to learn to regulate their own behaviors without external constraint and to engage in socially appropriate behaviors without adult supervision (Grolnick & Farkas, 2002). Two parenting constructs as defined by Grolnick and Pomerantz (2009) that are critical to the development of child behavior control are autonomy support and structuring. Autonomy supportive parenting takes a child-centered perspective and includes practices that encourage child initiative and autonomous problem solving. The opposite of autonomy support is parental control, which takes a parent-centered perspective and includes parent behaviors designed to compel children to meet parent demands and rigidly controls child problem solving such that the child's growth is stagnated.

The term structuring refers to efforts by parents to organize children's environments in order to facilitate learning and development. Structuring includes providing children with clear and consistent expectations, guidelines, and limits, and helping children understand the relationship between their decisions and outcomes by use of feedback, inductive reasoning, and consistent consequences (Farkas & Grolnick, 2008). A parenting practice central to structuring is scaffolding, in which parents provide the assistance necessary to enable children to accomplish tasks beyond their independent abilities, while allowing children as much responsibility as they are able manage (Grolnick & Farkas, 2002). The opposite of structuring is chaos, in which parents provide little or no support and guidance to children in the learning process, leaving children to their own resources without consistent boundaries to help them learn healthy behavior management and how to make positive choices.

Structuring and autonomy support have consistently been shown to be associated with a host of positive child outcomes, including higher levels of prosocial behavior, motivation,
self-regulation, and competence, and lower levels of symptoms and problem behaviors (Lamborn, Mounts, Steinberg, & Dornbusch, 1991; Wang, Pomerantz, & Chen, 2007). In contrast, children of parents who exercise high levels of psychological control experience increased externalizing and internalizing symptoms, low behavioral regulation, low self-esteem, and academic problems (Barber, Stolz, & Olsen, 2005; Goldstein, Davis-Kean, & Eccles, 2005). Similarly, children of parents who provide little or no structuring demonstrate low competence, high levels of distress, and increased likelihood for getting into trouble (Lamborn et al., 1991).

The third key child outcome is emotional regulation. Learning how to regulate emotion in socially appropriate ways is a critical element of children’s development (Denham et al., 2003). Children’s difficulty regulating negative emotions, such as sadness and anger, is associated with a variety of emotional and behavioral difficulties (Frick & Morris, 2004; Silk, Steinberg, & Morris, 2003). A number of parenting attitudes and behaviors have been shown to be instrumental in the development of healthy child emotional regulation.

First, parents who foster healthy child emotional regulation are aware of and effectively regulate their own emotions (Gottman, Katz, & Hooven, 1997). This likely results from the fact that well-regulated parents are able to model healthy regulation; are less likely to express excessive amounts of negative emotion, which can be dysregulating for the child; and are more able to put aside their own needs in order to appropriately respond to the child’s experience and expression of emotion (Denham, Mitchell-Copeland, Strandberg, Auerbach, & Blair, 1997; Halberstadt, Crisp, & Eaton, 1999). Second, parents are aware and accepting of the child’s emotion and view experience of negative emotion as an opportunity for intimacy and to facilitate child emotional learning (Denham et al., 2003; Gottman et al., 1997). Third, parents help the child label the emotion, show empathy, and validate the child’s emotion (Gottman et al., 1997; K leagues, Fearnow, & Miller, 1996). Finally, parents scaffold to foster child learning. Parents scaffold by keeping the child’s emotion in the range the child can successfully manage (Grolnick & Farkas, 2002). They do this by modifying the environment to provide opportunities for the child to experience or avoid particular emotional stimuli (Parke, 1994). Parents also scaffold by providing supportive guidance as the child struggles to regulate, appropriately express, and respond to the emotion (Gottman et al., 1997).

Research indicates children are more skilled at regulating their emotions, are more successful socially, and achieve more academically if their parents are aware of and value emotional expression, validate their experience, and support and scaffold their expression and coping strategies (Gottman et al., 1997). In contrast, children whose parents are dismissive or punitive in response to their negative emotions tend to be dysregulated in experience and expression and are more likely to use escape as a way to cope with emotional distress (Fabes, Leonard, Kupanoff, & Martin, 2001).

Parental reflective functioning is a necessary foundation for many of the parenting attitudes and practices essential in fostering the three key child outcomes described thus far. Reflective functioning is the ability to perceive mental states in oneself and in others (Fonagy, Gergely, Jurist, & Target, 2002). It is the ability to reflect on one’s own and others’ thoughts, feelings, and behaviors and to see them as separate, as well as to discern how one’s thoughts, feelings, and behaviors influence others’ thoughts, feelings, and behaviors, and vice versa (Powell et al., 2014). Reflective functioning is believed to be a critical competency in preventing parents from passing along their own attachment insecurities to their children. The parent–child interaction of parents with poor reflective functioning is likely to be reflexively driven by parent needs and insecurities.

In contrast, parents with well-developed reflective functioning can reflect on how their own insecurities and reflexive tendencies influence them and their interactions with their child. They
can become intentional in suppressing these tendencies in favor of responding according to their child's needs (Powell et al., 2014). Reflective functioning includes the capacity to understand child developmental capabilities, challenges, and needs, an understanding that is basic to positive parenting (Smith, Perou, & Lesesne, 2002). Parents who lack this awareness and who have unrealistic expectations for their children judge children more harshly, attribute more negative intent to their children, are more likely to respond with hostility and coercion, and are at increased risk to abuse or neglect their children (Azar, 1998; Azar & Rohrbeck, 1986; Chilamkurti & Milner, 1993; Larrance & Twentyman, 1983).

How FT Helps Parents Develop Key Skills and Attitudes

A primary focus of the FT play sessions is helping parents learn to set aside personal needs and agendas in order to be fully present and accepting of their child. The play session skills primarily associated with parental sensitivity are empathic listening and child-centered imaginary play. In learning and using empathic listening skills, parents become progressively attuned to the child's internal experience and increasingly better at capturing the depth of the child's experience in their reflections. In child-centered imaginary play, parents develop and demonstrate a higher level of attunement by playing their roles according to the child's needs and wishes. Frequently, parents are given few or no instructions on how to play their role in imaginary play and are dependent on attuning to child verbal and nonverbal communication to discern what the child needs from them. Parents use this information to play out their roles according to child desires with appropriate emotion and intensity. This helps parents hone their skills of attunement and also communicates profound caring, understanding, and investment to the child. As parents learn to use the play session skills more naturally, children experience their parents as available and responsive and as a secure base for exploration as they work through and seek mastery over fears, anxieties, and insecurities. After parents develop high levels of sensitivity in parent–child play, it is a somewhat natural process for them to carry those sensitivities with them into everyday parent–child interactions.

Parent–child play sessions are child-centered, and as such, they are focused on supporting child autonomy while children work through and seek mastery over challenges and insecurities. Similar to parental sensitivity, the FT skills most associated with autonomy support are empathic listening and child-centered imaginary play. Parents learn to allow their children space to struggle with and take primary responsibility for working through their challenges and frustrations in play. In order to do so parents learn to fight their impulses to rescue or take over responsibility for resolution of child struggles, and they learn to provide warm reflective support for their children as they problem solve and develop confidence and competence. As previously mentioned, parents also support child autonomy by playing imaginary play roles according to child desires. Parents suppress their needs to direct the play or drive the play toward their own desired resolutions.

The skills most associated with the general parenting competency of structuring are the FT structuring and limit-setting skills. Because of the child-centered nature of FT play sessions, structuring and limit-setting are kept to a minimum, and yet play an important role in creating safety, predictability, and boundaries in play sessions. The structuring skill helps orient children to transitions in and out of play sessions, as well as to the work within the session. The limit-setting skill provides children experience with boundaries and opportunities to make choices and learn from the consequences of their choices, which are important experiences in helping children develop behavioral regulation.

In later stages of FT, parents are taught to generalize the structuring and limit-setting skills beyond play sessions. They learn to set limits and enforce consequences in ways that maximize child choice and behavioral regulation. Parents are selective about the types of limits
(nonintrusive and noncontrolling); they are firm and confident, but not emotionally reactive or adversarial in the process; consequences are consistent and predictable; and shame-based or excessive consequences are avoided. The therapist helps the parents identify appropriate limits and consequences as needed. The generalization of the structuring skill is very much about scaffolding for the child. Parents learn to monitor environmental influences, difficulty of tasks, child emotional states, and child abilities, and they intervene as needed to provide only as much support as necessary to maximize child success and learning.

Through play sessions, parents and children learn a great deal about their emotions and healthy emotion management. The play session skill primarily associated with child emotional regulation is empathic listening. In the FT process, parents develop awareness of and acceptance of their child’s emotional experience and learn to communicate acceptance through reflecting and labeling their child’s emotions in play. The parent learns to scaffold the child’s experience problem solving and coping with emotion by providing a safe and accepting atmosphere and through the use of supportive reflections that help build esteem. For example, in response to a 4-year-old boy who is having trouble stacking the blocks, a parent might reflect, “You are trying to make a tower with those blocks but you are frustrated because they just won’t stay up there.” In response to the child’s continuing efforts, the parent might add, “You are trying different ways to try to make the blocks stay so you can stack them higher.” After the child succeeds, the parent might state, “It was very hard and frustrating to try to stack those blocks, but you kept working at it until you figured it out and you are so proud!” The parent’s scaffolding reflections help the child learn and accept his emotions, persist in the face of adversity, become more aware of and value his problem-solving efforts, and celebrate successfully working through his frustrations.

In post-play-session discussions, the therapist assists parents in becoming increasingly attuned to child emotion and to methods for most effectively responding. In addition, these discussions provide parents an opportunity to improve awareness and acceptance of their own emotions as the therapist helps parents recognize and label their emotional experiences in response to their child’s behaviors and emotions in play. The therapist validates and helps parents effectively manage emotions so they do not prevent the parents from being fully present and accepting of child’s experience. Parents become increasingly aware of and respectful of the separate and different emotional experiences they and their children have during this process. In later stages of FT, the therapist helps parents translate these skills into accepting, validating, labeling, and scaffolding problem solving for their children when they experience emotion outside of play sessions.

The parents’ capacity to reflect on and develop increased awareness of their own and their children’s thoughts, emotions, and behaviors is central to their ability to learn and master the FT parenting practices and attitudes. As parents gain greater confidence with the basic play session skills, increasing amounts of the post-play feedback sessions are devoted to helping them gain awareness of their child in play and the potential significance and meaning of child play behaviors and themes. Therapists scaffold the discussion for parents, providing guidance and offering suggestions as they struggle to reflect on and understand their child and themselves in play sessions. The therapists are particularly watchful for parents’ emotional reactions to their child’s play. If parents fail to bring these up in post-play feedback discussions, the therapist may gently make the observation and invite the parents to talk about the experience. This process allows the therapist to help parents become aware of their own reactions, to explore what the reactions are about, and to work through them so that they do not interfere with their ability to be fully responsive to their child.
FT Research Findings

Over 50 research studies have been conducted on FT interventions during the past half-century, and they consistently demonstrate the positive and enduring effects of FT (L. Guerney & Ryan, 2013; VanFleet, Ryan, & Smith, 2005). In 2005, Bratton, Ray, Rhine, and Jones conducted a comprehensive meta-analysis of play therapy studies published between 1953 and 2000. Of the 93 included studies, 22 exclusively focused on FT interventions. They found the effect size for professional-directed play therapy was 0.72, meaning those participating in play therapy interventions performed 0.72 standard deviations better than those in the comparison conditions. This strong effect size is well above what Cohen (1988) classified as a medium effect size (0.50) and just shy of a large effect size (0.80).

Bratton and colleagues found that the effect size for parent-involved FT studies was 1.15, which was statistically greater than the effect size for professional-directed play therapy interventions and quite a bit larger than the range of effect sizes for other reported child psychotherapy studies (0.66 to 0.84; Bratton et al., 2005). Bratton and colleagues found no association between age and gender of child and outcome, reflecting the flexibility and broad applicability of FT and play therapy.

Although research has yet to examine the effect of FT on child attachment, a substantial amount of research has demonstrated the relationship between FT and increased parental sensitivity. A common measure used in FT research is the Measurement of Empathy in Parent–Child Interaction (MEACI; Stover, Guerney, & O'Connell, 1971). The MEACI is an observational measure made up of three subscales: communicating acceptance (verbal acceptance of child behavior and feelings), allowing the child self-direction (following the child's lead rather than controlling the child), and involvement with the child (parents' undivided attention and participation in child-led play according to child wishes). The MEACI taps into parental sensitivity and attunement to and respect for the child's needs and feelings. Research has consistently shown that parents participating in FT demonstrate significantly greater increases in behavior for all three MEACI subscales (e.g., Kidron & Landreth, 2010; Lee & Landreth, 2003; Yuen, Landreth, & Baggerly, 2002) when compared to parent control groups.

Another commonly used measure in FT research that taps into the parental sensitivity construct is the Porter Parental Acceptance Scale (PPAS; Porter, 1954). The PPAS is a parent report measure that includes four subscales: (1) respect for the child's feelings and the child's right to express them, (2) appreciation of the child's uniqueness, (3) recognition of the child's need for autonomy and independence, and (4) a parent's experience of unconditional love for a child. Studies have consistently shown that parents who participate in FT experience significantly greater increases in acceptance of their child, as measured by the PPAS, than those in control conditions (e.g., Costas & Landreth, 1999; Sywulak, 1979; Yuen et al., 2002). Studies have also shown that increases in acceptance are maintained at 2-month (Johnson-Clark, 1996), 6-month, and 3-year follow-up assessments (Sensue, 1981). In examining the subscales separately, Tew and colleagues (Tew, Landreth, & Joiner, 2002) and Harris and Landreth (1997) found that parents participating in FT scored significantly higher than parents in the control condition on two subscales: the respect for the child's feelings and right to express them, and the recognition for the child's need for autonomy and independence.

Autonomy support has been shown to increase significantly as a result of participation in FT. Parents participating in FT report increased respect for and understanding of the importance of child autonomy and also demonstrate lower levels of control and higher levels of allowing child self-direction in play (Harris & Landreth, 1997; Kidron & Landreth, 2010; Tew et al., 2002; Yuen et al., 2002). The outcome of FT research most associated with child behavioral
regulation, or the lack thereof, is assessment of child behavior problems. A number of different measures of child behavior problems have been used in FT research, including the child behavior checklist (CBCL; Achenbach & Edelbrock, 1983), the Eyberg child behavior inventory (ECBI; Robinson, Eyberg, & Ross, 1980), and the filial problem checklist (FPC; Horner, 1974). Research has consistently shown that children participating in FT experience significantly greater reductions in child behavior problems relative to control groups (e.g., Oxman, 1972; Sheely-Moore & Bratton, 2010; Tew et al., 2002). Specifically, studies have found FT results in significant reductions in numbers of parent-perceived child problem behaviors (e.g., B. Guerney & Stover, 1971; Landreth & Lobaugh, 1998; Sensue, 1981), externalizing behaviors (Kidron & Landreth, 2010; Smith & Landreth, 2003), aggression, and attention difficulties (Bratton et al., 2013).

Studies by Bratton and colleagues (Bratton et al., 2013; teacher report) and Johnson-Clark (1996; parent report) found that a majority of children in the FT condition moved from clinical or borderline behavior problems to nonclinical levels from pre- to postassessment. Johnson-Clark (1996) found that behavior problems continued to decrease at the 2-month follow-up assessment, lending support to the idea that FT helps parents develop parenting practices that continue to have a positive impact on child development after the completion of treatment. Sywulak (1979) assessed parent and child functioning 4 months prior to treatment, just prior to treatment, at 2 months into treatment, and 4 months into treatment. Changes in parent behaviors were evident at 2 months and changes in children were evident by 4 months, suggesting that at least part of the positive child outcomes of FT are likely a function of improving parenting behaviors.

Although research has not yet examined the association between FT and child or parent emotional regulation, research has demonstrated increases in parent acceptance and validation of child emotion as a result of participation in FT (Harris & Landreth, 1997; Kidron & Landreth, 2010; Tew et al., 2002). Furthermore, qualitative research (parent report) indicates children who participate in FT exhibit less whining and arguing, become soothed more quickly after being upset, and are much more likely to express their emotions and needs to parents (Lahti, 1992). Research examining the predictors of treatment success in FT provides some promising results. Topham and colleagues (Topham, Wampler, Titus, & Rolling, 2010) examined the predictors of FT treatment outcome with FT conducted in an individual family format (as in VanFleet, 2014) and found that higher levels of parent psychological distress and poorer child emotional regulation at pretest were associated with greater reductions in child behavior problems across treatment. Similarly, poor parent emotional regulation at pretest was associated with greater increases in parent acceptance of the child across treatment. These associations were found whether examining outcomes as continuous indicators of amount of change or dichotomous indicators of reliable change. Although not empirically tested, these results provide support for the idea that increases in parent and child emotional regulation in FT may be partially responsible for positive treatment effects.

Although quantitative research has not investigated the effect of FT on parent reflective functioning, several qualitative studies provide evidence for an effect. Parents who participate in FT report increased awareness of children’s emotions and needs and more realistic expectations of their children (Edwards, Sullivan, Meany-Walen, & Kantor, 2010; Lahti, 1993; Wickstrom, 2009). In a study by Wickstrom (2009), parents identified several benefits of participation in FT, including developing a heightened awareness of their tendency to want to fix things for children or rescue them from struggles and a decrease in feeling personally responsible for their children’s behaviors. Lahti (1992) found that parents who participated in FT reported becoming more attuned to their children’s communication, behavior, and motives. Furthermore, parents reported an increased awareness of their own behaviors in interaction with their children, the reasons for the behavior, and how their behaviors impacted their children.
In addition to the FT outcomes associated directly with the key child outcomes and parenting practices outlined earlier in this chapter, a number of other meaningful outcomes of FT have been demonstrated across multiple studies. These include increases in child social adjustment (Boll, 1973; B. G. Guerney & Stover, 1971), increases in child self-esteem (Landreth & Lobaugh, 1998; Smith & Landreth, 2003), decreases in parental stress related to self-perception and child behaviors (e.g., Bratton et al., 2013; Bratton & Landreth, 1995), and decreases in internalizing symptoms (Grskovic & Goetze, 2008; Smith & Landreth, 2003) as well as anxiety and depression (Tew et al., 2002).

Perhaps most noteworthy in the FT literature is that FT has been shown to be effective with a wide range of presenting problems and family circumstances. For example, FT is effective with parents of children with conduct problems, chronic illness, learning disorders, pervasive developmental disorder, and children who have been sexually abused or who have witnessed domestic violence. In addition, FT is effective with foster parents, single parents, incarcerated mothers and fathers, and parents from a wide range of cultural and ethnic backgrounds (for a review, see Bratton & Landreth, 2010; L. Guerney & Ryan, 2013; VanFleet et al., 2005).

Table 7.1 provides a summary of the key child outcomes, parent competencies, FT skills, and research outcomes.

PROCEDURE

The process of FT is straightforward. It requires substantial therapist skill and sensitivity, as well as flexibility and creativity. The overall process remains the same in most cases, but the details differ considerably with each child and each family. This section discusses how to conduct FT competently and effectively, the types of problems that can be treated, how to establish the physical space, how clients are assessed and brought into FT, and what occurs during each stage of the treatment process.

Therapist Qualifications, Training, and Characteristics

FT requires advanced clinical skills. Practitioners must be highly experienced in conducting child-centered play therapy with a wide range of problems (VanFleet et al., 2010). They must be able to demonstrate a child-centered play session with each child in the family as the parents observe, and then teach and supervise parents as they conduct nondirective play sessions; being able to conduct CCPT in front of the parents as a demo requires the therapist to be competent in CCPT, basically. Therapists must also have an excellent working knowledge of family therapy, demonstrate skill in structuring interactions with parents or groups of parents, and be able to manage conflicting perceptions and needs between parents.

Therapists practicing FT must have a highly developed ability to be empathic and to show understanding through empathic listening, both to parents and children. When working with children, it can be tempting to fault the parents for the problems one sees. Indeed, sometimes the parents have played a large role in creating them, but not always. It is important to remember that little can change without engaging parents in the process. Superlative outcomes with individual play therapy can easily unravel when parents are not able to shift their own ways of thinking or behaving. As noted earlier in this chapter, part of the therapeutic intervention includes helping the parents reflect on their own feelings and behaviors while learning to be more empathic and attuned with their children. Therapists using FT create an atmosphere of safety and acceptance with the parents in order to help them learn and to put these new ways of thinking and interacting into practice. That is most effectively done by showing empathy at
<table>
<thead>
<tr>
<th>Child Outcomes</th>
<th>Parent Competencies</th>
<th>FT Skills and Interventions</th>
<th>FT Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure Attachment</td>
<td>• Sensitivity</td>
<td>• Empathic listening</td>
<td>• Increases in parental verbal acceptance of child behavior and feelings</td>
</tr>
<tr>
<td></td>
<td>• Accessibility</td>
<td>• Child-centered imaginary play</td>
<td>• Increases in parent following child's lead rather than controlling child in play</td>
</tr>
<tr>
<td></td>
<td>• Responsiveness</td>
<td></td>
<td>• Increases in parents' undivided attention and attuned following in child-led play</td>
</tr>
<tr>
<td>Behavior Regulation</td>
<td>• Autonomy support</td>
<td>• Empathic listening</td>
<td>• Decreases in child behavior problems</td>
</tr>
<tr>
<td></td>
<td>• Structuring</td>
<td>• Structuring</td>
<td>• Increases in parent recognition of child's need for autonomy and independence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Limit setting</td>
<td>• Lower levels of parent control and higher levels of parent allowing child self-direction in play</td>
</tr>
<tr>
<td>Emotion Regulation</td>
<td>• Parent emotion regulation</td>
<td>• Empathic listening</td>
<td>• Increases in parental verbal acceptance of child's behavior and feelings</td>
</tr>
<tr>
<td></td>
<td>• Awareness and acceptance</td>
<td>• Reflective functioning</td>
<td>• Increases in respect for child's feelings and the right to express them</td>
</tr>
<tr>
<td></td>
<td>of child emotion</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Label and validate child</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>emotion</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Scaffold child learning</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Post-play discussions</td>
<td>• Heightened parent awareness of child's emotions and needs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Heightened parent awareness of own behaviors, the motivation for the behaviors, and how their behaviors impact child</td>
</tr>
</tbody>
</table>
the deepest levels for the parents’ feelings about the child, themselves, and each other. Being empathic is a mindset in which all judgment and personal thoughts about the situation are put aside while the therapist truly attempts to understand what the parents’ messages are. Empathy is both an attitude and a skill, and it can be strengthened through in-depth FT training.

It is critical that those conducting FT have a full understanding of the values and principles of the method; the essential features and why each is important; the actual methods used to engage, train, and supervise parents; as well as how to process parents’ understanding of play themes and their own feelings (L. Guerney & Ryan, 2013; Van Fleet, 2014). The values, principles, and essential features form the foundation for the method and all treatment decisions. In terms of the skills needed to conduct FT, two are particularly critical: conducting the mock (pretend) play sessions to train the parents and processing parent reactions to the play sessions. These are both covered in FT training programs.

Reading a chapter or a book or watching a DVD is not enough to qualify one as a competent FT therapist. There are many subtleties to the approach and complex skills that can only be learned through observation and practice. Some didactic parent-education-style adaptations of FT exist and perhaps can be applied by experienced practitioners. Considerable training and supervised practice is required for those wishing to become proficient in the full family therapy form of FT as developed and refined by Guerney. It is well worth the effort to learn it for the results that are typically achieved.

The best training programs are those that teach professionals using the same principles and methods that they will eventually use with parents. This often takes place in a small training group where participants can learn and practice the skills used at different stages of the process and receive individualized feedback from the instructors. Learning via a parallel process that will be implemented with parents can be very valuable (B. G. Guerney, personal communication, June 3, 1980). The professional experiences what the FT process feels like when learning something new (how to conduct FT), just as parents experience it when they learn how to conduct the play sessions. A number of universities and Certified Filial Therapy instructors (continuing education providers) offer training in one or more forms of FT. At least two independent certification programs exist for FT. More information about training, resources, and certification in FT is available at www.play-therapy.com and at www.nire.org.

Client Characteristics

FT focuses on helping clients repair and strengthen relationships. Its flexibility, coupled with the universality of its basic premises and use of play, has resulted in a diverse range of clients who can be helped. It has been used as (a) a prevention program for parents who wish to create healthy attachments with their children and to stave off many potential problems, (b) a way to help at-risk families cope with and master the difficulties under which they live, and (c) a full-fledged family intervention for families experiencing the full range of mild, moderate, and severe problems. FT has been successfully used with families from all socioeconomic and educational levels, and from many cultures and countries throughout the world.

Generally speaking, FT is most relevant to children who are 3 to 12 years old, as those are the ages when children use their imaginations most actively in their play. Some colleagues have implemented FT with younger children by adapting the limit-setting language (shifted to a simple redirection) and some of the toys (larger, age appropriate) with good results. Although FT typically shifts to the use of special times (time spent together when parents still use most of the skills but without toys) after the age of 12, there are instances in which FT has been used in a playroom with toys with individuals as old as 16. This is sometimes possible when children’s trauma and attachment disruption histories have left them functioning socially and emotionally
at levels below their chronological age. Very often, these adolescents engage in more dramatic play during the play sessions, but they have required little change in terms of the overall structure and process.

**Indications and Contraindications**

Because FT is a process-oriented form of therapy that focuses on family relationships and a socialization-as-intervention approach, it can be applied to a wide array of problems (Cavell & Elledge, 2004). While other interventions might be required before, alongside, or after FT to meet specific needs of the child or family, it is common for FT to be the only form of therapy needed because of its systemic focus. Even when other interventions are added, FT maintains a central position in the treatment by virtue of its ability to create healthy attachment relationships and shift the entire family system to more adaptive functioning.

FT has shown clear clinical success with the following problems: anxiety, depression, behavior problems, trauma, abuse and neglect, divorce-related issues and parental alienation, domestic violence, foster care, adoption, medical illness, attachment disruptions and reactive attachment disorder, autism spectrum disorders, fearfulness, school refusal, bullying, attention deficit disorders, shyness, sibling rivalry, enmeshed relationships, oppositional behaviors, toileting problems, perfectionism and obsessive-compulsive disorder, addiction, and others (Van Fleet, 2014; Van Fleet & Guerney, 2003). There are times when FT is completely contraindicated or not recommended as the first treatment the child and family receive. It would very rarely be appropriate in cases in which one of the parents was the perpetrator of sexual abuse but was permitted to retain a relationship with the child. In other cases of child maltreatment, however, FT might be used at some point in the process. FT would not necessarily be the initial intervention, especially if the child had not had prior individual therapy. The perpetrator of abuse would only be considered for FT after showing genuine remorse and successful completion of other therapeutic programs to take responsibility for his or her actions, and only when the therapist deemed the child ready for this step. In this case, FT might provide better tools for that parent to use when the child is not behaving as desired as well as to help overcome the damage to their relationship and create a better one. The nonoffending parent could be involved in FT; this would typically occur after the child had some intervention with the therapist and with someone who was not part of the abuse context. If the nonoffending parent truly was unaware of the abuse happening, then involvement might come more quickly. If the nonoffending parent continues to justify the actions of the abusive parent, more work needs to be done before using FT. At all times, the child’s needs for physical and emotional safety are deciding factors in when and if to involve a parent in the play sessions. If the court and/or child protection agency determine the child remains with, or is returned to, the parents after intrafamilial violence, then FT can serve as a very useful tool to reunify the family and to help move unhealthy patterns of behavior toward health. In most cases of child maltreatment or domestic violence in which children have been traumatized with attachment disruptions, FT is possible as a mechanism for change and abuse prevention (Van Fleet & Sniscak, 2003a).

Another time when FT would generally be used later in the therapeutic process is when parents have absolutely no ability to keep their focus on the child. This often happens when they have serious emotional issues or distractions of their own. If parents show an ability to discuss their children without going off on tangents to discuss their own emotional distress for approximately 10 minutes during intake, they might be candidates for FT. If their own emotional needs are pressing, yet they can retain this focus, a version of FT can be implemented in which their initial play sessions are kept shorter than the usual half hour. An example of this is when parents have
been through an unpleasant divorce and their emotional energies are all directed toward the ex-spouse, with little left over for the children. The therapist might also suggest some individual therapy before bringing FT into the picture.

FT is useful for families who have experienced traumatic events (VanFleet & McCann, 2007; VanFleet & Sniscak, 2003b). A complication arises if the parents themselves have been traumatized or are experiencing traumatic grief. At times, they are able to conduct FT and have reported that it is beneficial in reducing their feelings of helplessness and hopelessness, and at other times they can be so filled with their own emotional reactions they are not yet ready to be able to focus long enough on their children’s emotions. In the latter cases, individual play therapy with the children can be offered while the parents seek the emotional help they need. To determine whether or when to include parents in FT treatment after traumatic events, therapists typically have open discussions with the parents about what this entails emotionally and how able they feel to see, hear, and respond to it. The therapist provides practice handling children’s trauma play and emotions during the FT training phase, and if the therapist and parents feel ready to move forward, the therapist’s presence during the parent–child play sessions, as well as the therapeutic processing and debriefing after the play sessions, provides an empathic “containment” of the parents’ feelings so they can participate together with their children.

Finally, FT would not be used if the parents did not have the ability to learn the four skills used during the play sessions. Because the skills represent emotional intelligence more than academic intelligence, very few parents are ruled out for this reason. FT has been used successfully with parents with developmental delays and disabilities. The therapist makes some adjustments in the training process at times, using more modeling and repetition until the skills are adequately learned.

Other than these situations in which FT would be delayed or inappropriate, the approach has wide applicability. Some client and family situations are much more difficult than others, and only practitioners with full training and experience should use FT in those circumstances. Practicing within one’s competence level is vital.

Logistics

The logistics of conducting FT can be challenging at times, but no more challenging than other forms of family therapy or family play therapy. Because the therapist sometimes works with the parents alone during the training and home play session stages, there are times when it is useful to have child care available. When the children are present, the therapist might elect to observe one parent–child dyad’s play session, and possibly a second, but the children are then excused as the therapist meets with the parents to provide skill feedback and discussion of play themes and parents’ reactions. Some children can wait by themselves in a safe, private waiting area, whereas others need more supervision. In the latter case, parents can either take turns staying with the children, or bring along another family member to watch them. The therapist might also decide to provide child care. In the case of FT groups, it is very important to provide child care for the children present at any given session (L. Guerney & Ryan, 2013; VanFleet, Sniscak, & Faa-Thompson, 2013). Other logistics are covered in the subsections that follow.

Playroom Setup, Toys, and Materials

The playroom for FT is set up in the same way as one that is used for child-centered play therapy (described in detail in VanFleet, 2006a, 2006b, 2012; VanFleet et al., 2010). In addition, a small
observation area is often added in the end or corner of the room from which parents can watch the therapist's demonstrations, and the therapist can watch the parent–child play sessions. A one-way mirror with observation booth is valuable, but not necessary for individual family sessions; it is, however, important for group FT. An alternative is to have a separate room from which the therapist and other family members can observe the sessions on a computer through a remote wireless setup. This is not the preferred option because it does not provide the details of subtle interactions, but it can work.

A variety of toys, drawn from different categories, is provided in an appealing layout, neither too tidy nor too messy. Highly structured games and toys are not included because they are less likely to have a range of imaginative uses. The primary categories of toys are (a) family and nurturance toys, (b) communication toys, (c) aggression toys, (d) mastery toys, and (e) creative expression toys. Toys need not be extensive or expensive, but some items from each category should be included. Parents are expected to provide a (mostly) separate set of toys for their home play sessions, so simple therapist playrooms keep children's expectations of the home toy sets within bounds. When parents do not have the means, therapists sometimes provide loaner toy kits or obtain funding to provide simple FT play kits that can be given to the families who need them.

**Treatment Frequency and Duration**

The length of FT varies with the individual families. The average number of sessions for families with mild to moderately serious problems is 17 to 20 one-hour sessions (VanFleet, 2012, 2014). Some, of course, will require less and some with very serious problems will need more. Group FT is usually conducted in 2- or 3-hour sessions and takes 12 to 20 sessions (L. Guerney & Ryan, 2013; VanFleet et al., 2013). The CPRT group model inspired by and adapted from FT follows a parent education–type format in 10 weeks and also has research support (Landreth & Bratton, 2006). FT is a flexible approach and has been offered to clients throughout the world in a variety of formats that suit the clients’ needs and circumstances.

When FT is conducted with individual families, weekly sessions are most common and offer the greatest continuity. Biweekly sessions seem to work well, too, although they lengthen the overall involvement of the family in the process. Sometimes families attend on a weekly basis during the training and supervised parent–child play sessions portions of FT, and once their home play sessions are off to a good start, they drop back to biweekly sessions (while the children are receiving at least weekly play sessions with their parents).

After parents are trained and have become competent enough to start the home play sessions, they each hold a half-hour play session with each child in the family who is between 3 and 12 years of age (approximately). Special times are held with adolescents. This frequency is not always possible, but each child should get at least one play session each week, perhaps with parents alternating between children.

**Pretreatment Intake and/or Assessment and Treatment Planning**

The assessment process usually requires two 1-hour meetings. The therapist meets with parents alone the first session, listening carefully and empathically to their concerns, asking follow-up questions, and obtaining appropriate background information. Any premeasures being used are given to the parents to take home to complete and return at the next meeting. This process is described in detail in VanFleet (2014).
Family Play Observation

The second meeting consists of a family play observation (FPO). Here, the entire family comes to the session, and they play together in the playroom for approximately 20 minutes. The therapist instructs the parents to explain to the children that they are going to a special place that has a playroom and where families go to learn to get along better and be happier together. The therapist sits in the corner of the room or in an observation booth behind a one-way mirror and observes the family as they interact. Little structure is imposed on this family play, as the purpose is to see natural interactions insofar as that is possible. The therapist watches for a number of things, such as the parents’ interactions with each child present and with each other, the children’s interactions with each other, the ones who initiate activities and those who play together, who might be left out, how conflicts arise and are handled, and other things of note. Near the end of the FPO, the therapist announces that they have 5 minutes left, and again when they have 1 minute left, and then tells them their time is over. The children are dismissed to a waiting area and the therapist meets with the parents alone to discuss the FPO.

The therapist starts with the following question: “What happened during your play time together that is typical of what goes on at home, and what was not typical?” The therapist ensures that both parents share their impressions and empathically listens throughout. The therapist then asks any questions that might have arisen, such as “I noticed you had to tell her to put the water down several times and she seemed to ignore you. How typical is that of what goes on at home?” The therapist maintains a nonjudgmental stance and listens carefully to parents’ responses.

Recommendation of FT

While therapists might have mentioned the possibility of FT during the initial phone call and/or the initial meeting, a more formal recommendation is made after the FPO. The therapist briefly explains what FT is and why he or she is recommending it for the family’s problems. As the therapist makes the recommendation, it is extremely valuable to tie the potential benefits of FT explicitly to the problems the family is facing and that the parents described during the first session. This is to help parents see the relevance of the recommendation. An example of this is when the therapist says, “Last time, you told me that your son has been very clingy, and we talked a little about his insecurities. I think that FT would really help with this by building his sense of safety and security and providing him with an opportunity to express some of his worries and find a way to overcome them.” The therapist also wants to explain what the parents might gain from this experience: “It seems that you have a really nice relationship with your adopted daughter already, and I think if we can build on that at the start of your relationship, it can help prevent some problems from occurring down the line. We know that she has had some pretty big disruptions in her family life along with significant trauma, so FT will help you build the kind of relationship where she will be able to open up with you, and in the safety of the playroom work through some of that trauma. If you can do that together with her, it can really benefit your relationship and give you the tools to handle emotional upsets whenever her past traumas are triggered.”

Parents are encouraged to raise questions and doubts about the recommendation, and the therapist responds with empathy and further explanation of the rationale and the specific things that occur during FT. If an additional meeting is needed to cover parental concerns or objections, then it is scheduled. This is not usually needed, however. Even if the parents remain unsure, the therapist does not pressure them. Instead, the therapist suggests they bring their children back the following week so that the therapist can hold a short child-centered play therapy session with each child while they watch. The therapist indicates that the parents will then have a much better idea of what to expect and how their children are likely to respond.
Play Session Demonstration

This session forms a bridge between the assessment phase and the therapy phase. The therapist conducts short child-centered play sessions of 15 to 20 minutes with each child in the family (or a select group in very large families) while the parents observe. The parents note their observations and questions for later discussion. After the demonstrations, the therapist meets to discuss them with the parents, answering questions, pointing out various things that occurred, and once again tying together the stated goals of the family with how FT might work for them. With a more concrete example of what is involved, parents usually are ready to commit to the process after this session.

Treatment Stages and Strategies

FT follows the sequence shown in Table 7.2, which includes the assessment phase. This section explains the phases of FT and what happens in each one.

Table 7.2  The Sequence of Filial Therapy

<table>
<thead>
<tr>
<th>Early Phase</th>
<th>Middle Phase</th>
<th>Closing Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial assessment</strong> (one session):</td>
<td><strong>Training of parents (three sessions):</strong></td>
<td><strong>Generalization (four to six sessions):</strong></td>
</tr>
<tr>
<td>- Discussion of problems</td>
<td>- Explanation of skills</td>
<td>- Discussion of home sessions</td>
</tr>
<tr>
<td>- Social/developmental history</td>
<td>- Initial skills practice</td>
<td>- Use of skills in daily life</td>
</tr>
<tr>
<td>- Completion of premeasures</td>
<td>- Two mock play sessions, feedback</td>
<td>- Additional parenting skills</td>
</tr>
<tr>
<td><strong>Family play observation and recommendation (one session):</strong></td>
<td></td>
<td><strong>Discharge planning (one to three sessions):</strong></td>
</tr>
<tr>
<td>- Family play observation, discussion</td>
<td></td>
<td>- Discharge plan developed jointly by therapist and parents</td>
</tr>
<tr>
<td>- Recommendation/rationale for FT</td>
<td>- Parents conduct play sessions under therapist direct supervision</td>
<td>- Phased out sessions with therapist</td>
</tr>
<tr>
<td>- Description of process</td>
<td>- Feedback about skills, processing of themes, and parent reactions</td>
<td>- Direct supervision of one last play session (optional)</td>
</tr>
<tr>
<td>- Answer questions</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Demonstration (one session):</strong></td>
<td><strong>Transfer (one session):</strong></td>
<td><strong>Final assessment (one session):</strong></td>
</tr>
<tr>
<td>- Therapist conducts child-centered play therapy sessions with each child; parents observe</td>
<td>- Planning for home play sessions</td>
<td>- Conducted jointly with therapist and parents</td>
</tr>
<tr>
<td>- Therapist discusses with parents alone afterward</td>
<td>- Preparation of toy kits, space, time</td>
<td>- Options for follow up</td>
</tr>
<tr>
<td></td>
<td>- Discussion of how to handle interruptions or cancellation of home sessions</td>
<td>- Completion of postmeasures</td>
</tr>
</tbody>
</table>

Source: Adapted from VanFleet (2012).
Training Phase
Immediately after the play session demonstrations, the therapist begins the training process with the parents. This usually takes three 1-hour sessions. During the first training session, the therapist explains the four skills used in the FT play sessions, the rationale for each, how it is done, and an example, usually from the demonstration sessions the week prior. The four skills are described here (VanFleet et al., 2010). VanFleet (2006b) provides a video example of this session.

Structuring
This skill helps children understand the atmosphere and relative freedom of the play sessions. Parents learn what to say when entering the playroom, how to provide 5- and 1-minute notices as the session draws to a close, and how to manage children who resist leaving.

Empathic listening
Parents learn to put their own thoughts and feelings aside and truly see the world through their children’s eyes. They learn to watch the entire child (words, facial expressions, voice intonation, and body language) and to reflect the basic things the child is doing and any feelings that are present. In essence, parents learn to be empathic and accepting of their children for who they are.

Child-centered imaginary play
Parents learn how to engage in pretend play with their children when the children request it. They follow the child’s lead, either by doing as the child asks or assuming the role they think the child wants them to play. They learn to refrain from asking questions about the role, and instead learn to attune better to what the child and context are suggesting, adjusting with the child’s responses to ensure compliance with the child’s wishes. This skill represents another form of empathic attunement.

Limit-setting
Parents learn how to create only those boundaries necessary to ensure their child’s and their own safety and to prevent significant damage to toys or furnishings. Limits are necessary to help children feel a sense of security and to help them take responsibility for their actions. A three-step limit-setting procedure works well: (1) when a boundary is first breached, parents state the limit specifically and behaviorally and redirect with “but you can do almost anything else,” which puts the responsibility of solving the problem in the child’s hands; (2) when the same boundary is broken again, or imminently so, the parent reminds the child of the limit, adds what the consequence will be, and then provides the general redirect again; and (3) when the same boundary is crossed a third time in the session, the parent enforces the consequence, which is to leave the playroom. This process quickly reestablishes parental authority. If children become upset after leaving the room, or for children with significant attachment problems, the parent can tell them, “We will come back here again next time” after they are completely outside the playroom.
At the end of this first training session, the therapist plays with some toys and asks parents, one at a time, to practice using the empathic listening skill. The therapist provides feedback, mostly in the form of positive reinforcement to the parents as they practice.
During the second and third training sessions, the therapist conducts mock play sessions until each parent has practiced twice. Here, the therapist pretends to be a child and plays in such a way that the parent gets to practice using all four skills. The therapist provides fleeting feedback and minor corrections interspersed with playing, and at the end goes through a more detailed feedback process that recognizes the parent’s strong points and offers just one or two suggestions for improvement. It’s essentially a shaping procedure. The therapist keeps the atmosphere light and playful, which helps reduce parents’ performance anxiety. The mock play sessions require some practice for therapists to master, especially because they require three different mental processes—playing, giving quick feedback, and remembering details for in-depth feedback at the end—but they provide one of the most effective and efficient ways to prepare parents to conduct the play sessions. Training programs in FT typically include practice conducting mock play sessions to help therapists master this unique method of teaching.

After the three training sessions, parents are usually ready to start the play sessions with their own children under direct therapist supervision. Most have not mastered the skills at this point, but they have learned them well enough to start. The first few play sessions with their children are considered an extension of their skill development.

**Direct Supervision of Play Sessions Phase**

During this portion of the therapy, the therapist directly observes the live half-hour dyadic play sessions each of the parents conducts with one of his or her own children, usually until each parent has been observed between four and six times. The therapist does not intervene in the session, but quietly observes, noting the child’s play and the parents’ responses. At the end of the session, the child is excused to a safe waiting area or child care, and the therapist meets with the parents for the remaining half hour. During this time, several things occur:

1. The therapist asks the parent how the play session felt, what was easy about it and what was more challenging, and empathically listens.
2. The therapist provides his or her own feedback about the use of the four skills. At least 75% of the feedback is positive and specific, and the therapist ends with just one or two suggestions for improvement at each session.
3. After the skill feedback, the therapist asks parents what they think the play might mean, eliciting their ideas about play themes. Again, the therapist listens empathically.
4. The therapist shares his or her own ideas of what the play themes might mean, and provides a reason for that. The therapist often helps parents generate several possible play themes and encourages patience as the patterns of play emerge over several sessions. The therapist helps parents become better at recognizing play themes during this dialog. VanFleet et al. (2010) has a chapter on play themes that covers this topic in depth, and A Parent’s Handbook of Filial Therapy (VanFleet, 2012) includes information on play themes written with parents in mind.
5. The therapist asks parents how they felt about the play themes if they don’t express this themselves. It is common for parents to have emotional reactions, both positive and negative, to their children’s play, especially as it relates to family dynamic issues, and the therapist needs to listen and help the parents work through those feelings. Sometimes the therapist employs other basic counseling strategies to help parents understand and put play themes in perspective. This is another part of the FT process that requires great sensitivity and skill, and it is the part that helps parents develop their reflective functioning most profoundly.
Transfer to Home Play Sessions

Parents must be proficient at conducting the play sessions before they transfer to unsupervised home play sessions. This is critical so that they are set up to succeed and not fail, as only higher levels of skill are likely to be maintained when the therapist is not present. When the training and direct supervision phases are done well, this speeds up the time period within which parents can take FT home.

One session is devoted to planning how the sessions will work at home. The therapist reminds parents to prepare their home FT toy kits and helps them plan where, when, and how they will hold the home play sessions. This is a point in the therapy where progress that is usually evident by this stage can be eroded if the parents do not follow through. The importance of continuing the play sessions is emphasized, and the therapist talks the parents through the entire process as they decide how they wish to implement it.

After this, the parents go home, and each one has a play session with each of the children, or at least with one of the children. The key is that all children should get a play session, and preferably one with each parent, during the week. The parents return and report on the home play sessions, and the therapist goes through the same feedback process as described in the preceding section. Sometimes clients bring videos of their sessions, and the therapist can watch segments and go through them much as they did when observing the live sessions. Otherwise, the therapist relies on the clients’ self-reports and spends more time discussing play themes and parent reactions to them. This process continues until the therapist and parents agree they are competent and feeling confident in the process. When parent skill levels are high and they are progressing through the home sessions well, it is time for the therapist to help them generalize what they have learned to everyday life. This phase of therapy, coupled with the generalization process described next, typically lasts four to eight 1-hour sessions, although there is great variability depending on family needs.

Generalization

Generalization does not come easily to people. Professionals in many fields become frustrated with clients when they do not follow through on their own. In FT, the generalization process is made deliberate in order to ensure client success. This happens when the therapist and parents discuss the home sessions. These meetings involve only the therapist and parents and typically range from four to eight sessions.

The first part of every session during this phase focuses on the home sessions and how they are going. The last half of the session is devoted to generalizing the skills to everyday life. The therapist discusses with the parents how empathic listening, structuring, and limit-setting work in the more complex daily life situation, often providing some light reading material and suggesting some “homework” in which the parents begin to use the skills outside the play sessions as well. Usually the therapist focuses on one skill during each session. Once the parents are successfully using their skills in daily life, other skills, such as positive reinforcement and parent I-messages (where parents state their feelings from their own perspectives without blaming or shaming), are added. In many ways, the generalization phase begins to resemble parenting skills classes with one important difference: The parent has already mastered the skill and is much better prepared to implement it successfully.

Play sessions can continue indefinitely, but if significant progress has been made, the skills have been generalized, and parents are satisfied with the outcomes, the therapist and parents begin to discuss ending the formal FT process.
Discharge Planning

If the parents have been coming weekly to report on their home sessions, the therapist suggests that they come biweekly for a short while to see if the progress “holds.” If the parents have been coming biweekly, the therapist might suggest that they come again in three or four weeks. The final sessions are spread out over a greater period of time, and if the progress is maintained or continues, discharge can proceed.

The therapist provides tips to continue the home play sessions and covers what signs would warrant a follow-up session. The “signs” are specific for each child and family. The therapist might ask to see one final family play session, in person or on video, especially if there are any indications that progress has halted or slid backward. Postassessments are completed at this time. Beyond that, the therapist assures the parents of future availability as needed, and arranges for a follow-up phone call one to three months later. This then concludes the formal FT sessions.

Progress

Progress is often rapid in FT, although it is highly variable. Even when parents are not as skilled as a therapist, or as they will eventually become, gains are seen in the problem areas. This is likely because of the relationships that children already have with their parents. Even if those relationships are damaged, the importance of parents and children to each other facilitates progress once the parents learn and use the skills and the key parent practices in the play sessions.

It is quite common to see some signs of progress within the first three FT play sessions done under the therapist’s direct supervision. Those changes might be apparent in the child’s play or in the parent’s behavior, and often in both. Most parents are quite skilled by their fourth play session, and more progress is seen then. By the time parents shift to the home sessions, typically after the therapist has supervised four to six parent–child play sessions, significant progress in the relationship and toward the goals is noted. Progress is also monitored in the child’s behavior in the “real world.” As the relationships strengthen between parents and their children, the presenting problems begin to lessen, and this often shows in daily behavior without any specific intervention being done in those settings.

CASE EXAMPLE

Identifying information about the case that follows has been completely changed to protect the confidentiality of the persons involved.

Background

Brian was 8 years old when he was brought to therapy by his parents, Ted and Nina. Nina was his biological mother and Ted was his step-father. Brian’s biological father, Carl, had lived with Nina for nearly 5 years after Brian was born, and it was a relationship full of violence. Brian had been spanked by Carl sporadically, and the spankings seemed more related to the mood Carl was in than to Brian’s behavior. Brian had also witnessed numerous domestic violence incidents in which Carl savagely beat Nina, resulting in serious bruises, a broken nose and forearm, and one hospitalization for a concussion. Nina had grown up in a household of violence herself, and for some time she believed that this was simply how families lived. After the hospitalization, she filed charges against Carl, who was imprisoned. She had never married him, so no divorce was necessary, and Nina sought therapy for herself. She did well, developed a clearer understanding of the patterns of victimization in her life, and became determined to protect herself and Brian
from that point forward. She met Ted about a year later, and they eventually married. There was no violence in their relationship, and they both reported feeling happy and close with each other. During the period when Carl had been abusing Nina, Brian initially lashed out at Carl. He yelled at his father when he was hurting his mother, but Carl struck him and locked him out of the room, and thereafter, Brian became more withdrawn. Even as Nina pulled her life back together, Brian was quiet, and she and his teachers had attributed it to shyness.

As Nina and Ted began dating, Brian seemed to like Ted. Ted took him to fun places, and Brian especially liked going for ice cream with him. There were occasional outbursts, but the threesome seemed harmonious most of the time. Later, when Nina told Brian that she and Ted would be getting married and Ted was going to live with them, Brian looked at her strangely, said only “Why?”, and walked away to his room. Brian continued to be quiet, and in retrospect, he withdrew even further. The marriage took place and Ted moved into their small home with them.

After the first month, Brian's outbursts and tantrums increased, both in frequency and intensity. He openly expressed his disdain for Ted, saying, “Why do you have to be here? Why don't you go back to your own place?” Nina and Ted tried to talk with him and explain, but nothing seemed to have an effect. Brian's school performance began to deteriorate, and he had more arguments and two physical fights with his friends. He became increasingly isolated. After 8 months of family distress, Nina and Ted sought help.

Assessment
I met with Nina and Ted alone for the first meeting. They provided the background and listed their concerns about Brian. He had not accepted Ted as his new father, despite Nina and Ted's wishes that they could form a happy family. Brian often withdrew and rarely discussed anything with them, and when something triggered him, he lost control. He began by shouting at both of them about how Ted had ruined everything and all bad things were Ted's fault. His shouting escalated into physical destructiveness, usually in the form of throwing and damaging items that were valuable to his mother or Ted. He had broken several pieces of decorative glassware that were favorites of his mother, and he had smashed one of Ted's athletic trophies from college with a hammer. If Nina or Ted tried to calm him down by holding him, he punched and kicked at them. When he began destroying some of his own favorite toys, Nina and Ted realized this was worsening and sought help.

I empathically listened to their concerns for about 35 minutes, occasionally asking questions to fill in gaps. They both were hurt and afraid. Nina expressed worry that Brian was going to turn out like Carl. When I reflected how painful and worrisome this was for her, she cried briefly. Ted was disappointed but not angry. He was aware this was probably not about him so much as it was about Brian's traumatic history. He was increasingly frustrated with the destructive rages, and especially with Brian's insolent behavior toward Nina.

I discussed how trauma and attachment issues can affect children's feelings and behaviors, and how they sometimes become worse when children perceive their world changing once again, reinforcing the idea that nothing is in their control. I also discussed how sometimes play therapy can be useful for such problems and gave some preliminary information about FT.

Family Play Observation
I watched Brian, Nina, and Ted in the playroom during the next session for approximately 20 minutes. Brian enjoyed exploring the toys, even showing a few items to Ted. Most of the time, he played by himself in a corner, or he interacted with his mother, ignoring Ted. Ted made efforts
to engage him, but most of those were rebuffed. Nina encouraged Brian to play with Ted, but that led to Brian walking to the opposite side of the room and turning his back to his parents as he fiddled with some toys there. Despite the tensions, Brian seemed to have a good time. We let Brian wait in a private and secure waiting area where he could play with some other toys. I then met alone with Nina and Ted.

I asked them how typical these behaviors in the playroom were of the behaviors at home. They agreed they were typical, but more toned-down than they had seen lately. I reassured them I believed them, and we discussed some details of the FPO. I then recommended FT as a means of helping Brian express and make sense of his feelings related to his many experiences with violence, to help Nina reestablish her relationship with him and show him she is no longer a victim and is capable of handling all of his bad feelings and behaviors, and to help Ted make a connection with him through play. They agreed to participate in FT.

Play Session Demonstration

The following session, I conducted a child-centered play therapy session with Brian. Nina and Ted sat in the corner of the room and watched. I had given them each a clipboard with paper to write down their observations and questions. Brian kept his back to them for nearly the entire 25-minute play session. He mostly explored the room, but concentrated on looking at some soldiers and seemed to enjoy hitting the bop bag. He tried on some of the monster masks and pretended to scare me. I did not have to set any limits with him, and it was a rather typical first play session. I was able to demonstrate the structuring, empathic listening, and child-centered imaginary play skills. I discussed the session with Nina and Ted afterward, answered their questions, and we decided to get started with their training the following session.

Training Nina and Ted

Nina and Ted learned quickly. Their training period was quite usual. After they completed their second mock session, we squeezed in a third mock session during that same meeting. I wanted to prepare them for some of the intense angry behaviors Brian might exhibit. We discussed it, and then I practiced the approach with each of them. We also identified the parameters under which they would use empathic listening (if he was expressing feelings of any kind) and limit-setting (if he was lashing out). As is usual, but especially important for a case like Brian’s, we discussed using the same consequence for any limits that Brian broke three times in a session: ending of the play session. If Brian couldn’t control his destructive behavior when given two chances to do so, they would manage the situation by ending the session. We all felt they were prepared to begin the play sessions with Brian the next week.

The First Five FT Play Sessions With Brian

Brian seemed pleased to return to the playroom. Ted and Nina had scheduled for an hour and a half so they could each have a play session with Brian but still leave sufficient time for me to discuss those sessions with them. With Nina, Brian did a lot of exploratory play, much as he had played with me. Nina described his play behaviors well, but did not reflect his feelings very often. For most of the session, she let him lead the way. He did try to squirt her with water in the baby bottle, and she seemed hesitant, unsure whether to set a limit. She decided not to, and Brian seemed to lose interest and moved on to other things. With Ted, Brian continued to explore but kept his back turned most of the time. Ted kept a good distance away and used a gentle voice as he reflected what Brian was doing. Brian once turned to him and said, “You’re talking
funny. Dummy.” Because we had prepared for this, Ted did a great job reflecting, “You noticed I sound weird and you don’t like it much.” In an irritated voice, Brian said, “Well, yeah.” Ted again reflected, “Seems pretty dumb to you.” Brian said nothing further. Ted continued to reflect but mostly limited his comments to feeling reflections in order to follow Brian’s implied wishes.

Afterward, Ted, Nina, and I discussed how things went. They both felt good about the sessions, knowing they could have gone much worse. I had much good feedback for both of them, and asked Nina to try to reflect more of Brian’s feelings next time. I told Ted how wonderfully he had handled the interaction where Brian called him a dummy, and we all talked about how the empathic listening kept Ted from engaging in an argument by focusing on Brian’s feelings and then honoring them by the shift in how he was responding.

During the next two sessions, things went well overall. Both Nina and Ted continued to improve in their skills. Brian had done some mild limit-testing with Ted, such as trying to climb up on the sandtray and “accidentally” throwing some small items toward Ted. Ted set the limits and Brian did not try the same behavior again. Both parents were encouraged to see this.

In the third session with Nina, Brian used the sandtray for nearly the entire half hour. He created an elaborate war scene with many soldiers and weapons placed carefully in a large semicircle. Facing the semicircle was a lone figure of a soldier. Nina did a particularly good job reflecting during this play, “The army is getting bigger and bigger. They have lots of weapons. There are even more of them. You’re being really careful how you place them; you know just how you want them to go.” Brian said nothing the entire time he worked on the tray. As he placed the lone figure at the end, Nina reflected very well, “There’s just one guy on the other side. He’s all alone. He’s facing a huge army. He’s facing lots of danger.” Brian glanced quickly at her and away when she said that, but said nothing.

During the discussion period afterward, Nina and Ted were excited. They began to see how Brian was expressing himself in his play. We talked about the play theme of the sandtray that seemed to convey how he felt about the world, and very likely about the domestic violence he had witnessed. He felt small and outnumbered while facing a very large threat. As we talked about this, Nina began to cry. I reflected how sad this was making her feel, and she shared that she felt so guilty she had put him in that position. I continued to listen empathically to her profound feelings, and later I told her there was good news in all this. In just three sessions, Brian had felt safe enough to share that with her, and this process seemed as though it was working well for him as he regained trust in her. Perhaps this was the first step to his giving the problems back over to her, an adult, and letting go of the big burden he had felt in needing and failing to protect her.

I directly observed two more sessions with both Nina and Ted. Their skills were well-developed, but we all thought it best to see how Brian’s play would develop before taking the sessions home. They continued to do well with their use of the skills, and his play seemed more relaxed. His amount of aggressive play increased, but when they occasionally had to set limits with him (there was a risk of someone getting hurt), he complied. They had expected much more pushback from him, but he seemed content to be in the playroom with them and accepted the boundaries.

Brian’s play with Ted had changed considerably by the fifth session. He had been cautious at first, but the more Ted showed empathy and acceptance, and thereby avoiding getting into any power struggles with him, Brian visibly relaxed. He began showing some items to Ted, and invited Ted into a play role near the end of their fourth session. The play segment began with a sword fight with each other, but Brian changed after a few moments and said, “Okay, you have to do exactly what I do. Exactly what I do! We’re going to go get those guys.” He dressed both of them with shields and weapons, and with wigs and masks. Letting Brian lead the way, Ted followed him as he searched for “those guys.” At last, “those guys” emerged in the form of a couple of large...
dolls, one of them wearing a black leather jacket and the other sporting piercings made from safety pins in his ears. Together they battled the bad guys until they won, and Brian handcuffed the two together and took them to jail behind a chair. During our discussion afterward, Ted was excited this had occurred. We talked about how this seemed to be another indication Brian was ready to let others help him create a defense against the threats and dangers in his life. Brian recreated this same scenario in the fifth session as well.

Home Play Sessions
Ted and Nina were excited to start their home sessions. By this time, the number of raging incidents at home had diminished from an average of one per day to one per week. They also did not seem as intense as before. Brian was interacting with Ted more frequently, and they began tossing a ball around in the backyard and occasionally going for ice cream. Brian spent more time out of his room and with them in the family room. He was also laughing more.

Nina and Ted had assembled a modest set of toys for use at home, and they included some of the items Brian had enjoyed most in my playroom. Brian was happy to begin the home play sessions. Initially, he was disappointed there were not as many toys, but we had already discussed how to empathically listen to his feelings if that came up. He soon dropped his complaints and began playing. Once again he asked Ted to follow him to go get the bad guys. They enacted the now-familiar scene, but Brian added something at the end after the bad guys were in jail. He walked over to where Ted had sat on a small chair and sat in his lap. Ted rubbed his back. It lasted just a moment before Brian got back up, but Ted was pleased yet another barrier was coming down.

During the home sessions, Brian engaged in nurturance play with Nina. They took turns taking care of the babies. At times Brian spanked the babies, and as we had covered during their training, Nina was able to reflect, “You’re really mad at those babies. They’ve done something wrong.” Brian nodded but gave no further hints. During the discussion after this session, Nina was worried. She saw this play as confirmation of her worst fears: Brian would grow up to be like Carl. I empathically listened to her intense worries, and then we talked about how this was Brian’s way of talking about the bad things that happened in his life. I suspected he would work through this theme and emerge on the other side feeling less fearful and more secure with her. In the next session, he spanked the babies again, but then he gave them to Nina to “take care of.” She felt better seeing he was able to consider their needs.

At home during their daily interactions, they now noticed big changes. Nina described it as, “the old Brian has come back.” She referred to his more relaxed manner, greater engagement in family activities, and more spontaneous expressions of physical closeness with both of them.

As we began the generalization of the skills, the play sessions continued. Brian had other aspects of the helplessness and hopelessness he had experienced for so long to work through, and he actively used the play sessions for that purpose. His play was symbolic, but usually it was not hard to figure out what he was expressing and working on.

After they had completed 11 home sessions (a total of 20 sessions because both parents held a session with him nearly every week), Brian’s problematic behaviors in daily life had decreased dramatically. Nina and Ted had developed excellent play session skills and could readily identify play themes and interpret them accurately in context. We began the discharge planning process. We had been meeting weekly or biweekly, depending on schedules, so we decided to have the next meeting after 3 weeks and yet another 1 month after that. They were to continue holding the play sessions and using the skills in daily life, and they knew to call me if something unusual came up.

We followed through on that plan, and while they experienced occasional challenges, Ted and Nina felt they had the tools to handle them now. Brian had continued his connection with
Ted, and he regularly turned to both of them for nurturance and comfort when he needed it. The school reported his problems with his peers and his academic performance had greatly improved.

With a more secure attachment well underway, a significant decrease in Brian’s problematic behaviors, and Nina and Ted using their skills regularly, we ended the formal FT process. They knew they could call me should any other concerns arise. I heard from them again about one year later, when they sent me a photograph of the three of them and a short note. The photo showed them all in funny dress-up outfits, laughing heartily. The note simply said, “As you can see, we’re doing great! Still having filial sessions and we know we can weather any storm—together. Thank you for this wonderful gift of each other!”

REFERENCES


Guerney, B. & Stover, L. (1971). Filial therapy: Final report on NIMH grant 1826401. (Available from NIRE/IDEALS, 12500 Blake Road, Silver Spring, MD 20904-2056.)


CHAPTER 8

Theraplay®: Creating Secure and Joyful Attachment Relationships

PHYLLIS B. BOOTH AND MARLO L.-R. WINSTEAD

In this chapter, we present a picture of Theraplay®. First, we discuss the theoretical basis for Theraplay: our basic assumptions; the core concepts, including the supporting theory that guides our work; and the Theraplay dimensions that help us plan treatment. Next, we focus on procedures and techniques, the kinds of clients for which Theraplay can be useful, contraindications for the use of Theraplay, and the logistics of treatment. We then describe the treatment process from intake through graduation. Next, we present a series of case examples illustrating the wide range of applications of the method. Finally, we present a summary of Theraplay evidence-based research.

THEORY

In this section we describe Theraplay, provide the background and evolution of the model, and present Theraplay’s theoretical framework.

What Is Theraplay?

Theraplay is a unique form of play therapy that focuses on the dyadic relationship between caregiver and child. It is interactive, physical, personal, and fun. Its principles are based on attachment theory and its model is the responsive, attuned, empathic interaction between healthy caregivers and their children—the ongoing way of being together that leads to secure attachment

1 Theraplay is a Registered Trademark of The Theraplay Institute, Evanston, IL.
2 Examples and case studies are carefully disguised in order to protect the confidentiality of the families.
3 In this chapter, the term caregiver will be used to refer to a biological, foster, or adoptive parent, as well as to a familial or nonfamilial caregiver.
and lifelong cognitive and socioemotional well-being. Bowlby supports Theraplay’s clinical application of his attachment theory when he says, “the pattern of interaction adopted by the mother of a secure infant provides an excellent model for the pattern of therapeutic intervention” (1988, p. 126). Caregivers are actively involved in sessions and are helped to become more mindful and thus able to respond to their child’s signals and needs and to create a loving, supportive relationship with their child. “The goal is to enhance attachment, increase self-regulation, promote trust and joyful engagement, and empower parents to continue on their own the health-promoting interactions developed during the treatment sessions” (Booth & Jernberg, 2010, p. 3).

How Theraplay Began
Theraplay is one of the earliest efforts to create a therapeutic intervention based on attachment theory. In 1967, faced with the daunting task of providing psychological services to children in the Chicago Head Start Program, Ann Jernberg, a clinical psychologist, came up with a simple solution for the problem: We would train lively, young people to play one-on-one with each child. Rather than providing these mental health workers with the toys and materials often used in play therapy settings, we asked them to engage each individual child in the same way caregivers play with their infants and young children: spontaneously, with no need for toys. Each troubled child was face-to-face with an engaging adult who was able to pay full attention and to invite the child into joyful, interactive play.

To our delight, and after an average of only 15 sessions, we found this kind of play made a great difference. Soon, unhappy, withdrawn children became livelier, more outgoing, and responsive, and angry, aggressive, acting-out children settled down and began to interact appropriately with others. It was obvious these children felt much better about themselves and were ready to engage with others in friendly interactions. They became lively, alert youngsters who, when we visited a few of them 3 years later, were doing well in school (Booth & Jernberg, 2010; Jernberg, 1979; Jernberg & Booth, 1999; Jernberg, Hurst, & Lyman, 1969, 1975).

Currently, mental health and education professionals in the United States of America and 37 other countries practice Theraplay in a variety of settings with children ranging from infancy to adolescence. Current best practice is described in the third edition of the Theraplay book (Booth & Jernberg, 2010) and in several articles and book chapters (Booth, Lindaman, & Winstead, 2014; Booth & Winstead, 2015). The group Theraplay model was developed (Rubin & Tregay, 1989) and it has been expanded and described in further publications (Munns, 2000, 2009; Rubin & Winstead; in press). Sunshine Circles® (Schiefier, 2013) is a classroom application for implementing the Theraplay principles of connection, cooperation, and social-emotional growth. Theraplay training and certification programs are administered by the Theraplay Institute in Evanston, Illinois (http://www.theraplay.org).

Basic Assumptions
Theraplay is based on attachment research demonstrating that sensitive, responsive caregiving and playful interaction nourish a child’s brain, form positive internal representations of self and others, and have a lifelong impact on behavior and feelings (Booth & Jernberg, 2010, p. 4). Caregivers’ attitudes toward attachment and their ability to reflect on their own and their child’s experience have a powerful influence on their relationship with their child. For this reason, Theraplay places a strong emphasis on including caregivers in treatment.

The self and personality are created within the early caregiver–child interaction. Children learn who they are and what to expect from others as they see themselves mirrored in the loving eyes of their responsive caregivers. Good caregiving experiences (as described in the vignettes in the Dimension section later in the chapter) create healthy neural pathways within the brain that
Theraplay: Creating Secure and Joyful Attachment Relationships 167

reflect a child's implicit view of self and others. Children learn they are lovable and competent, that others are loving and responsive, and that the world is a safe and interesting place to explore. Repeated experiences of having a caregiver co-regulate the baby’s arousal through attuned, bodily responses to the baby's emotional state provide the foundation for the developing capacity for self-regulation. The outcome of good care is long-term mental health with all of its associated benefits: the capacity for self-regulation, good social skills, the ability to learn, feelings of competence, and a positive view of oneself and the world.

Children who grow up in an environment of neglect, misattunement, and harsh, uncaring responses develop a negative internal working model. They view themselves as unlovable and incompetent, others as uncaring and untrustworthy, and the world as unsafe and full of threats. The result is poor self-regulation, unhealthy brain patterns, and insecure or disorganized attachment with all the behavioral and relational problems associated with poor mental health. While these internal models are stable, they can be changed by engaging these children in new, noncongruent experiences.

Our basic assumption is that such children can be helped by a therapy modeled, as Bowlby suggests, on the good caregiving experiences we will describe in our discussion of the dimensions of Theraplay.

Core Concepts

In order to replicate the interactive experiences of young children and their caregivers with all the benefits that accrue, Theraplay incorporates the following distinctive features, which we call our core concepts. We provide:

- Interactive and relationship based experiences
- Direct here-and-now interaction
- Adult guidance
- Attuned, empathic, and reflective responsiveness,
- Preverbal, social, right-brain focus
- Multisensory experiences, including touch
- Playful attitude

For each core concept of Theraplay, we present the supporting theory and research relating to attachment, brain development, and the elements leading to therapeutic change.

Interactive and Relationship Based Experiences

Treatment focuses on the relationship between the caregiver and child and provides an active, reparative experience for each of them. With caregivers and their child together in the session, the Theraplay therapist guides the interaction so they can experience the synchronous dance of attunement and shared well-being so essential to long-term mental health.

Healthy caregiver–infant relationships are supported by two crucial, biologically based drives: staying physically close in order to be safe and sharing meaning and the joy of companionship (Bowlby, 1969/1982, 1988; Trevarthen & Aitken, 2001). Feeling safe is essential before it is possible to share meaning and companionship. Babies signal their need for connection and protection by smiling, gazing, crying, and clinging. Adults instinctively respond in ways that reassure and support their infant and readily create the essential sense of safety and connection. Many life circumstances can disrupt the smooth functioning of these natural exchanges, such as illness on the part of the caregiver or the baby, separations, caregiver depression, stress, poverty, drug abuse, and the caregiver’s own lack of good/healthy attachment experiences.
The families who seek help through Theraplay have all suffered some adverse circumstances that disrupted the natural processes that make connection possible. By providing an interactive and relationship-based experience, the Theraplay therapist creates opportunities for the dyad to learn healthier ways of interacting. They also help caregivers reflect on their own and their child’s experiences so they can respond to their child’s sometimes confusing signals and create this sense of safety and security.

**Direct, Here-and-Now Interaction**

Change in a relationship can best be achieved by interacting affectively in the moment. Attachment relationships and their accompanying internal working models are formed in face-to-face, lively, synchronous interaction and are stored in nonverbal and movement-oriented memory. Theraplay provides similar interactions to create a direct, reparative emotional experience. Repeated, playful, accepting responses that are not congruent with what the troubled child has come to expect create new neuronal connections and new ways of being together. These then form the basis of a healthier relationship. The therapist guides caregivers to provide the attuned responses needed to repair the disrupted relationship and form a positive connection. These can be subtle, microscopic interactions that change the neural circuits bit by bit (Hart, 2008), or they can be moments of great excitement that suddenly shift the child into a state of joyful connection. These moments of intense connection and synchrony, referred to as now moments, lead to a major shift in internal organization and sense of self (Mäkelä, 2003; Tronick et al., 1998). New meanings are created in the interaction, not by talking about them.

**Adult Guidance**

Adult guidance is an essential ingredient in creating the sense of safety so necessary to healing. This guidance includes not only planning sessions to meet the child’s needs, setting clear limits, and creating a sense of order and clarity, but also coregulation, which is at the heart of the attachment process. The coregulation attuned caregivers provide for their infants—maintaining body temperature, providing food, soothing the agitated infant—is the first step in the process that leads to the child’s later development of the capacity for self-regulation. As children grow, they gradually become less dependent on external regulation for survival; however, for many years they continue to need help to modulate their level of excitement, organize their experience, and make sense of the world. A parenting style that includes adult guidance and clear rules balanced with warmth and support has long been known to be the most effective way to create competent, resilient, independent adults (Baumrind, 1991; Grotberg, 1997). Rather than creating dependency, adult guidance and supportive structure are the foundation for self-reliance. “Autonomy grows out of attachment” (Shahmoon-Shanok, 1997, p. 38).

Many of the children who come for help have missed out on the organized, supportive and coregulated experience that would have made it possible for them to respond to others in calm, appropriate ways. For this reason, Theraplay provides clear guidance and safe limits and initiates activities appropriate for the child’s developmental needs as well as the current state of agitation or calm. The therapist carefully guides and regulates the child’s experience so the child feels safe and well regulated. The therapist provides guidance and regulating structure for caregivers as well.

**Attuned, Empathic, Reflective Responsiveness**

Theraplay treatment is patterned on the attuned, empathic, reflective caregiver responsiveness research tells us is a crucial factor in the development of secure attachment (Ainsworth, Blehar,
Waters, & Wall, 1978; Fonagy, Gergely, Jurist, & Target, 2002). A range of biologically based capacities make it possible for babies to signal their needs and for caregivers to respond in the health-promoting ways that create a sense of shared meaning and companionship (Trevarthen & Aitken, 2001). We all have the capacity to resonate with the affective experience of others (Trevarthen & Aitken, 2001) and mirror and synchronize our behavior (Iacoboni, 2008). In their review of many studies of the caregiver–infant relationship, De Wolff and van Ijendoorn report that sensitive, synchronous interactions between the infant and caregiver are key factors underlying secure attachment and positive child development (1997). Well-defined neural circuits support shared social engagement behaviors and the defensive strategies of fight/flight or freeze (Porges, 2011). All of these interwoven capacities make it possible for caregivers to attune to their baby’s needs, respond appropriately, coregulate the baby’s experience, (Tronick & Beeghly, 2011) and achieve what Trevarthen and Aitken call intersubjectivity (2001), that is, to establish a shared view of the world. They are present to each other and have matched vitality and congruent intentions (Hughes, 2007; Siegel, 2006).

Children who feel anxious and fearful do not readily enter into rhythm, resonance, and synchrony, and they therefore find it difficult to understand the intentions of others and join in the interactive dance (Hart, 2008). In their recommendations for treatment of children who have experienced relational trauma, Gaskill and Perry (2014) say:

The key to helping the child begin to move back to a more regulated state making the child feel safe … is to utilize the direct somatosensory routes and provide patterned, repetitive, rhythmic input. Therapeutic change starts from a sense of safety; in turn, the sense of safety emerges from these regulating somatosensory activities. (p. 185)

In order to respond sensitively to their child’s signals, caregivers must be able to reflect on their own and their child’s internal states (Fonagy et al., 2002; Slade, 2002). A caregiver who has not been well parented finds it very hard to achieve the level of mindfulness necessary for sensitive responding. A major goal of our work with caregivers is to support the development of their capacity to reflect on their own and the child’s emotional experiences. In order to do this, we respond in an attuned way to caregivers as well as to their children, making use of our own innate capacity to resonate, synchronize, regulate, and read the intentions of both children and caregivers. Through discussions, watching videotaped interactions, and their own interactive Theraplay experiences, caregivers are helped to get in touch with their feelings as well as to understand their child’s feelings. Having a direct Theraplay experience helps them understand how their child might feel in the Theraplay interaction and also provides intersubjective experiences missing from their own childhoods.

Preverbal, Social, Right-Brain Focus

Theraplay provides the same sort of nonverbal, body-based, interactive experiences that organize the brain in the first place (attunement, synchrony, resonance, and reciprocity). Schore and Schore (2008) suggest effective therapy must be “rooted in an awareness of the centrality of early dyadic regulation, a thorough knowledge of right hemisphere emotional development, and a deep understanding of the dynamics of implicit, procedural memory” (p. 17). During the first 2 years of life, just at the time when attachment is being formed, rapid neuronal growth takes place, especially in the right, social-emotional structures of the brain. Interactive experiences with caregivers create neural connections and organize the brain. The right brain limbic system, along with the developing orbitofrontal cortex, attunes to the social environment and regulates the internal state of the body. “Loving connections and secure attachments build healthy and resilient brains,
while neglectful and insecure attachments can result in brains vulnerable to stress, dysregulation, and illness” (Cozolino, 2010, p. 180).

Based on our understanding of brain development, we match the activities we choose to the child’s level of emotional development and current physiological state (e.g., calm, alert, fearful). We thus follow Gaskill and Perry’s (2014) suggestion that therapists need “to use bottom-up modulatory networks (somatosensory) to establish some moderate self-regulation prior to the implementation of insightful reflection, trauma experience integration, narrative development, social development, or affect enhancement” (p. 186). They go on to say that deeply troubled children … will require therapeutic environments that immerse them in positive, repetitive rehearsals of healthy interactions and activities. These interactions and activities often need to be regressive in nature … activities frequently associated with much younger children, as many foundational experiences (neural networks) have been missed or are incomplete. (p. 186)

Early interactive experiences make use of the nonverbal, “primal” language of the right brain—soft voice; accepting facial expression; loving eye contact; soothing repetitive, rhythmic movements; and gentle touch. They create the deep levels of neural integration that make it possible to communicate on the mentalizing and narrative levels later on. Because it takes many repetitions to change ingrained low-brain patterns, we encourage caregivers to continue these kinds of activities at home so the child is immersed in an ongoing reparative experience.

**Multisensory Experiences, Including Touch**

The lively, nurturing attention caregivers give to their babies provides stimuli to all the senses. The infant’s capacity to make meaning out of the interaction with a caregiver occurs primarily through nonverbal cues, such as affect and movement (Tronick & Beeghly, 2011). “Attuned interactions between parent and child are nonverbal (body-based) communications that assist … in building empathy/understanding and developing healthy attachment relationships” (Devereaux, 2014, p. 84). The tactile, vestibular, and proprioceptive experiences involved in lively interactive play lead to a clear bodily sense of self and a sense of how to interact with others (Williamson & Anzalone, 1997). Touch is fundamental to the human experience (Brazelton, 1990; Mäkelä, 2005). From the very beginning, infants require the warmth of body contact to support their immature regulatory system. Touch and warmth raise the levels of the hormone oxytocin, which is calming to both adult and child and aids in the management of stress (Tronick, Ricks, & Cohn, 1982).

In Theraplay we use a wide range of safe, appropriate, playful therapist–child and caregiver–child physical contacts, including calming touch and soothing sensory experiences. We resonate with the child’s autonomic nervous system through body communication and thus contribute to the child’s affective sense of self. Caregivers are encouraged to engage in active, rhythmic, physical play and to use touch to become their child’s source of comfort and safety.

**Playful Attitude**

Play is the essence of our Theraplay approach. We create the joyful, interactive, coregulated play that occurs naturally between caregivers and their young children when they are feeling safe and relaxed. Such play creates a strong emotional bond and a feeling of being alive and full of energy. It is important to note that this type of play is quite different from the type of play so important to most play therapy models, in which toys and expressive art materials are used to
create opportunities for symbolic expression. Many children who have experienced distress or disruption in their early attachment relationships are not yet capable of symbolic play.

Playful, patterned, rhythmic, and repetitive interactions with a caring adult can be an important first step in creating the safety and optimism that will help a child heal. “Play therapists should never forget that if something is not fun, it is not play and that it is impossible to have pleasure in a relational interaction if the child’s brain is in an alarm state” (Gaskill & Perry, 2014, p. 186). When caregivers meet their children with joy and interest, they promote a sense of connectedness and empathy. By generating a sympathetic arousal in the child’s nervous system, they also create spontaneity and resilience in the face of stress (Sunderland, 2006). When the excitement of physically active play is coregulated by an attuned caregiver, the child develops the capacity to regulate high states of arousal (Stern, 1974).

Play enhances the development of brain synapses by creating opportunities for affective synchrony (Hart, 2008). Interactive, joyful play leads to flexibility, compassion, and sharing and creates a basic trust in the world (see http://www.originalplay.com/develop.htm). The better the nervous system is at handling high arousal levels without disintegrating, the more flexible and resilient the child will become. “Play is an effective therapeutic agent when it provides a developmentally appropriate means to regulate, communicate, practice and master” (Gaskill & Perry, 2014, p. 179). Panksepp argues that rough-and-tumble play promotes “affectively positive social engagements and friendships” (2013, p. 187). “The natural movement toward joint laughter and positive affect in the therapeutic environment can open doors to clinical change that can be remarkably effective” (2013, p. 180). Families who have experienced trauma often have lost the capacity for play or may feel play is not appropriate in their situation (James, 1989). Play can serve as a less intense form of affection for a child who fends off adult caregiving following trauma (Hughes & Baylin, 2012).

Dimensions

Theraplay replicates the range of experiences that are an essential part of the healthy caregiver–infant relationship. In order to tailor our work to the needs of each dyad, we divide this broad range of activities that make up the daily interaction between caregivers and their babies into four dimensions: structure, engagement, nurture, and challenge. Play is an essential ingredient that adds spice to all the dimensions.

In the following discussion, we will

- Present examples of caregiver–child interactions that inform our model
- Describe how the Theraplay therapist makes use of each dimension to meet a child’s particular needs
- List the kinds of children and caregivers who most need the dimension being discussed

See Booth and Jernberg (2010) for a full list and descriptions of the Theraplay activities listed by dimension.

Structure: Making the World Feel Safe and Well Regulated

Twelve-year-old Luke arrives home after zooming around the neighborhood on his bike. He was told to be home at 6:45 p.m. for dinner at 7:00, but it is now 7:23 p.m. He looks in the window and sees his parents and siblings are not yet sitting down to dinner, and he thinks, “Whew, I made it.” But as Luke sneaks in the door, his father meets him and says, “You’re late. You’ve lost your
Luke argues, “Dad, you’re no fun. You don’t even know what it’s like to be a kid and have friends. We were on the last level of our game. That’s why I couldn’t leave!” Sensing how agitated Luke is becoming, his father softens and embraces him saying, “I don’t give you these rules to ruin your fun. It’s to keep you safe and let you know I love you. Any time you’re late it makes me worry.” Luke considered arguing because the plan for tomorrow’s after-school fun was going to be epic, but he knew the consequence would not be lifted, and he knew his dad truly was worried about him.

Parents like Luke’s, who provide trustworthy, predictable, and responsive leadership, create a sense of safety for their children, organize and coregulate their experiences, and help them understand and cope with their world. They establish regularity, define and clarify the child’s experience, and set clear boundaries. All these aspects of the interaction send the message to the child that there is someone “bigger, stronger, wiser” and kind looking out for him (Bowlby, 1988, pg. 62). These interactions say, “You are safe with me because I will take good care of you.”

In order to meet the child’s needs for order, safety, and coregulation, Theraplay therapists provide structure. They plan sessions carefully to provide maximum safety. They give clear signals for when an activity should begin and end and plan an appropriate mix of excitement and calm. They also take responsibility for making sure no one gets hurt.

Structure is particularly helpful for children who are overactive, unfocused, easily dysregulated, or who have a need to be in control all the time in order to feel safe. It is also useful for caregivers who are easily dysregulated themselves, have difficulty being confident leaders, or rely too heavily on ineffective verbal/cognitive structuring.

**Engagement: Connecting With the Child and Sharing Joy**

Six-month-old Sarah is just waking up from her nap. Her mother, Jane, hearing her gentle cooing sounds, comes to look down at her in her bassinet. Seeing her beautiful baby, Jane smiles. Sarah looks up, smiles in return, and her whole body wiggles in excitement. Sarah turns away briefly to calm herself before smiling again and reaching her hand toward Jane, who gently takes Sarah’s hand and waves it back and forth singing, “Good morning merry sunshine, What makes you wake so soon?” in a rhythmic, lilting tone of voice. Jane’s face lights up as she returns Sarah’s happy smile. This moment of meeting reinforces their belief that it will always be possible to reconnect after moments of separation or mismatching.

Caregivers like Sarah’s engage with their children in a playful manner, drawing them into synchronous interactions that are exciting and delightful but contained within an appropriate window of arousal. These experiences communicate to the child, “I like being with you. You are not alone. You are capable of interacting in healthy, appropriate ways with others.” In Theraplay, the therapist focuses on the child in a playful, positive, personal way to maintain engagement. The child is invited into an interaction that creates moments of meeting and attuned connection. Engaging activities offer opportunities for synchronous interaction, provide a fresh view of life, and help caregivers and child experience the joy of shared companionship. Because engaging activities can lead to high arousal, the therapist is careful to modulate the activity so the child does not become dysregulated.

Engaging activities are helpful for children who are withdrawn, avoidant of contact, or too rigidly structured. They are also helpful for caregivers who are disengaged, preoccupied, out of sync with their child, who rely primarily on verbal engagement, and who do not enjoy the child.

**Nurture: Making Sure the Child Feels Physically Comforted**

Fifteen-year-old Patrick arrives home from school and calls out, “Mom, Mom, where are you?” His mother, Olivia, is surprised Patrick is looking for her instead of grabbing his snack and heading
up to his bedroom to play video games. She responds, “I’m down here, in the basement.” Patrick comes down the stairs and makes a beeline toward her, and gives her an uncharacteristically warm hug. Olivia asks, “Are you okay? Everything okay at school?” He nods his head yes and says, “Yea, everything was fine. I’m going to go to my room.” Olivia isn’t convinced everything is fine, so a few minutes later she heads upstairs to Patrick’s room and finds him crying quietly on his bed. She goes to him and hugs him. She learns her son is crying over a very public and embarrassing breakup with his girlfriend at school today. Patrick says, “Mom, it really wasn’t that big a deal.” Olivia rubs his back and assures him his feelings are real, that breakups do hurt, and this most certainly is a big deal. Feeling validated and free to feel, the young man lays his head on her lap and cries as she comforts him.

Parents like Patrick's mother are adept at reading their children's affective cues and are ready to respond to their need for comfort and reassurance. They provide many soothing, calming, comforting, and reassuring experiences at whatever level the child needs. These activities contribute to the child’s sense that he or she is well cared for and that there is always a safe haven to return to. These experiences convey the message, “You are worthy of good care. You can count on us to take good care of you.”

The Theraplay therapist plans many nurturing, calming activities to help agitated children relax and allow themselves to be taken care of. Caregivers are guided to provide nurturing activities in such a way as to help meet their troubled child's unfulfilled younger needs. These warm, responsive caregiving activities reassure the child that adults will provide comfort, support, and soothing when needed.

While all children need to have good, responsive caregiving experiences, nurturing activities are particularly helpful for children who are overactive, aggressive, or pseudo-mature. Caregivers who are dismissive, harsh, punitive, or have difficulty with touch and/or displaying affection also need special help becoming comfortable with this dimension.

**Challenge: Helping the Child Feel Confident and Successful**

Jake goes into 22-month-old Jamie's room and pats his back gently to rouse him. Jamie's eyes open slowly, he looks at his father, starts to growl, points at the door, and insists, “I don’t want my eyes to be open Daddy. You go out!” Jamie does not want to wake up this morning. He also doesn’t want to put on his clothes for daycare, eat his breakfast, brush his teeth, have his hair combed, or do any of the things his father is suggesting. Jake finally gets all of those things done, takes a deep breath, and says to himself, “Okay, now how am I going to get his shoes on, convince him to get in the car, and drop him off at daycare? Oh gosh!” Suddenly Jake has an idea. He picks up Jamie's shoes in one hand and his own in the other and says, “Jamie, Jamie come here.” Jamie looks at his father suspiciously and starts to turn away, but Jake, with a twinkle in his eye, says, “Jamie, look, I don’t have my shoes on and you don’t have your shoes on. Let’s see who can put his shoes on faster, you or me. Who do you think will win? I can’t wait to see!” Jamie tries to resist at first, but his father's animation, playfulness, and competitive spirit draw him in.

Parents like Jamie’s are successfully creating opportunities for their children to try new things, master tension arousing experiences, and gain new skills. Their confidence in the child’s capacity to manage challenging tasks and their helpful support and scaffolding (Vygotsky, 1978) make it possible for the child to succeed and for them both to share a sense of accomplishment and competence. These adult-supported experiences convey the message: “Wow, look what you can do! You are competent. You are capable of growing and making a positive impact on the world.”

Theraplay sessions are conducted in a noncompetitive, upbeat atmosphere of shared warmth, spontaneity, optimism, and fun. Activities are chosen that help the child take a mild, age-appropriate risk and promote feelings of competence and confidence. Caregivers are
helped to understand the child’s developmental needs and to set appropriate expectations for accomplishments.

Noncompetitive but mildly challenging activities are helpful for children who are timid, fearful, and lack self-confidence. Caregivers who have difficulty supporting their child’s natural instincts toward growth and exploration, as well as caregivers whose expectations are too high, will benefit from being guided in challenging interactions with their child.

PROCEDURES AND TECHNIQUES

Client Characteristics

Theraplay has been applied with a wide range of individuals, families, and groups in various settings and circumstances. The language of play, and particularly relational connection through play, is relevant throughout the lifespan (Brown & Vaughan, 2010). Interacting with an infant through a game of peek-a-boo, a 10-year-old while creating a stack of hands, an 18-year-old during a game of balloon tennis, a 47-year-old playing Miss Mary Mack, or a 92-year-old in a game of wink ‘ems are examples of the Theraplay approach across the lifespan.

As mentioned, Theraplay has been used with clients who have many different characteristics. Trained Theraplay therapists work with clients of varying ages and family constellations:

- Mothers and fathers during and after pregnancy (Salo, 2014)
- Children and youth from birth through adolescence
- Young adults, middle-aged adults, and the aging
- Married couples
- Children and their birth parents, adoptive parents, step-parents, and kinship caregivers
- Nonrelated caregivers, including foster parents (Winstead, 2009), residential care staff (Brennan, 1998; Robison, Lindaman, Clemmons, Doyle-Buckwalter, & Ryan, 2009), and orphanage workers

They also work with clients from varying backgrounds, such as clients who:

- Are economically advantaged
- Are economically disadvantaged
- Have extensive support networks
- Are very isolated and rely on social services for support
- Live in urban, suburban, and rural areas

Theraplay therapists work with clients with different diagnoses (American Psychiatric Association, 2013) or presenting issues, such as:

- Attention deficit/hyperactivity disorder (Myrow, 1999/2000)
- Separation anxiety disorder
- Social anxiety disorder
- Oppositional defiant disorder
- Posttraumatic stress disorder
- Selective mutism
- Reactive attachment disorder (Booth et al., 2013; O’Connor, 2004)
- Disinhibited social engagement disorder
• Depressive disorders
• Speech and language disorders
• Autism spectrum disorder (Reiff, 1994)
• Neglect
• Victims and/or perpetrators of physical, verbal, sexual, or emotional abuse
• Loss of a parent or primary caregiver
• Negative reactions to difficult transitions: divorce, relocation, starting a new school
• Infants or toddlers born prematurely (Lampi, n.d.)
• Physical disabilities
• Individuals who have experienced natural disasters (e.g. tornado, earthquake, fire, tsunami, hurricane)

Clients who participate in Theraplay have a common need: to repair or strengthen a relationship and work toward social and emotional health. The strength of the model's foundation—the theory base, core concepts, and dimensions—facilitates adaptability and applicability to many different clients. A few examples may prove helpful:

• Six-year-old Nina presents with symptoms consistent with the diagnosis of attention-deficit/hyperactivity disorder (ADHD) (American Psychiatric Association [APA], 2013). Her parents report minor issues at home directly related to attention issues, but they are more concerned with her inability to focus and her impulsivity at school. They would like to avoid putting her on medication. Using Theraplay, we have the opportunity to help Nina increase her attention span by practicing focus in a playful engaging way that appeals to her. Over time, the clinician will gradually challenge Nina to participate in activities for a longer period, stretching her attention span and helping her manage impulsivity. Throughout the process, her parents will be included so they are able to utilize the successful techniques in other environments and promote generalization of Nina's skills.

• Nine-year-old Emilio was placed in foster care after experiencing physical violence and neglect from a paternal uncle who cared for him on the weekends while his single father worked. He has been given a diagnosis of Posttraumatic Stress Disorder (PTSD) (APA, 2013) but he might equally be considered to have suffered relational trauma. Emilio's symptoms include night terrors, a generalized fear or wariness of men, and severe anxiety. The father is trying to reunify with his son and bring him home. Implementing Theraplay with his foster parents will increase Emilio's feelings of comfort and safety with them. Sessions with Emilio and his father will strengthen their relationship and facilitate relational healing. As Emilio regains confidence in his father’s commitment to keep him safe and learns that his foster parents will do the same, his behavioral symptoms will diminish.

• Eleven-year-old Zachary's parents bring him to therapy because he has very low self-esteem and he lacks confidence in his abilities, which holds him back from trying new things. By using the Marschak Interaction Method (MIM), the Theraplay therapist confirms the parent’s report regarding Zachary’s self-esteem and confidence. The therapist also discovers that both the mother and the father have unrealistically high expectations for their son, and they provide him with very little encouragement to succeed, help when he is struggling with a difficult task, or praise when he does succeed. For Zachary and his parents, the therapist will emphasize the dimension of challenge. Activities within Zachary's range of abilities will be chosen for him to accomplish. The therapist will support and encourage him to succeed and share his pleasure when he is successful. The therapist will also educate, model, and coach the parents to have standards that are
appropriate and obtainable for Zachary and to celebrate his accomplishments. Zachary's experiences of success, along with his parents' delight in him, will increase his feelings of self-worth and confidence and encourage him to try new things.

**Contraindications to Theraplay Treatment**

When a child is dangerous to himself or to others, it is critical for the clinician to ensure the child's safety before initiating treatment. The therapist should rely on his or her clinical training and the setting's (e.g., practice, agency, institution, organization) policies and procedures to ensure the child's safety. Theraplay is not indicated when children are experiencing active psychosis. However, when they have received treatment to manage their psychoses, the history of these features would not preclude the children or their families from participating in Theraplay treatment. Likewise, if a caregiver is experiencing psychosis, the caregiver is not currently capable of providing the consistency and predictability needed to participate in Theraplay sessions.

If a caregiver's daily functioning is compromised by mental health issues, substance abuse, or addictive behaviors, the therapist will recommend treatment for the parent and consider working with the child while the caregiver is in treatment. The goal is to reintegrate the caregiver into Theraplay sessions when the caregiver has progressed in treatment and is able to consistently participate in sessions with the child. If a caregiver is actively abusing the child (i.e. physically, verbally, emotionally, sexually), the therapist will make a report to the relevant child welfare agency and will not include the caregiver in treatment with the child. If a caregiver has a history of hurting the child in some way, the therapist will carefully screen the caregiver to determine whether the caregiver and the child are emotionally ready to work on healing and repairing their relationship.

A history of trauma for the caregiver and/or the child is not a contraindication for Theraplay treatment. In training, the therapist is encouraged to complete a very thorough assessment to learn about the caregiver's and the child's histories and what triggers may be present. The therapist is also taught how to use assessment information to adapt Theraplay treatment when necessary. Trainers teach specific strategies for responding to children with trauma histories. The clinician takes an overarching therapeutic approach that is very sensitive, highly attuned, and responsive. The therapist is flexible and makes changes in the moment if a child is uncomfortable, scared, or fearful.

**Logistics**

In this section we address the practical aspects, such as space, props, and settings, for implementing Theraplay.

**Theraplay Space and Materials**

The ideal space for Theraplay sessions is an uncluttered, low-stimulus room approximately 10 feet by 10 feet (Booth & Jernberg, 2010) with a blanket or soft mat on the floor and several large cushions or a beanbag for the child and caregiver to sit on. The clinician creates a therapeutic atmosphere that combines playfulness and comfort. Theraplay relies on the interpersonal interactions between the participants in the session rather than on interactions with a toy or an object, so props are minimal and used solely to connect with the child. Therefore, it is best to minimize potentially distracting toys and decorations. Shelves or containers of toys or therapy tools can easily be covered with a piece of fabric. In some practice settings clinicians do not have an ideal space, so it is helpful to remember Theraplay is very mobile and easily adapted to different environments. Many therapists have worked with children and families in less-than-ideal locations.
In these situations, the therapist decreases the distractions as much as possible and creates a structured play area by spreading out a blanket on the floor to delineate the workspace. If necessary, the clinician may acknowledge the challenges posed by the space and preemptively communicate the boundaries to the child or family by saying, “There are several shelves over here (pointing to them), and a few tables on this side of the room, but we’re going to be playing right here on this mat together.”

The materials used in Theraplay are common, inexpensive household items that have no special appeal for a child other than as they are used to enhance the interaction between them and the clinician (e.g., cotton balls, a balloon, a scarf, bubbles, lotion, toilet paper). In therapy sessions, the clinician keeps the materials in a bag or container, out of reach of the child, until each one is needed. The child does not have access to the materials, and the therapist does not use them as representational objects or as vehicles for therapeutic communication. Once the activity is over, the clinician usually puts the prop back into the bag or container. Many Theraplay activities do not require any props at all. Simple materials and the therapist’s careful management of them help keep the focus on the relationship rather than the objects.

Settings

Theraplay is used in many settings with a variety of clients. The wide treatment applicability, minimal space requirements, and simple materials allow professionals from numerous disciplines in many settings to creatively integrate Theraplay techniques into their work. Some of the diverse settings where clinicians integrate Theraplay include:

- Hospitals
- Schools
- Residential treatment facilities
- Group homes
- Churches
- Orphanages
- Social service agencies/nonprofit organizations
- Adult day centers
- Home-based therapy programs
- After-school programs
- Private practice
- Medical clinics
- Community centers
- Head Start programs
- Day care centers or preschools
- Community mental health centers
- Hospice centers

Therapist Qualifications, Training, and Characteristics

Theraplay training and practice can be useful to anyone who works with children, for example, caregivers, grandparents, therapists, adoption support workers, teachers, caregiver aids or visitation specialists, and in-home workers. They can make use of the principles and activities

---

4For detailed information about training, certification, and supervision, please visit the official website of The Theraplay Institute at http://www.Theraplay.org.
to enhance their work with children of any age, with adults, with marital couples, or with individuals in the aging population. However, in order to practice Theraplay professionally and to describe the work as Theraplay, it is necessary to fulfill the rigorous requirements to become certified. These include receiving training sponsored by The Theraplay Institute and supervision with a Certified Theraplay Supervisor. Once certified, it is important for therapists who engage in attachment-based work, such as Theraplay, to receive ongoing reflective supervision and engage in vital self-care because this work may activate the therapist’s attachment system and lead to countertransference.

**Treatment**

Here we will provide a step-by-step overview of the typical Theraplay treatment protocol.

**Preparation for Treatment**

Completing a detailed intake, including the caregiver’s relational history, the Marschak Interaction Method, and Feedback Discussion provides an in depth needs assessment of the family, which leads to a strong treatment plan and maximizes treatment efficacy.

**Intake**

The first step in treatment with a family is to complete a psychosocial assessment. The clinician gathers information about the child’s history, family system, strengths, and presenting issues. During this phase, the therapist should also administer a number of pretests. Some examples include: the Child Behavior Checklist (Achenbach & Rescorla, 2001), the Beck Depression Inventory (Beck, Steer, & Brown, 1996), the Conner’s Rating Scale—Revised (Conners, 2008) (there are different versions, one for caregivers, one for teachers, and one for the child to complete), the UCLA PTSD Index (Pynoos, Rodriguez, Steinberg, Stuber, & Frederick, 1998) or the UCLA PTSD Reaction Index (Steinberg, Brymer, Decker, & Pynoos, 2004), the CARE Index (Crittenden, 2003), the Infant Strange Situation (Ainsworth et al., 1978), the Preschool Assessment of Attachment (Crittenden, 1994), and the School-Aged Assessment of Attachment (Crittenden, 2005; Crittenden, Koslowska, & Landini, 2010). Observing the child or family in the natural environment, possibly home or school, is also valuable.

**Caregiver attachment**

It is critical for the clinician to be aware of caregivers’ relational strengths and areas of difficulty. When parenting their own children, caregivers often replicate both the healthy and unhealthy relational patterns learned through their interactions with their own caregivers. If caregivers are aware of the dynamics that facilitated growth as well as the patterns that hindered growth, they can choose to repeat the positive patterns and make changes to improve the unhealthy ones. The Theraplay Institute recommends the Adult Attachment Interview (George, Kaplan, & Main, 1985) or the Questions for Parental Self-Reflection (Siegel & Hartzell, 2003) as instruments to learn more about a caregiver’s attachment strategies.

**Marschak interaction method (MIM)**

The MIM (Booth, Christensen, & Lindaman, 2011) is a play-based, structured assessment technique consisting of nine specific tasks a caregiver and child complete together. The tasks are chosen to focus on the four dimensions of Theraplay. The dyad is seated at a table, side by side, and the therapist provides instructions to the caregiver, “So Dad, please do each of the nine tasks...
in order; each envelope is labeled one through nine. Be sure to read the task aloud so I will know which task you are doing as I watch from the other side of the mirror. There is no right or wrong way to do the tasks. When you are done go on to the next one, and when you have completed all nine, please knock on the door and I will come back to ask you some questions.” Then the therapist leaves the room to observe the dyad. After the MIM is completed, the therapist watches the video several times and analyzes the interactions through the lens of the four dimensions. This analysis guides the feedback discussion and the treatment plan.

Feedback discussion
In preparation, the Theraplay therapist chooses short segments of the MIM video that demonstrate the strengths in the dyad as well as segments showing where the dyad needs help. The therapist and caregiver(s) watch the video clips together. The therapist takes an exploratory approach to learn more about the caregiver’s thoughts and feelings during the MIM: “What was that like for you? Did I get a good picture of how things go at home? Were there any surprises? Put yourself back in that moment: What were you thinking and feeling? As we watch your child in this segment, what do you think he is feeling right now?”

The feedback discussion is another opportunity for the therapist to empathize with caregivers about difficulties with their child and to empower them to enhance and maximize the strengths identified in the MIM assessment. The therapist is sensitive to verbal and nonverbal cues to avoid shaming or blaming the caregiver. At the end of the session, the caregivers and therapist agree on treatment goals. The therapist leaves this session with additional knowledge about the caregiver and the child and a clear sense of how to proceed with therapy. The caregivers leave this session feeling empowered by the therapist’s encouragement and the video examples of strengths in the relationship with their child. They have a clear understanding of how Theraplay treatment will help their family and a renewed hope for change.

Note Theraplay can be used with children even when a parent, caregiver, or caring adult is unable or unwilling to participate. In training, clinicians are taught how to adapt the model to work individually with children.

Treatment Stages and Strategies
In this section we present a description of each treatment stage, and describe how caregivers actively participate in the process.

Caregiver session
After the feedback discussion, the therapist finalizes the treatment plan based on the strengths and needs identified in the MIM as well as the caregivers’ goals for treatment. The clinician can now plan the activities for the caregiver session and the first Theraplay session with the child. Caregivers are asked to come in for an experiential and educational session that will help them understand what their child will experience in Theraplay. The clinician prepares all of the materials and the play space for the session, as well as the video camera if the caregiver has granted permission for filming, and then the clinician conducts the Theraplay session with the caregiver. During this session, the clinician gives the caregiver an interactive experience along with the rationale for each activity as it relates to the core concepts, dimensions, and the treatment plan. The caregiver practice session provides valuable information for the clinician as the caregiver shares how each activity felt, and how she thinks her child will respond.

---

5 It is ideal to observe the MIM through a one-way mirror while filming, but it isn’t necessary.
Treatment

Theraplay sessions typically take place once a week. Treatment sessions consist of a 15- to 20-minute discussion time with the caregiver, while the child is in the waiting room and a 30- to 45-minute Theraplay session. During the first three sessions with the child, the caregiver observes while the therapist interacts directly with the child. The caregiver may be sitting in the room in an unobtrusive place where the child will not be distracted, or with a second therapist behind a one-way mirror. The fourth session is with the caregiver only. In this session, the therapist discusses treatment progress and goals and shares video clips with the caregiver to demonstrate specific areas of growth or need. The therapist also prepares the caregiver for his or her active role in the upcoming sessions. Sessions five through eight include the child and the caregiver. Session nine is again scheduled for the therapist and caregiver to meet without the child. The pattern of sessions continues in this manner, three sessions with the caregiver and child, and one session with the caregiver alone. The treatment protocol for clients with mild to moderate issues is 25 sessions. Treatment may take less time for clients with minor issues who have a healthy caregiver available to participate. For clients with more severe issues, the protocol will most likely need to be extended and include other treatment modalities.

Sequence of a session

The session starts with a playful entrance into the room, signaling to the child, “We’re going to play together, this will be fun!” The play space is set up ahead of time, and the therapist guides the child to take a seat on a cushion or beanbag, and sits in front of the child. In the first session, the therapist explains why the child is there, where his or her caregiver is, and that they will be playing games to get to know each other. Several ritual activities are included in each session. The session begins with the check-up, in which the therapist notices special things about the child, for example, the child’s sparkly eyes, long fingers, strong muscles, or how high she can jump. The check-up often flows into the next activity in which the therapist provides nurture by putting lotion (or powder if the child does not like lotion) on the child’s special freckles or hurts. The middle portion of the session is a combination of specifically selected activities related to the dimensions identified in the treatment plan. The session ends on a quiet, nurturing note, usually including feeding the child a small amount of food. For younger children, there is a special song; for older children, there is a special handshake.

Caregiver involvement

The caregiver typically begins participating in a few activities in the fifth session. As the caregiver and child’s comfort grows, the caregiver’s level of involvement in the session increases. Focusing

---

6 If childcare is an issue, and the child is not capable of occupying himself/herself safely while the caregiver and therapist meet, we suggest a phone call earlier in the day for this discussion time.

7 There are several exceptions to having the caregiver physically separate from the child, such as if the child is very young, if the child is fearful or scared, if the child has separation anxiety, or if the child was recently adopted or moved into the home with the caregiver. We do not recommend having the caregiver behind a one-way mirror if there is not a second trained therapist to be with him/her. The caregiver will be disconnected from the experience.
on the therapist–child relationship first allows the child to experience healthy relational patterns with a safe, caring adult. Gradually including the caregiver encourages a transfer of the new skills from the therapist to the caregiver. Over time, and with the therapist’s support, the caregiver is involved in more of the session, is encouraged to take on a leadership role, and is given homework to practice Theraplay at home. As graduation nears, the caregiver is empowered to select activities and lead entire sessions.

The therapist uses several strategies to help caregivers prepare for participation, maximize their involvement, and take on a change agent role in their family. The caregiver practice session is a valuable tool for preparation, and the meetings with the caregiver alone create opportunities to celebrate the caregiver’s successes in and out of sessions and to empathize with the challenges a caregiver is facing. These sessions provide time to review portions of session videos to promote confidence and competence and to brainstorm together about areas of improvement. The trust that builds between the caregiver and the therapist increases the likelihood the caregiver will honestly share with the clinician and accept praise and constructive feedback. This, in turn, increases the clinician’s understanding of the dyadic relationship.

When caregivers are included in the session, the therapist does the activity with the child first, and if the child responds well, the therapist guides the caregiver to do the activity with the child. As the caregiver is doing the activity, the therapist supports and encourages the child and the caregiver, and if an unexpected issue arises the therapist intervenes. Verbal and nonverbal in-session coaching helps caregivers adjust their expectations, tone, touch, and so forth in order to be attuned to and connect with their child. When issues are too complicated or troublesome to discuss within the session, the therapist schedules a session with the caregiver to explore the difficulties and try to resolve them.

Graduation

The family graduates from therapy when the treatment goals are achieved. Therapist and caregiver(s) will agree on a graduation date and then speak with the child about the transition. The therapist explains, “Remember when you first started coming to see me. You and your father were coming to my office because things weren’t going so well between the two of you and your father asked me to help the two of you get along better and have more fun together. Well, now that is happening for you and your father, and that means it is time for your family to graduate from therapy. You may have some feelings about this, some happy and some sad, so we’ll talk about those in the weeks to come. I know I have some sad feelings about not playing with your family anymore, but I’m also very excited you and your father are doing so well, and that the two of you will still play together at home. So, we are going to play together three more times, and the fourth time we get together it will be your graduation party.” It is helpful for the therapist to model a healthy relationship by disclosing his or her feelings, and it fosters an atmosphere of honesty so the child can share his or her feelings as well. Giving the child a set number of sessions allows him or her to prepare for the close of the relationship.

In the sessions leading up to graduation, the child may exhibit sadness, anger, frustration, resistance, or other feelings related to the pending end of the therapeutic relationship. It is important to validate the child’s feelings and encourage the caregiver to provide comfort. For the final session, the therapist selects several of the child’s favorite activities, prepares a special snack for the feeding, and may choose to give the family a list of activities with a note of encouragement to continue playing.
Case Examples

In this section we provide two diverse case studies to exemplify the treatment stages described above.

Case Example: Ben

Ben’s mother and father, Lauren and Scott, tried very hard to make their marriage “work,” but after several years of unbearable tension, constant arguing, and unsuccessful marriage counseling, their final decision was to divorce. Lauren and Scott came to my office, together, for the intake interview. I was surprised by how well they got along and how supportive they were of one another. They did not interrupt each other, neither explicitly or implicitly belittled the other, they expressed a very strong commitment to helping their son, and they shared how confused they were by his behavior. They told me about how excited and happy they were when Ben was born, but before his first birthday their home was full of tension. Lauren said, “We fought when we were together, and these nifty inventions, cell phones, e-mail, texting, kept us fighting when we were apart. We didn’t agree on anything. I felt all alone with a newborn baby, and Scott started spending more and more time at work. I was afraid he was having an affair, but he wasn’t, he was just avoiding me and our home.” Scott chimed in, “I felt bad, but my office was the lesser of two evils. Everything was turning out all wrong in my marriage, and when I was with Ben I felt like I didn’t know anything about being a dad and I could never get anything right. We tried really hard to make it work and it didn’t. I think we’re both much happier now since the divorce.” Lauren nodded her head and said, “Yes, we’re happier, but Ben definitely is not! We thought that ending the fighting and negativity and all of the problems might actually help him. Instead we’re seeing things we’ve never seen before.”

Ben had just turned 3 when the divorce was finalized, and they both described Ben’s first 3 years as “tumultuous, chaotic, stressful, and anxious” for them all. However, Lauren did not notice any troubling behavior with Ben before the divorce. His in-utero experience and delivery were uneventful, he achieved his developmental milestones on time, he had minor colds but no major medical illnesses or accidents, his cognitive development was on track, he ate well, his toilet training went smoothly, he slept well, and he was an all-around happy baby and toddler. Now, 7 months after the divorce, Lauren and Scott reported Ben was constantly whining, he cried very easily, he wet his bed almost every night and wet himself during the day as well, he no longer enjoyed his favorite foods and often refused to eat, and his temper tantrums were becoming unmanageable and dangerous because he was banging his head on the floor and the walls. When Ben was with Lauren he cried for his daddy, and when he was with Scott he cried for his mommy.

Lauren and Scott both wanted to participate in treatment with Ben. I was skeptical of this arrangement so I met with each parent individually to confirm their relationship was not conflictual and they would be able to participate in treatment together. Many divorced or separated couples do not participate in Theraplay together because of the nature of their relationship. When a couple is together but has a highly conflictual relationship, it may also be clinically indicated to work with them separately.

They both reported they were getting along much better now they were divorced. Lauren said, “Don’t get me wrong, I do not want to be married to Scott again, ever, but it’s almost like we have our friendship back now that we don’t have the pressure of living together, sex, money, our
families, and other stuff.” I decided to include both parents in treatment sessions, but met with them individually for part of the initial assessment process. I conducted the Adult Attachment Interview with each parent separately to learn more about their history and their relationships with their parents and other important people in their lives, and had each complete the MIM with Ben.

The MIM analysis revealed several strengths for each dyad and several areas of interaction in need of help. With his mother, Ben was very controlling during nurture tasks. For example, in task three, “Adult and child each take one bottle of lotion. Apply lotion to each other” (Booth & Jernberg, 2010, p. 521), Ben quickly grabbed both bottles of lotion and squeezed a large amount onto his mother’s arm. When she tried to take one of the bottles of lotion from him he started to cry and tried to keep it away from her. When Lauren tried to put some lotion on Ben, he shouted at her and ran away. Ben also had extreme difficulty accepting structure and following his mother’s directions. During the second task, “Adult builds a block structure. Then says to the child, ‘Build one just like it with your blocks,’” (p. 521) Ben quickly grabbed all of the blocks out of his mother’s hands and started building his own structure. When Lauren playfully tried to get her set of blocks back, Ben started to whine and cry and then threw the blocks on the floor. In contrast to his resistance to nurturing or challenging activities, Ben responded with pleasure to his mother’s very effective verbal and nonverbal efforts to involve him in playful, engaging activities. During the MIM with his father, Ben behaved very similarly. He vied for control during nurture tasks and had difficulty accepting his father’s directions during structure tasks. When the task focused on engagement, Ben was very cooperative and interactive. For example, during task eight, “Adult and child put hats on each other,” Ben and Scott gently put all of the hats on each other’s heads as they laughed and giggled about how silly they looked.

My overall impression was that Ben’s behavioral difficulties were directly related to the divorce and the new living arrangements. Having to adjust to living half the time with each parent was taking a toll on him. Ben was very confused about his relationships with his parents and was experiencing uncertainty and a lack of emotional safety. The anxiety and fear of being left or losing his primary attachment figures was manifested in his behavior. I predicted a fairly short course of treatment, possibly 8 to 14 sessions. The primary goal was to reestablish safety for Ben in his primary attachment relationships and to provide Lauren and Scott with strategies to help Ben cope with the cyclical separations from his parents.

I met with each parent separately for the feedback discussion. Due to funding constraints, as well as Lauren and Scott’s desire to start sessions with Ben as soon as possible, I combined the feedback discussion and the parent practice session, spending 40 minutes on the feedback discussion and 20 minutes on the parent practice session with each of them. Lauren, Scott, and Ben arrived for Ben’s first Theraplay session with smiles on their faces. In the waiting room I greeted Ben’s mother and father and then knelt down and said, “Hi, Ben, remember me? I’m Ms. Marlo. It’s nice to see you today. How about we shake hands or have a high five?” I held my hand out and he shook it with confidence. “Wow, that’s a great handshake! Mom and Dad, is it okay if I hold Ben’s hand so we can see how many big steps it takes us to get down the hall to the play room?” Lauren and Scott both nodded in approval, so I took Ben’s hand, motioned to his mother and father to follow us, and guided Ben to take big steps with me as I counted, “One, two, three, you’re great at big steps, four . . . thirteen, wow, it took us thirteen big steps to get here. Now, this is a special seat for you on this big...
green cushion, and these two chairs are for Mom and Dad. Today they are going to sit here and watch us play. They will be here the whole time.” I thought Ben might protest a little when his parents were not involved, but he gladly accepted and plopped down on the green pillow. I said, “Now Ben, I know you’ve had a tough time with eating and going potty and missing Mommy and Daddy when you change houses, and I’m so sorry. Your mommy and daddy called me because they love you so much and want you to feel better, and I help kids feel better. When you come here to my office, Mommy and Daddy are going to be here in our playtime together, but Mommy will still go home to her house and Daddy will still go home to his house. They are not going to live at the same house again.” Ben insightfully exclaimed, “So the divorce is the divorce,” and I responded, “Yes, that’s right, your mommy and daddy are divorced so that means they don’t live together anymore.” He looked at me questioningly and said, “I already knewed that,” and I said, “Well my goodness, you are such a smart boy!”

In the first session, Ben was very engaged and participated cooperatively in every activity I planned without resistance or hesitation. He enjoyed himself thoroughly, and he communicated his joy through smiles, laughs, and shouts of glee. Next we played a game of beanie drop: I put a beanbag on my head, counted to three, tilted my head forward, and helped Ben catch the beanie in his hands, and then put the beanbag on his head, and did the same. Ben followed my lead, made eye contact, and smiled and laughed when he caught the beanbag. Each time he was successful, he looked toward his parents with pride, saying, “Look, look Mommy, look Daddy, I did it!” They returned his enthusiasm with smiles and clapping. Ben accepted the snack I offered him and the Twinkle Twinkle song without attempting to be in control the way he did in the MIMs with both of his parents. He eagerly asked, “Mommy, Daddy, do you know that song?” At the end of the session, I helped Ben get organized to leave by putting his shoes on and helping him stand up. Since he was going home with Lauren, I put his hand in hers and said, “Now, let’s see if you can walk all the way to Mommy’s car without letting go of each other.” Lauren looked at Ben and said, “I think we can do it!” and Ben said, “I think for sure!”

I received an e-mail from Lauren the next day reporting that Ben was in a cheerful mood all night, even during dinner, which he gobbled up, and he did not wet his pants when he was awake or asleep. She also asked for the words to the Twinkle Twinkle song because Ben requested it when she was putting him to bed, but she didn’t know all of it. Scott expressed his disbelief of both Lauren’s report and Ben’s “all in” attitude during the Theraplay session. Several days later, when Ben transitioned from his mother’s house to his father’s house, some of his signs of distress returned; he cried for his mother and was not interested in eating, but he did not have any toileting issues or severe tantrums. We discussed various strategies for helping Ben manage the transition, including transitional items, regular phone calls with the absent parent, and a book of photos containing pictures of both parents and their homes for Ben to carry with him. We also decided to schedule the Theraplay sessions on Ben’s transition day with the hope it would make the move easier for him.

Ben’s second and third Theraplay sessions were much like the first. He was delighted to engage in the activities with me, he was very cooperative, and he accepted nurture willingly. I met with Lauren and Scott together for session four. They expressed their amazement at Ben’s progress and their excitement about participating in the sessions. They both reported that his behavior at their homes was improving significantly and that they were following through with the strategies we had discussed. I spent the majority of the session preparing them to participate the following week.
After entering the therapy room for session five, playfully trying to be “quiet as mice,” and settling Ben on his green pillow, I said, “Today we’re going to play a few games together, and then Mom and Dad are going to join us so we can all play.” Ben responded with excitement and empathy, “Yessss, I think they are sad when they have to watch but not play.” I started with the check-up, “I see you brought your great big smile with you, and your strong muscles (he raised both of his arms to show off his muscles and flashed his parents an ear-to-ear grin as he held up his hands with fingers spread), and let’s see how many fingers. One, two, three … ten! Wonderful!” I did several activities with him, including sticker match, and then invited his parents to come and sit on the cushions on either side of Ben. This excited Ben so much that he squealed, “Oh my golly, oh my golly, oh my golly!” and started taking stickers off of himself and putting them on his parents. I said, “Wow, you are so excited to have Mom and Dad next to you. Mom, how about you take a moment and give Ben a big hug to help him calm down, and Dad can do the same.” After Dad hugged Ben, he said, “That’s funny, when he gets excited I usually try not to hug him and touch him so he can calm down, but those [hugs] seemed to really help him.” With one hand on Ben’s arm to keep him regulated, I replied, “Great observation Dad. This is an example of the external regulation we talked about. Sometimes Ben gets overexcited, by either positive or negative emotions, and your touch helps him to get calm and reconnected. It’s great for both of you to use touch as a strategy to support Ben when he is having a difficult time managing his own energy. Now, if we talk too long we’ll lose him, so let’s get back to the playing and we can talk about this more in our next parent session.” In the session, Lauren and Scott followed my lead; they praised Ben for his successes and offered attuned responses.

At the end of session five, I assigned Lauren and Scott two activities to do with Ben, separately, at home before the next session. The following week, in the 20 minutes before beginning our Theraplay session with Ben, Lauren and Scott both reported that they did beep-honk and airplane at home, and Lauren was also singing the special Twinkle, Twinkle song to Ben every night. Scott also said, “Ben did ask for his mommy when he was with me this week, but he didn’t demand Lauren and he didn’t throw a fit. It was at bedtime. He asked me to sing the special song and I couldn’t remember it. Ben was so disappointed, but he just stayed in my lap and said he wished Mommy were here to sing it to him. And you know, it was one of the first times I was really okay with him feeling that. It didn’t make me angry or frustrated at you [Lauren], and it didn’t hurt my feelings. Before when he asked, or screamed really, for Mommy, it kind of made me feel like I couldn’t do anything right and he didn’t want me.”

With emotionally available, highly functioning caregivers like Lauren and Scott, Theraplay treatment may be shorter than the typical 25 sessions. Starting with session eight, Lauren and Scott actively participated in the entire Theraplay session. I met with them alone during session nine and shared my plan for them to move into leadership positions with Ben in the coming sessions. I also suggested that if sessions continued in the same manner, and they carried on with the home assignments, we should start discussing graduation. Lauren and Scott were very excited about the transition and graduation, and his mother playfully echoed her son, “Oh my golly, oh my golly, oh my golly!”

In sessions 10 through 12, Lauren and Scott participated in planning sessions and took turns leading the activities. I subtly stepped back and transitioned into the role of parent guide and coach rather than directly interacting with Ben. Based on the high quality of the interactions between Ben and his parents, I increased the home assignments, and between weeks 11 and 12, Lauren and Scott each enjoyed a whole Theraplay session at their homes. At the next parent meeting, session 13, Lauren said, “I think we have our Ben back. He’s not wetting, he’s not fussing, well, no more than a normal almost 4-year-old, he’s eating
well, and he is really open about what he's thinking and how he's feeling.” Scott said, “He seems to be getting it.” I asked, “Getting what exactly?” and he said, “That we both still love him, and that we're not fighting anymore, and that neither of us will ever leave him.”

At the end of the parent session, we agreed it was time for graduation, so we put a plan together. In session 14, which Lauren and Scott led, we told Ben, “You and Mommy and Daddy came to see me to help you all feel better, and the three of you have done such a good job of finding good ways to play with each other that you don’t need to come and see me anymore. It is time for your family to graduate from therapy,” and Ben said, “Graduation, like preschool graduation? Like with a hat and a cake?” I responded, “Yes, I think we should have a hat and a cake. That’s a great idea! So, you and Mommy and Daddy will come here two more times, and the second time you come here, we’ll have the graduation party. After that, you will get to keep playing with Mommy at her house, and with Daddy at his house. What do you think?” Ben’s forehead wrinkled a bit, he thought for a moment, and he said, “Well, I like you Ms. Marlo, but we have better snacks at our house [leaning toward his father], and my mama [leaning toward his mother] sings me my special song lots of times at home.” I said, “Ben, thanks for being honest. I’ll miss you too, and I’m so glad I got to play with you and your parents, but playing at home with Mom and Dad is pretty awesome.”

Two weeks later, during session 16, the family graduated from therapy. I met with Lauren and Scott once a month for 3 months after graduation to provide support and to encourage them to continue their home play sessions. Scott and Ben were still doing full Theraplay sessions every week, and Lauren reported doing activities every week and a full play session every other week. Both parents described minor, developmentally appropriate difficult behaviors from Ben but did not feel the need to return to therapy.

Case Example: Yvonne

Fifteen-year-old Yvonne started cutting herself when she was 14, after witnessing her 19-year-old cousin and his 16-year-old girlfriend be shot and killed. The school administration told Yvonne’s mother, Patrice, that Yvonne would be expelled if she did not have a psychiatric evaluation and some type of counseling because the open wounds and scars on her arms and legs were distracting to teachers and students. Yvonne was also cutting herself in the bathrooms at school, and the school was not equipped to monitor her and keep her safe.

Patrice, Yvonne’s mother, contacted me and, for a variety of logistical reasons, we decided it would be necessary to conduct the sessions at their apartment.

Once in the apartment, I completed a psychosocial assessment and discussed the therapeutic process and how we would set treatment goals. Patrice was open to answering questions, but when I mentioned her involvement in treatment, she adamantly refused. I turned my attention to Yvonne; she was very shy when I spoke to her. She didn't make eye contact, she shook her head “yes” or “no” in response to my questions, and anxiously picked small balls of lint off of her well-worn sweatshirt. When I asked open-ended questions, she shrugged her shoulders as if to say, “I don't know.” Patrice pressured Yvonne to talk, “Vonnie, Ms. Marlo is here to help you. You need to talk to her so she can make you stop cutting yourself. If you don’t do this you're gonna be on punishment.” I delicately intervened, “Ms. Patrice, this is really frustrating and difficult for you, and I know you want to see Yvonne get better. Like you said, since she saw what happened to her cousin and his girlfriend she hasn’t been talking much. Now, I’m a stranger, so it will probably take a while
for you, Yvonne, to trust me and want to talk to me, and that’s okay. We have a pretty good start today with learning about each other, and I would like to schedule another time for me to come and meet with you, Yvonne.”

Sessions two and three were very challenging. My goal was to establish rapport and learn more about Yvonne, but her nonverbal communication and significant lack of verbal communication were sending the message loud and clear: Yvonne had no interest in talking to me. We also had many interruptions. Her younger siblings and their friends ran in and out of the apartment shouting loudly. Patrice was in the living room watching television and several of her friends came in and out of the apartment as well. Each time a friend of hers arrived, she recounted Yvonne’s issues, made it clear she didn’t know why Yvonne was so troubled, and that I was there to fix her. She also griped about how much laundry Yvonne’s “problem” was creating and expressed her doubts about me because I had not even looked at Yvonne’s arms and legs yet. The environment was not conducive for therapeutic work and did not provide enough safety for Yvonne to open up and allow herself to be vulnerable with me.

In an effort to create a more therapeutic environment, I got permission from Patrice and the management staff at the complex to use one of their on-site offices for sessions with Yvonne. Starting with session four, we met in a small, quiet office. I brought expressive arts materials to provide Yvonne with several nonverbal options for communicating. She was not interested in painting, drawing, or shaping clay. At one point she looked up sheepishly, I blinked my eyes at her twice, she blinked back twice, I blinked my eyes four times, and she blinked back at me four times. This pattern of interaction continued and we had multiple exchanges before Yvonne averted her eyes. We had at last managed a brief, nonverbal, but tangible exchange—a connection. I met with my supervisor that week and we discussed using Theraplay with Yvonne to reach her at an experiential, right-brain level rather than a cognitive level with talk therapy.

I described Theraplay to Patrice on the phone to keep her in the loop, and her response was, “I don’t care. Whatever works, works.” When we started the fifth session I said, “Well Yvonne, we still don’t know each other very well, and I think talking about how you’re feeling and what you’ve experienced is too hard right now, especially with me because we don’t know much about one another. One of the best ways I know to get to know someone is by doing some activities together. So I planned some things for the two of us to do so we can learn about each other and maybe have a little fun. Are you willing to give them a try?” Yvonne nodded her head yes, but did not make eye contact. I was concerned about her passivity, so I said, “Yvonne, I want these activities to be fun for both of us, so if there is anything we do together that you don’t enjoy or doesn’t feel comfortable to you, you can tell me with your words, your face, or your body. You can put a hand up just like this [demonstrating with one hand held up] and I’ll know you would like to do something else, and I’m going to watch very closely.”

Yvonne was apprehensive during our first Theraplay session, but not as withdrawn as she was in previous sessions. Her nonverbal cues signaled cautious curiosity as I tried to engage her by measuring her hand, her arm, and her foot with crepe paper. Yvonne’s face communicated surprise when we discovered her foot was longer than her hand, and for the first time I saw a small smile. Yvonne shook her head “yes” or “no” in response to my questions, but did not offer verbal responses. Although she was guarded and reserved, Yvonne participated in all of the activities I planned. At the end of the session I said, “One of the last things is a little snack. I usually put the pretzels right in the client’s mouth, but
I'm not sure if you're comfortable with that?” Timidly, Yvonne said, “That's kind of weird.” I was thrilled to hear her use her voice, and to set a limit. I said, “Thank you so much for letting me know that doesn't feel right to you. I definitely want to respect your boundaries. Do you like pretzels?” Yvonne nodded yes, “Okay, then I'll just put it in your hand today and you can feed yourself, and maybe in the future you'll be comfortable with me feeding you. We'll see.” Yvonne chewed her pretzel quietly and put her hand out for another when it was gone.

Our second Theraplay session—the sixth time we had met—was very similar to the first. Yvonne participated with a curious but skeptical look. However, when I met Yvonne for the next session, she surprised me. She smiled when she first saw me, and then removed her sweatshirt, revealing many scars as well as a few still open self-inflicted cuts on her arms. I had not seen her arms before. I decided not to mention anything immediately because I did not want to call attention to her vulnerability. When I did the check-up, noticing hurts and special spots on her arms, she joined me with interest. Yvonne seemed ashamed and surprised when I noticed the cuts on her arms and applied lotion around the open wounds. She bowed her head down low and seemed ashamed, but she looked up at me when I said, “Yvonne, I know that sometimes it hurts inside and hurting yourself on the outside can relieve the pain, or maybe when you're feeling numb it helps you feel something, anything.” While making eye contact I said, “Any kind of hurt, inside, outside, one from someone else, or one from ourselves needs attention. I'm going to take care of these hurts each time I see them, and maybe one day we'll talk more about them, but I don't think you're ready for that yet. Let's keep working on getting to know and trust each other.” This open exchange between the two of us was a turning point in Yvonne’s treatment. She immediately started to engage, not just participate sheepishly, in all of the activities I planned. She was more verbal and physically active, and she laughed and joked around with me.

In order to pace treatment, I planned to continue with pure Theraplay for a total of 10 sessions, and then I would reassess and consider integrating other therapeutic modalities into the treatment. My primary goal was to facilitate a safe space for Yvonne to be playful, vulnerable, and honest and to experience the range of emotions she was feeling. At the end of session 12, the eighth Theraplay session and two less than the 10 I originally planned, Yvonne changed my plan to her plan. It was time for the feeding, I took out the gummies, and as I prepared to put one in Yvonne's hand, which was our pattern in each of the previous sessions, she opened her mouth and signaled me to feed her. I fed her, and we chatted about which colors she enjoyed the most as I continued to feed her. When all of the gummies were gone, Yvonne said, “I really, really like playing these games. I feel like, I don't know, free or something, I feel like myself, and I don't want to stop, but I think I'm ready to talk some too.” I said, “Yvonne, I totally agree. You seem so free when we're playing, and it is refreshing to see you smile and have fun. I've also noticed that for the last 2 weeks you haven't had any fresh cuts on your arms. I'm so glad you trusted me enough to be yourself, and I'm looking forward to talking some too. We don't have to stop playing, we can play and talk in therapy. How does that sound?”

After eight Theraplay sessions, I integrated several modalities into treatment at various times, including trauma-focused cognitive-behavioral therapy (Cohen, Mannarino, & Deblinger, 2012), sandtray therapy (Homeyer & Sweeney, 2010), and eye movement desensitization and reprocessing (Lovett, 2007; Shapiro, 2006). Patrice reported that Yvonne's mood and attitude were improving, and that she was no longer cutting. The school officials reported Yvonne was starting to participate in her classes and was no longer a concern.
Theraplay: Creating Secure and Joyful Attachment Relationships

Yvonne graduated from therapy after 42 sessions\(^\text{10}\) and said, “I’m so glad I did all this stuff. I think I’m gonna have a better life. I feel like my eyes are different you know. Like I have new glasses or something.”

**THERAPLAY TREATMENT OUTCOME RESEARCH**

Theraplay has been rated as demonstrating “promising research evidence” by the California Evidence-Based Clearinghouse (in December 2009). The Clearinghouse rates programs on a scale of 1 to 5. Ratings from 1 to 3 indicate the program is well supported by research, with a rating of 1 being the highest attainable. With a rating of 3, Theraplay has been judged to meet the following standards:

- Two peer-reviewed studies utilizing some form of control have been published.
- The outcome data support the benefits of Theraplay.
- No empirical or theoretical evidence exists that Theraplay has a substantial risk of harming clients as compared to its possible benefits.

Theraplay has also been rated as a promising practice by Washington State Inventory of Evidence-Based, Research-Based, and Promising Practices for Prevention and Intervention Services for Children and Juveniles in Child Welfare, Juvenile Justice, and Mental Health Systems under “mental health.”

**Published Research in Peer-Reviewed Journals: Controlled Studies**


**Published Research in Peer-Reviewed Journals: Model Reviews**


\(^{10}\)Treatment with clients who have severe trauma generally lasts longer than the typical Theraplay treatment protocol.
Published Research in Peer-Reviewed Journals: Case or Program Descriptions


Other Publications


Other Research Pending Publication


CONCLUSION

Many individuals throughout the world experience pain, distress, and daily difficulties because of poor mental health. While relationships may be a source of stress, they can often be a resource for healing. With support, education, and guidance, Sam and Ben’s parents were able to be sources of healing and repair. Unfortunately, Yvonne’s mother wasn’t in a position to be an active part of her healing process, but the authentic relationship with her therapist facilitated therapeutic change for Yvonne. The curative power of relationships cannot be underestimated. Theraplay helps families reconnect and experientially teaches members to support one another emotionally. The mother of a client said it best, “When we started this [Theraplay] I had no idea what to expect. I didn’t know how my son would respond, and whether or not it would help. But as I watched my 14-year-old ‘tough guy’ become a toddler in front of my very eyes, my fears washed away. He played, he laughed, he let himself be vulnerable with me and let me comfort him. I didn’t get to take care of him when he was a toddler because he was four when he came to
us, and I’ve always felt a hole in my heart. I don’t feel that hole anymore, and I don’t think he does either.”

REFERENCES


CHAPTER 9

Ecosystemic Play Therapy

KEVIN J. O’CONNOR

THEORY

The Ecosystemic Model

The Ecosystemic Play Therapy (EPT) model first appeared in the literature in 1991 (O’Connor, 1991). Since then it has been refined and developed with the most detailed description of the theory and its application appearing in Play Therapy Treatment Planning and Interventions: The Ecosystemic Model and Workbook, second edition (O’Connor & Ammen, 2013). While the theory underlying EPT has always been presented in the literature as being specific to play therapy, it is, in fact, a theoretical model that can be easily applied to work with clients of any age or with any presenting problem. The reasons the theory is so universally applicable will be discussed throughout this chapter. At this point, however, it is important to recognize that this universality means the ecosystemically oriented play therapist is not forced to transition to alternate theoretical models when working with parents and families, or even when providing individual or couples therapy for adult clients. This allows the therapist to develop and deliver consistently high quality interventions across clients and over time.

From the time it first appeared in the literature, EPT has been described as an integration of multiple theories. Recently, the importance and relevance of integrative or prescriptive approaches to therapy in general, and play therapy in particular, have been increasingly recognized in the literature. However, the definition of either integrative or prescriptive theories and practices has not always been clear and, frequently, both seem very similar to what used to be called eclecticism, which has always had both its advocates and its detractors. Those who advocate for integrative models focus on the flexibility these give the therapist in selecting elements from whatever theory or technique will best meet the needs of the client. Those who argue against such models describe them as “kitchen-sink eclecticism,” an atheoretical treatment approach in which practitioners apply techniques from various schools of thought in a manner that ignores the theory underlying them (Norcross, 1987). Such an approach, Norcross warns, is haphazard and ineffective at best, and may in fact be harmful to some clients.

In the worst cases, integrative theories or models do not have a clearly defined overarching theory to guide play therapists in developing their case conceptualizations or making treatment
decisions. Rather than relying on a single, organizing theory, therapists make clinical decisions that are therapist driven, client driven, or problem driven. In the therapist-driven approach, therapists select the theories or techniques with which they are comfortable and at which they are skilled. This is an excellent approach so long as the therapists who use it are aware of the scope of their skill set and are willing to refer out clients whose needs they cannot meet. In the client-driven approach, therapists choose theories and interventions with which the client is comfortable. For example, clients who are not comfortable with creating and implementing a reinforcement schedule with their child would not be asked to use a behavioral approach, even if it seems suited to the child’s presenting problem. On the positive side, this approach ensures clients are fully invested in the therapy process. On the negative side, therapists may be pushed to offer services with which they are not entirely comfortable, and clients may not receive the treatment that will most effectively address their needs. In a problem-driven approach, the therapist chooses a theory or intervention best suited to a client’s presenting problems. On the face of it, this could be a very scientific approach, and it appears to be entirely consistent with the move in the field of psychology toward the use of empirically supported treatments. There are two potential drawbacks to this approach. Once again, therapists may be pulled to use interventions with which they are not entirely familiar or skilled. Further, it can be very difficult to match a specific treatment method to the needs of the typical client who presents with many multifaceted problems or a client who is embedded in a system unlikely to support or implement the ideal treatment.

When used well, integrative theories do not just pull haphazardly from various other theories and techniques; they serve as metatheories that provide play therapists with a solid decision-making model to use when integrating ideas and methods. Most practitioners in the field of psychology in general and play therapy in particular seem to be moving away from adherence to single, narrow theories toward more of a metatheoretical approach (Drewes, Bratton, & Schaefer, 2011). Ecosystemic theory is an integrative metatheory. As presented in this chapter, EPT draws on multiple theories including psychoanalytic, object relations, attachment, cognitive, behavioral, family systems, and developmental, as well as multiple therapy models, including Theraplay® (Booth & Jernberg, 2010) and Reality Therapy (Glasser, 1975). EPT is also flexible enough to allow therapists to integrate new developments in the field as they arise. Because many of these very diverse theories contain elements that directly contradict one another, ecosystemic theory is tasked with providing a rationale for integrating them. EPT does, in fact, provide therapists with a rationale for selecting one theoretical element over another, as well as a solid model upon which to base case conceptualizations and to develop, implement, and evaluate treatment plans.

As is evident from its name, Ecosystemic Play Therapy is, first and foremost, ecosystemically grounded. This means every element of a case (i.e., assessment, conceptualization, and the implementation and evaluation of interventions) is entirely dependent on the context in which the child client and his or her family are embedded. The importance of an ecosystemic approach often seems most apparent in the case conceptualization process. Typically, diagnosis follows a simple, linear decision-making process. Therapists check for the presence of specific symptoms listed under the various diagnoses in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition; DSM-5; (American Psychiatric Association [APA], 2013) and, if a sufficient number of symptoms consistent with any one diagnosis are identified, then the diagnosis is made. On the other hand, case conceptualization considers both symptoms and their context and the likelihood of complex interplay between the two. Children who have experienced abuse or a traumatic

---

1Theraplay is a registered service mark of The Theraplay Institute, Evanston, IL.
injury or who have survived a natural disaster might all exhibit symptoms of Posttraumatic Stress Disorder, but the underlying cause and dynamics of their conditions will necessitate very different treatment approaches. Throughout the therapy process, therapists must consider the impact of various systems on the child, the impact of the child on the systems in which he or she is embedded, and the impact of the various systems on one another. It is also important to remember that even highly distressed systems will work to resist change and maintain homeostasis, so changes made to or within any one system will likely trigger pushback or resistance from other systems. This occurs because, at some level, the systems or the people in them find change more threatening than the existing symptoms because these are at least familiar and typically represent the client’s or system’s best attempt to cope with some form of distress. Many caregivers resist trying any new forms of behavior management or discipline, often using a common refrain, “Oh, I’ve tried that and it didn’t work.” Yet, at the same time, they readily admit what they are currently doing is not particularly effective. When pushed, many often admit to two reasons for resisting change. One is their fear of losing what little control they have. Things may feel horribly out of control but, what if they get worse? The other is their sense of simply not having the emotional or physical energy needed to make changes. They are so exhausted, the idea of making any sort of change seems overwhelming. To address these types of resistance, the EPT therapist works to ensure the relative needs of the various systems and the people in them continue to be met as changes occur.

Secondarily, EPT takes children’s developmental level into consideration at all stages of the treatment process. In fact, a routine aspect of the EPT pretreatment assessment process is the completion of a developmental screening or assessment. By the time most children enter treatment, they have usually been symptomatic for anywhere from a few months to a few years. Emotional distress and symptoms divert the limited psychic energy we all have away from normal day-to-day processes, including making important developmental gains. The most severe manifestation of this phenomenon is psychosocial dwarfism (Money, 1992), in which even children’s physical development is arrested until the distress they are experiencing is resolved. Although all lines of development, including physical, emotional, social, and moral, are considered within EPT, cognitive development is considered central because it determines children’s ability to understand their problems and to engage in problem solving with the therapist. Effectively, cognitive development creates an upper limit on children’s ability to move forward in other areas of development. For example, children cannot reach Kohlberg’s (1976, 1979, 1984) highest level of moral development until they have acquired the ability to develop hypotheses and to think abstractly. This is not to say children who are cognitively advanced will necessarily progress in the other areas of their development; rather, it is to say they degree to which they can progress in these other areas will be contingent on their level of cognitive development.

Beyond the degree to which it focuses on both children’s developmental level and the systems in which they are embedded, five other elements are more or less unique to EPT.

First, while all theories and models of both psychotherapy and play therapy identify the importance of the therapist–client relationship, this relationship takes on a central role in EPT. In psychoanalysis, the client develops a transference relationship with the therapist in which the therapist reenacts and then resolves elements of earlier, primary relationships (Lee, 1997; O’Connor, Ewart, & Wolheim, 2001; O’Connor & Lee, 1991; O’Connor, Lee, & Schaefer, 1983; O’Connor & Wolheim, 1994). Yet, at the same time, the analyst is taught to interact with clients as little as possible to avoid contaminating the transference of clients’ past interpersonal issues with real therapist–client issues in the present. In client-centered therapy, clients’ experiences of their therapists’ unconditional positive regard is believed to be the primary curative element of the treatment (Axline, 1947; Landreth, 2012; Rogers, 1942, 1951, 1957, 1959, 1961). In spite
of this, client-centered play therapists are taught, much like analysts, to focus more on observing the client's play rather than engaging in it directly. This observing–supporting stance is believed to empower clients and to avoid the possibility of therapists imposing their agendas on their clients to the point it interferes with the clients' drive to self-actualize (Rogers, 1942, 1951, 1957, 1959, 1961). In EPT, the centrality and nature of the therapist–client relationship is much closer to that described in Theraplay (Booth & Jernberg, 2010), where the therapist takes responsibility for all aspects of the session and is fully engaged with the child at all times.

Second, the imperative for EPT therapists to take responsibility for the sessions is often interpreted to mean EPT therapists are very directive in sessions. This is not necessarily true. All forms of play therapy exist along a continuum with respect to how much the therapist directs the play session. At one end lie those very nondirective therapies in which the child is allowed to take the lead in determining the content and process of the session. Both psychoanalytic and child-centered play therapy fall at this end of the continuum. At the other end of the continuum are those therapies in which the therapist is very directive, taking responsibility for, and even controlling, the content and process of the session. At this end of the continuum are the more behavioral forms of play therapy and Theraplay (Booth & Jernberg, 2010). Various writers have erroneously placed EPT at the directive end of the continuum. In fact, EPT is very goal oriented but not necessarily directive. EPT therapists formulate goals for the treatment as a whole, for any given session, and even for activities within sessions. While the therapist is responsible for determining how and when the goals will be accomplished, this does not mean the therapist will necessarily direct the session. Rather, it means the degree to which the therapist structures the session is inversely proportional to the developmental level of the child. This is similar to the pattern of interaction between healthy caregivers and their children. Caregivers naturally provide more structure and guidance when they interact with very young children. They tell a toddler what to wear, when to eat, and when to sleep. As the child's ability to self-regulate improves, the caregivers allow the child to assume more control, stepping in only as needed. EPT therapists do the same. With highly dysregulated, young children, EPT therapists are very directive and they structure as many aspects of the session as needed. With developmentally older children, EPT therapists may be entirely nondirective, allowing the children to engage in more spontaneous self-exploration and problem solving.

Third, most play therapy theories and models also exist on a continuum from those that are more experiential to those that are more cognitive-verbal in nature. Both behavioral and client-centered play therapies, as well as Theraplay (Booth & Jernberg, 2010), fall at the experiential end of the continuum and focus on providing children with positive, health-promoting experiences as the essential intervention strategy. Psychoanalysis and the cognitive play therapies fall at the other end of the continuum and rely more on insight and cognitive problem solving to help children resolve their symptoms. EPT therapists may move more toward one end of the continuum or the other, depending on the developmental level of the child. Young children naturally learn more from experience, whereas older children can engage in complex, language-based learning. Irrespective of how far EPT therapists move toward either the experiential or cognitive-verbal end of the continuum in a given session, they never completely relinquish either approach. Again, this mimics the way caregivers interact with their own children. No matter how little infants understand, their caregivers still speak to them, realizing how important their tone of voice can be in regulating the child and knowing children only learn to use language by hearing it. Caregivers also realize that no amount of talking to children about something will teach them as much as a single experience. Similarly, EPT therapists continue to use some basic interpretation and verbal problem solving with the youngest and most developmentally immature clients, while providing opportunities for experiential learning for older, more mature children.
Fourth, the way in which the EPT playroom is laid out and the way the toys and play materials are presented to the child are both quite unique. The playroom is not conceptualized as having any therapeutic value in and of itself; rather, it is seen as a neutral container for the therapeutic relationship. As such, the room should in no way distract the child from either interacting with the therapist or engaging in the play. Further, unlike most playrooms, children are not given free access to the toys or materials. Rather, the therapist controls those items to which the child has access. The logistics of setting up an EPT playroom are detailed later in this chapter.

Finally, the development of an explicit, phenomenologically based treatment contract with the child may be the most unique element of EPT. In most theories and models of play therapy, the child has, at best, only a vague idea of why he or she is in treatment, much less the specific treatment goals. In these models, when children are made aware of the treatment goals, it usually occurs very early in the treatment, and children's awareness of the goal usually fades over time until they tend to believe they are coming to therapy just to play. In EPT, the therapist co-creates a specific treatment contact with the child. This usually happens during the transition from the intake/assessment process to the treatment proper. Based on the intake, the therapist determines the emotions and/or behaviors the child finds most distressing. These may not be the things that motivated the caregivers to bring the child to therapy; however, because they bother the child, he or she will be motivated to work toward change. The caregiver may be distressed by the child's aggression, while the child may believe the aggression gives him or her a much needed sense of control and, therefore, he or she will resist giving it up. For the child, the issue may be underlying anxiety. The treatment contract might be as simple as the therapist saying, “I know you don’t like feeling worried and nervous so much of the time. You and I will work together so you spend less time worrying and have more time to play and have fun.” This type of contract works with even very young children, so long as they have the minimal language needed to understand it. With an older child, the contract could be more elaborate and might include some of the specific symptoms to be addressed. During each session, the therapist finds at least one opportunity to restate the contract as it applies to the session content or activity. A formal intervention, such as relaxation training, might be introduced as a way of taking control of or “being the boss” of the anxiety. Alternatively, a simple game might be introduced as a way of practicing how to escape anxiety while having fun at the same time. The regular restatement of the treatment contract ensures children both know how therapy is supposed to be improving the quality of their lives and are able to assess the effectiveness of any particular intervention and the therapy as a whole.

One other relatively unique aspect of EPT is not specific to the therapy process itself but to the role of the play therapist. EPT not only allows for, but also encourages, the therapist to take on an array of roles while working to improve the child's life. By taking an ecosystemic perspective, the therapist may become aware of the ways the various systems in which the child is embedded may be interfering with or facilitating the child's overall health and development. This may mean working with the caregivers or with the family as a whole. It may also mean the child's needs will be best addressed by consultation with his or her teacher, pediatrician, or even a legal representative. As a consultant, the therapist is working as an equal with representatives from the different systems. The therapist and teacher might work together to design classroom-friendly ways to manage the child's anxiety so as to improve the child's ability to attend and learn. The EPT therapist may even go a step further and take on the role of advocate. In this role, the therapist attempts to work cooperatively with representatives from the other systems but is willing to be confrontational if needed. The therapist needs to be very cautious in determining when to move beyond the boundaries of the traditional play therapist's role. If possible, others, such as the child's caregivers, should be assisted in working directly with the various systems to make the changes necessary to meet the child's needs. The therapist should only step into these alternate roles when necessary.
roles if doing so will truly address the needs of the child and not interfere with the therapy process or disrupt the future functioning of the other systems.

Case Example

Dr. Smith was working with a child named James, a gifted child who had such severe Tourette's Disorder it caused him to be a major disruption in in the classroom. James' school had decided to resolve the problem by moving James into a self-contained, special education classroom. While this plan would have met the school's needs, it meant James would be spending his days in a classroom where all of his peers would have significant developmental delays. When it became clear the school intended to coerce James' parents into agreeing to the move, Dr. Smith joined them for a meeting with the school's administrators. At first, he attempted to be cordial in addressing the conflict between the school's plans and James' educational needs. When it became clear the administration was not interested in developing an alternative plan, Dr. Smith pointed out the fact their plan was actually in violation of the state's educational laws and, therefore, could not be legally implemented. In the long run, he was able to work with James' parents and the school personnel to develop an alternative plan that better met James' needs.

Having reviewed some of the concepts and elements specific to EPT, we now move on to discuss the ways in which EPT frames the elements common to virtually all of the more fully developed theories of psychotherapeutic intervention, including its underlying philosophy, theory of personality, way of conceptualizing psychopathology, concept of cure (treatment goals), and theory of what it is about therapy that makes it curative.

Philosophy

Most theoretical models do not articulate the philosophies upon which they are based. Philosophy underlies theory on at least three different levels: overall worldview, values, and scientific approach. At the worldview level, EPT can be best described as being grounded in contextualism (Price, 2008). In this philosophical approach, there are certain fixed values (such as do no harm), but virtually every action must be evaluated in context. For example, there was a period in history when exorcism made sense as a primary intervention because demonic possession was believed to be the cause of mental illness. As our understanding of mental illness moved to more intrapsychic and medical models, other interventions took precedence. Contextualism often underlies many of the models used to understand and incorporate cultural issues into play therapy theory and practice. At the values level, EPT uses a primarily humanistic (Law, 2011) or utilitarian (Mill, 1863/2007) model when it comes to making the values decisions that are an inescapable part of the diagnostic, treatment planning, and intervention processes. In this model, behaviors and situations are evaluated based on the degree to which they maximize the total benefit while minimizing any negative impact. Thus, behaviors are only considered problematic if and when they cause harm. When there is no harm, there is no need for intervention. Even a symptom as severe as hallucinations does not necessarily cause harm either to the children experiencing them or to those around them, and, therefore, one might question whether therapy is always necessary simply because a child is hallucinating. When the hallucinations begin to interfere with the quality of the child's life or cause him or her to become a danger to self or others, then, of course, treatment becomes a necessity. Finally, at the level of its scientific
Ecosystemic Play Therapy combines two somewhat opposing philosophies, namely a Western or hard science philosophy and phenomenology (Giorgi, 1983, 1985). The hard sciences approach tends to be the dominant view among those living in industrialized cultures. According to this philosophical stance, all questions have one and only one correct answer. Interestingly, even the hardest of sciences, mathematics and physics, are discovering problems to which the answers seem to be more chaotic than linear. From a phenomenologic perspective, all questions can only be answered from the unique perspective of the observer (Giorgi, 1983, 1985). What may be the correct answer for one person and situation may be the wrong answer for someone else in another situation. While caregivers and children rarely see a problem in the same way, that does not mean either one is wrong. It also does not mean either perspective can be ignored in the process of implementing an intervention. On the one hand, when little Billy hits his sister, both his sister and his parents will see this as a serious problem. Billy, on the other hand, may see it as the most efficient solution to the problem of his sister touching and breaking his toys. Addressing the problem phenomenologically means ensuring both Billy's sister and his toys are safe. The implications of this philosophic approach are most evident in the way EPT therapists go about creating treatment contracts to address the needs of both the child and his or her caregiver, even when those contracts may, on the surface, appear to conflict.

Personality

The degree to which various theories of play therapy focus on defining personality varies enormously. At one end of the continuum is psychoanalytic theory with its highly developed and well-elaborated model of personality. Freud's (1933) theory of personality includes four major components: energy/drive, structure, topography, and development. Freud postulated libido, a somewhat sexualized variant of the survival instinct, as the primary energy driving human behavior. At the same time, he postulated the human psyche to be a closed, hydraulic system in which there was a limited amount of energy. By default, energy directed toward any one function would therefore limit the energy available to other functions. Freud proposed three personality structures: ego, id, and superego. He also proposed a topographical element to personality consisting of the individual's conscious, pre- or subconscous, and the unconscious. Lastly, he developed a complex model of psychic developmental stages including the oral, anal, phallic, latency, and genital stages. While the model has many gender, cultural, and even scientific limitations, it is probably the most comprehensive personality theory in all of psychology.

At the other end of the complexity continuum is behavioral theory, with client-centered models following close behind. Traditional behavior theory simply eliminates the concept of personality altogether in favor of a stimulus-response theory (Skinner, 1966). Humans do not have stable personalities leading to predictable patterns of behavior; rather, their behavior simply consists of specific, predictable responses to stimuli. If one can adequately define the stimulus, then one can accurately predict the behavior. The client-centered model dominates the field of play therapy in the United States and is based on a personality theory that is also much less complex than the psychoanalytic model. Though client-centered or humanistic personality theory has evolved since he first developed it, Rogers (1951) put forth 19 propositions in which he described how people viewed and experienced their surroundings, how and why they reacted to these perceptions in certain ways, and how these experiences and response patterns become organized into one's sense of self.

The model of personality put forth by ecosystemic theory is not nearly as well developed or comprehensive as the psychoanalytic model, yet it does cover the key elements play therapists need to formulate a solid case conceptualization and to, in turn, develop a client-specific treatment plan.
Basic Drives and Motives

Most of the major theories of play therapy posit there to be a primary drive or motive underlying human behavior. In psychoanalytic play therapy, there is the concept of libido, a hybrid concept incorporating both sexual energy and the basic drive to survive. In client-centered play therapy, there is the drive to self-actualize. In behavioral play therapy, there is the motivation to maximize reward and avoid punishment. In EPT, two interrelated drives are thought to underlie most human behavior. One is the drive to survive, which in this case is conceptualized as being more similar to the behavioral drive to maximize rewards and avoid punishments than to the psychoanalytic concept of libido. The drive to survive is the most primitive of human drives and gives rise to multiple higher order drives in a manner consistent with Maslow’s (1970) hierarchy of needs. At the base of the hierarchy are basic survival needs like air, water, and food. At the next level are basic safety needs such as shelter and some level of control over one’s survival. At the third level are people’s need to affiliate and belong. At the fourth level are the needs for individual self-esteem and achievement. Finally, at the top of the hierarchy, is the need to self-actualize. Human beings are seen as being motivated to get their needs met and to prioritize needs lower in the hierarchy. Within EPT, the other fundamental drive is the drive to attach, which is seen as inextricably related to the drive to survive. Human infants are born completely dependent on their caregivers and unable to meet any of their own needs; as a result, they are much more likely to survive if they form an attachment to a caregiver. Simultaneously, the experience of having a caregiver meet the child’s needs stimulates and reinforces the attachment process. Whichever drive is primary, both are critical to healthy human functioning.

Mind–Body Interactions

Different theories of play therapy place more or less emphasis on the importance of mind-body interactions. From the outset, psychoanalysis recognized the degree to which the mind could affect the body, particularly when looking at the causes of conversion disorders in which clients develop medically impossible physical symptoms. More recently, neuropsychology has made great strides in identifying the importance of brain–body interactions, particularly in early years of life. Children’s brain development is enormously affected by early experience, particularly the experience of being in an attuned caregiver–child relationship (Schore and Schore, 2008; Siegel, 2009). In turn, children’s brain development affects their capacity for emotional regulation and future interpersonal relationships (Schore, 2000, 2003, 2009).

Typically, less emphasis is placed on the degree to which the children’s physical state can affect their psychological functioning. Everything from a brief illness to a severe, chronic medical condition can severely affect children’s mental health. Every caregiver knows how depressed or irritable children can become when suffering from something as simple as a cold. The short- and long-term impact of a serious illness, such as cancer, and the accompanying and often debilitating treatments can wreak havoc on children’s emotions and disrupt their psychosocial development. Even commonly prescribed medications, such as an asthma rescue inhaler, can have a negative impact on children’s mood and behavior. It is important for play therapists to be aware of the potential impact of various illnesses, medical treatments, and medications on their clients so they can tailor their play therapy interventions accordingly.

Role of Development

EPT also recognizes that the structure and function of children’s personality changes over time. For a complete discussion of the EPT model of child development, the reader is referred to The...
Play Therapy Primer (O’Connor, 2000). In the model, the primary focus is on the role of cognitive development in determining the way clients understand and react to both the problems they encounter in life as well as any play therapy interventions. Because children are lower on the developmental continuum than their adult counterparts, they are more likely to misunderstand their experiences and to have difficulty engaging in heavily abstract cognitive-verbal work in therapy. Given these limitations, play interventions for children at the younger end of the developmental continuum need to be more experiential while still accompanied by cognitive-verbal work. At the other end of the developmental continuum, children can be engaged in complex, cognitive-verbal work, though this learning should still be reinforced with experiential learning on a regular basis.

Pathology

Although EPT therapists do make use of traditional DSM-5 (American Psychiatric Association, 2013) diagnoses, the way in which psychopathology is conceptualized in EPT follows from the way in which personality is described and defined in the model.

Definition

Within EPT, pathology exists when children are either unable to get their needs met or are unable to get them met in ways that do not interfere with other’s getting their needs met. When, for whatever reason, children cannot get their needs met, they will use whatever strategies and behaviors they have at their disposal to resolve the deficit. Symptoms arise as problematic behaviors are intermittently reinforced or the child runs out of ideas and continues to engage in behavior that is no longer functional. Eventually, the child becomes “stuck,” using a nonfunctional or minimally functional response set. Thus, children’s symptoms are not the pathology per se; rather the symptoms represent their best efforts to address the pathology—the unmet need. In some cases, children’s attempts to get their needs met interfere with others getting their needs met. When a frightened child attempts to regain a sense of safety and control by lashing out aggressively, he or she interferes with others’ need to feel safe. While the strategy may be effective, it is not appropriate (Glasser, 1975). Humanistic philosophy can be useful in helping the therapist determine whether a given symptom is inappropriate based on the degree to which the negative consequences of the symptom outweigh the benefits.

Case Example

By the age of 6, Brian had already suffered years of physical abuse at the hands of both of his caregivers, and was finally removed from their care and placed in a foster home. When he was referred to therapy at the age of eight, he had been in multiple, failed foster placements due to his tendency to launch into homicidal rages if he felt in any way threatened or deprived. He had once thrown a knife at a caretaker when she refused to give him a cookie. Most adults who interacted with Brian focused on his aggressive behavior as pathologic and worked to eliminate it by any means possible. His EPT therapist, however, saw the degree to which Brian’s need to feel safe and in control was not being met in the ever-changing foster placements as the pathology. Brian’s aggression was his best attempt to get those needs met.

By any standards, Brian’s behavior in the context of his foster placements was terribly inappropriate because it threatened not only the safety, but also the actual lives, of those around him. At the same time, Brian was often the victim of significant bullying at school,
during which a small group of boys would taunt and then physically threaten him. Ironically, in most of these situations, Brian reacted by shutting down instead of fighting back. However, on several occasions when the bullying progressed past threats and the other boys had actually touched him, Brian had reacted violently, punching and kicking the bullies. It is a bit harder to determine the level of inappropriateness of Brian's behavior in these situations. While his therapist did not want to condone Brian's aggression, he also did not want to make Brian feel as if he needed to recapitulate his role as the passive victim of abuse in his peer interactions.

In this case, the therapist decided to proceed in four steps. First, he focused on helping Brian identify different levels of threat. Clearly, not having a cookie represented virtually no immediate threat, whereas verbal intimidation was a higher level of threat and actually being touched in a hostile encounter was a very high level of threat. Second, the therapist worked to help Brian differentiate the feelings associated with the different threat levels ranging from disappointed, to anxious, to genuine fear for his safety. Through these first two steps, the therapist also helped Brian differentiate the threat level and feelings associated with the various scenarios in the present from the threat level and feelings he had experienced in response to having been abused in the past. Last, the therapist worked simultaneously on two different aspects of the problem. First, he focused on addressing the underlying pathology by helping Brian find ways to get his needs for safety and control met across a variety of situations in as many settings as possible. Second, he worked with Brian to develop a range of responses to these different levels of threat and feelings. While the therapist focused on teaching Brian nonviolent responses, he did allow for the possibility of situations arising in which fighting back would be an appropriate response, so long as Brian's response was scaled to protect himself as opposed to hurting his attacker. Virtually all of this cognitive work was supported through the use of pretend play and role-playing.

**Etiology and Maintenance**

In formulating a case conceptualization, the EPT therapist must consider both the etiology of children's pathology as well as the factors supporting or maintaining the pathology in the present. Taking a systemic approach, the EPT therapist looks for underlying causes of children's symptoms in the individual, dyadic, and higher order systems, as well as the potential for the interaction of these systems to create difficulties. On an individual level, some children are inherently more prone to developing symptoms in response to life's stresses and strains. Children born with various neurological, developmental, or learning disorders, as well as those with autism or sensory disorders, are more likely to have trouble accurately interpreting and responding to problems in their lives irrespective of how good a job their caretakers do or how much support they receive from other systems. Similarly, some caregivers are inherently less able to competently provide for their children's needs no matter how functional and responsive their children are. On a dyadic level, even a healthy child and caregiver may have difficulty establishing positive interpersonal dynamics. For any of a wide variety of reasons, they may seem virtually unable to establish a goal-corrected partnership (Bowlby, 1969/1982) in which both of their needs are met. Lastly, even when healthy children receive optimal caretaking, they may still become symptomatic if something goes wrong in any of the systems in which either the child or the caregiver is embedded. Numerous healthy children face situations at school, such as being confronted by emotionally unhealthy teachers or bullied by difficult peers, and, as a result, their most basic needs are not met. Many caregivers face similarly difficult situations in their work settings. The stress caused
by these systems negatively affects the dyad's interaction and, in turn, this produces symptoms in child, the caregiver, or both. In the same way, problems at the individual, dyadic, or systems levels can serve to maintain children's symptoms once they have begun. Unfortunately, many children who enter play therapy are experiencing difficulty at every level, and treatment must take all of these into account if it is to be optimally effective.

Treatment Goals

Three primary goals apply to the treatment of all children in EPT, and all three follow from the model's definition of psychopathology. The first goal is to help children get their needs met effectively and appropriately. The second goal is to maximize children's attachment to others in their environment. This second goal serves two functions. On the one hand, given the degree to which children are dependent on others to meet their basic needs, establishing attachment relationships ensures there are caring people around to help them get their needs met. On the other hand, focusing on attachment ensures children will not become overly self-centered or narcissistic as they seek out ways to get their needs met. Healthy attachment relationships are always reciprocal, so both the child and the person to whom he or she is attached mutually benefit. The third goal is to gear treatment toward helping children resume normal development as the energy previously diverted to their symptoms is freed up and made available to promote optimal development in all areas, including the physical, cognitive, emotional, and social spheres.

Beyond the goals common to all EPT treatment plans, clients will also have individualized treatment goals. These goals:

- Are codetermined by therapist, parent, and child and take the needs and demands of the various systems in which they are all embedded into consideration
- Balance the needs of the client, family, and relevant systems to make sure as many people as possible are getting as many of their needs as possible met as often as possible
- Are set forth in treatment contracts with both the child and the caregivers
- Are regularly articulated by the therapist so the child client, the child's family, and representatives of the systems in which the child is embedded remain fully aware of the purpose and direction of the treatment process

Last, treatment success is measured by the degree to which the therapist, parent, and child agree the treatment goals have been achieved.

Curative Elements

Within EPT, the development of a strong working alliance between the therapist and the child and the process of helping the child to break his or her response set are considered essential to the resolution of children's symptoms. The alliance or therapist–client relationship is a necessary, but not a sufficient condition for a successful treatment outcome. In the context of the relationship, children must find a way to break set and learn new, more functional and appropriate ways of getting their needs met. The term response set is often used in education to describe the patterns of response people learn to use when faced with repetitions of a familiar problem. If you give a child a page of simple addition problems and embed one subtraction problem somewhere toward the middle of the page, the child will most likely add the numbers in the problem rather than subtracting. The repetition created by answering the initial problems causes the child to use the same strategy continuously, even when it is wrong. In EPT, children's symptoms are conceptualized as response sets. They are patterns of behavior representing children's best attempt to get
their needs met, and, even though they either no longer work or only work very sporadically, children keep using them because they are familiar and because they do not know what else to do. The EPT therapist helps children (and caregivers) break their response sets by helping them redefine the problem and by providing them with alternative experiences and, whenever possible, by doing both.

Children break their response sets in play therapy as the result of either cognitive or experiential shifts. The EPT therapist may modify the child's cognitions in one of two ways. The therapist may help the child redefine the problem so as to make it possible for the child to respond in new ways. This is usually done through the use of reframing. For example, Joey came to therapy experiencing terrible guilt after his younger brother died from leukemia. Joey firmly believed his resentment of and antagonism toward his younger brother had cause the leukemia. Through a combination of medical education, psychoeducation, and reframing, the play therapist was able to help Joey see how he couldn't have caused the leukemia even if he wanted to because it simply was not in his power to do so. Alternatively, the EPT therapist might intervene cognitively by teaching the child a different response strategy. Highly anxious children can be taught to take very slow, deep breaths to minimize both the physical symptoms of anxiety and to manage the degree to which these interfere in their lives. Alternatively, one therapist taught a child who was being bullied on the playground not to go and tell the teacher because the other children perceived this to be “tattling” and therefore it increased their bullying. Instead, the therapist taught the child to make sure she and her friends played rather noisily within the playground supervisor’s line of sight. This ensured the adult regularly checked on the children without requiring them to actively call for assistance. While not an ideal solution, this new strategy provided a way for the child to feel safe without being scapegoated.

Children may also learn new response sets in play therapy as the result of having experiences in which their usual patterns of responding are neither effective nor reinforced. For example, some children become hypervigilant in response to having been physically abused and tend to avoid direct interaction with others because they fear it will trigger aggression. The EPT therapist would be careful to both prevent the child’s resistance from interfering with establishing a therapeutic relationship and to reinforce engagement when it does occur. This is easily accomplished through the use of interactive toys and activities. The goal would be to make the amount of fun the child has sufficient to overcome the fear. The process of interacting with a therapist who is not put off by the child’s resistance and who is able to help the child engage in highly interactive play while having fun helps the child come to realize he or she is not in danger and to break his or her avoidant response set. Providing children with mastery experiences is another common way of breaking up children’s problematic response sets.

Mastery play can be particularly effective in overcoming symptoms such as focal fears or obsessive-compulsive behavior. Children who are afraid of the dark can learn to master their fears by playing flashlight tag either outdoors or in a dark room. The space in which flashlight tag is played needs to be at least moderately dark, and the person who is “it” needs to have a flashlight that is easy to turn on and off. Rather than trying to touch the other players, as in regular tag, the goal of flashlight tag is to touch the other person with the flashlight’s beam. For most children, being able to eliminate the dark with the simple flip of a switch is sufficient to make them less fearful, especially when the experience is paired with having fun. Similarly, many children can master their fears of medical procedures through pretend play in which they get to be the doctor ministering to a favorite doll or stuffed animal. Alternatively, the very thing a child fears can become part of the play. A child who is afraid of monsters can pretend to be one as the therapist models first fear and then mastery. Monster masks can be made in the play session and the child and therapist can then take turns being the one who is scared and the one being scary. The book
There's a Nightmare in My Closet (Mayer, 1968) can be a great take-off point for both learning how to make monsters look silly and for normalizing a child's fears.

Mastery play can also be used to overcome repetitive thoughts and behaviors, such as those seen in obsessive-compulsive disorders. In these corrective experiences, the goal is to make the symptom silly while providing the child with some sense of control. One little girl who presented for treatment had tried to manage her long-standing anxiety by creating many rules for herself, such as putting clothes on in a specific order and eating her food in a set color sequence. Her therapist chose to engage her in pretend play where they entered into a “Land of Many Rules” of which they were the king and queen. For every rule one created, the other one was to try and go a step further. The king (therapist) declared, “No one in the playroom can wear shoes.” The queen added they could not wear socks. The king said they could only step on alternate tiles … and so it continued. Every time they played, the therapist was able to build the rules to the point it was hard for either of them to move about the room. In so doing, the child began to make rules undoing the therapist's rules. As she did so, the therapist began to identify the pros and cons of rules and how they could be freeing or confining, while making sure the game was playful and silly (this included having to wave an oversized wand while stating the new rule). Gradually, the child broke set, noting how the rules sometimes got in the way of having fun.

**PROCEDURE**

In the following paragraphs, EPT theory is operationalized and the elements unique to its implementation are described.

**Therapist Qualifications, Training, and Characteristics**

To effectively practice EPT, a play therapist should, at a minimum, meet the following criteria for becoming a Registered Play Therapist as set forth by the Association for Play Therapy (2014).

**Education**

A master's degree or higher in a mental health field with coursework in child development, personality theory, principles of psychotherapy, child and adolescent psychopathology, and ethics, as well as a minimum of 150 hours of play therapy-specific instruction.

**Clinical Experience**

General clinical experience as required for licensure as a mental health provider with a minimum of 500 hours of supervised play therapy experience.

**Licensure**

An active license in good standing to independently provide mental health services.

Beyond these basic requirements, an ecosystemic play therapist should have academic knowledge of and clinical experience with the multiple systems in which children and their families are embedded, such as various cultural, educational, legal, and medical systems, to name but a few. Finally, it is important for the play therapist to participate in continuous professional development, to stay abreast of the many changes in the fields of child development, psychopathology, treatment methods, and play therapy.
In our ever more global society, adequate cultural knowledge and awareness are essential to the practice of competent and ethical play therapy. In this context, the word culture is used all inclusively to refer to all aspects of diversity, including gender, gender roles, sexual orientation, religion, race, ethnicity, nationality, language, age, physical ability, and socioeconomic status, to name but a few of the potentially pertinent variables. The awareness, skills, and knowledge, or ASK, model is often cited as the best example of good, culturally responsive practice (Pedersen, 1994). At the awareness level, play therapists are literally aware of how their own cultural influences play out in their lives and how these issues play out in their client's lives. While full awareness is never possible, it is important for play therapists to constantly reappraise the degree to which they are considering the potential role all aspects of diversity may play in both triggering children's symptoms and in providing critical solutions or support.

While there are some population-specific skills the play therapist may need, the ASK model focuses on two broad skills important to working with diverse clients. One is skill is called scientific mindedness, which refers to therapists’ ability to formulate diversity-based hypotheses regarding their clients and to then systematically test these out in the therapy process, rather than making assumptions and acting on those as if they were facts (Sue, 1998). The other is called dynamic sizing, which refers to therapists’ ability to determine the degree to which an individual client is similar to or different from other members of a diverse group (Sue, 1998). The following example illustrates the use of both skills.

**Case Example**

Dr. Stevens was quite familiar with the very strict child rearing practices and the common use of corporal punishment among members of a fundamentalist Christian group in his area. He also knew the group had faced regular criticism by child protective services, which believed some of the group's practices bordered on abuse. Based on this knowledge, Dr. Stevens hypothesized that the parents of his new client, a 6-year-old boy with extreme anxiety, used similar practices in raising the child and that these might be triggering some of the child's anxiety. Rather than either assuming this to be true or risking alienating the family by asking directly about their childrearing, he set about indirectly testing his hypotheses in the course of his interactions with both the child and his parents. Through this process, he discovered a significant difference between each of the parents in the degree to which they ascribed to their religion's beliefs and practices. Eventually, Dr. Stevens determined this difference in their views was contributing more to their son's anxiety than were any of their beliefs or practices.

Cultural competence requires play therapists to have at least a basic knowledge of the way various cultural issues may play out in their clients' lives. First and foremost, it is important to have a basic knowledge of how the specific diversity variable is manifested in a nonclinical population. Even if one works therapeutically with a large number of clients from a specific ethnic, religious, or any other group, it is important to know and interact with members of the group who are not in treatment. Second, it is important to know how to access accurate information about a group with which one is unfamiliar. Fortunately, modern technology has put global information at our fingertips. Unfortunately, not all of the information is accurate and, in the absence of electronic publication standards, it is up to play therapists to do their best to winnow the kernels from the chaff. Lastly, it is important not to use clients as one's primary source of diversity information. This is true for two reasons. One is the fact that clients are there to receive services they desperately
need, not to provide the clinician with free education. The other is the fact an individual client may or may not accurately represent the majority of the people of any group of which he or she is a member.

It is also important to have a good working knowledge of other systems, such as the educational and legal systems, as these have an impact on the lives of virtually every child at one point or another. EPT therapists should have basic knowledge of the educational laws in the jurisdiction in which they are practicing, as well as a working knowledge of how those laws and guidelines are implemented in various schools and school districts, because this information may influence treatment planning. For example, although states are required to provide an education to all children, one of the school districts in central California is known for making every effort to push parents to home school their “difficult” children and the school threatens expulsion if the parents do not comply. Clinicians who are aware of this practice are better prepared to help parents advocate for what is both educationally and clinically best for their children, as opposed to what best meets the needs of the school district. Similarly, when working with children who are involved in the legal system, it is important to know how the various systems work and do or do not interact. For example, most states have family courts (where matters such as child custody are decided), criminal courts, and civil courts (where lawsuits are heard). Typically, these courts operate independently, so their decisions may seem unrelated. Whether or not a child who is abused is removed from his or her abuser’s care will be decided in family court, and the outcome may be completely independent of whether the child’s abuser is convicted of criminal child abuse in criminal court. That is, a child might be removed from the care of someone who is found not guilty of abuse in a criminal trial and, conversely, might be left in the care of someone who is found guilty. Similarly, someone acting on a child’s behalf might file a suit requesting monetary compensation from the abuser for the child’s injuries and care. The outcome of such a suit would not necessarily be predicated on whether the abuser was found guilty in criminal court. While the particulars of the law are beyond the scope of most play therapists’ training and knowledge, a basic understanding of the way the systems work can go a long way in helping children embedded in these systems cope with processes and outcomes they may have to endure.

Aside from academic training and clinical experience, it is important for EPT therapists to be able to see problems from multiple perspectives and to have good personal and professional boundaries. Maintaining a solid, phenomenologic stance as one works with children and their families makes it easier to see problems from the perspective of the various people involved and to genuinely empathize with each. To some degree, basic empathy allows one to see the world through clients’ eyes. A good, foundational knowledge of child development and its impact on the way children understand and respond to the world around them can also foster empathy. All other factors being equal, the age at which a child’s parents divorce will play a huge role in how the child responds to the event. An 18-month-old is likely to be most concerned about the separations from one parent or the other during visits. A 5-year-old may feel overwhelming responsibility for the separation. A 10-year-old may be very concerned about how the divorce will affect the continuity of his peer friendships at home and at school. Similarly, intellectual knowledge about the life experiences of a particular group may foster empathy. It is one thing to see the pain of a young boy as he reports being teased at school for being effeminate; it is quite another to augment that empathy with knowledge of the high rates of physical violence against gender nonconforming youth in schools and the risk for depression in this population.

The ability to maintain good personal boundaries helps the EPT therapist in two ways. While the ability to be very empathic and see problems from multiple perspectives is crucial to being a good therapist, doing so may cause the therapist to want to intervene in ways that may not be in either the child’s or the family’s best interest. Empathy with an abused child can easily trigger
rescue fantasies in a therapist. A recalcitrant caregiver can trigger resentment or even anger. Good personal boundaries help to ensure therapists act in children’s best interests, regardless of their own feelings. At the same time, it can be very appropriate for an EPT therapist to take on various advocacy roles on behalf of their clients. The more a therapist moves out of the playroom and into clients’ real lives, the more the therapist needs to be attuned to the importance of personal and professional boundaries.

**Case Example**

Dr. Kern was working with a young girl named Amy who was undergoing prolonged chemotherapy for bone cancer. As the treatment progressed, Amy did not adjust to it; rather, her nausea became more and more pronounced and she lost more and more weight. The medical staff sought to help Amy cope by normalizing her experience and referring to her as “the best vomiter in the history of the hospital.” Meanwhile, Amy was becoming more depressed, and her mother, Kathryn, was becoming more frustrated. Dr. Kern felt so strongly that something else needed to be done to assist Amy she considered getting Kathryn’s permission to contact the oncologist directly. On the one hand, she thought the oncologist might be more responsive to the concerns of another professional than to the concerns of a parent. On the other hand, she recognized that, even if this was the case, it might make Kathryn feel disempowered and make it even harder for her to advocate for Amy in the future. Given the risks, Dr. Kern decided to help Kathryn learn how to maneuver in the medical system and to support her in her desire to do what was best for her child. Kathryn learned some medical terminology so she could more clearly communicate her concerns to the doctor. She also talked to the parents of other children with cancer and found out about a drug used to treat nausea in adults undergoing chemotherapy. When Kathryn approached the oncologist armed with this new information, he still refused to give Amy the drug, saying it had some addictive properties about which he was concerned. With Dr. Kern’s support, Kathryn made the decision to take Amy to a teaching hospital for a second opinion. The new oncologist agreed Amy’s situation was dire and agreed to a trial of the medication. Over the next few months, Amy gained weight, and her mother showed a clear sense of pride as she became both more knowledgeable about and engaged in her daughter’s treatment. In this case, Dr. Kern’s decision not to advocate directly but to empower the mother to do so helped not only the child, but also the mother, and it strengthened the relationship between mother and daughter.

**CLIENT CHARACTERISTICS, INDICATIONS, AND CONTRAINDICATIONS**

Ecosystemic theory can be used to guide the treatment of clients of any age or cultural background, regardless of their presenting problems, because the theory is designed in such a way as to take these variables into consideration. Similarly, the EPT theory and model are so flexible they can be adapted to the needs of any child. EPT therapists adjust the degree to which they structure the session to suit both the child’s developmental level and the need to be regulated versus ability to self-regulate. EPT therapists also adjust the balance of cognitive versus experiential interventions they provide in the play therapy sessions to suit the child’s developmental level and cognitive abilities. Last, EPT therapists are experts at finding ways to combine play techniques with the
ever-growing array of empirically supported treatments to bring effective intervention strategies into the playroom.

**Logistics**

As was stated earlier in this chapter, the way in which the EPT playroom is laid out and the toys and play materials presented to the child are both quite unique.

**Playroom, Toys, and Materials**

In EPT the playroom itself is not conceptualized as having any specific therapeutic value; rather, it is seen as a neutral container for the therapeutic relationship. As such, the room should in no way distract the child from either interacting with the therapist or engaging in the play. A simple playroom also minimizes opportunities for children to engage in dangerous or problematic behavior, reducing the likelihood the therapist will need to set limits. Ideally, the playroom will have water- and dirt-resistant surfaces, such as vinyl flooring and washable wall coverings. An area rug can serve as a comfortable area for playing on the floor or engaging in quiet activities. A small table is useful for playing games or doing artwork. Beyond these very basic items, the playroom is left empty to provide plenty of space for active play. Unlike traditional, client-centered playrooms in which the toys are displayed on shelves and easily accessed by all children, in the basic EPT playroom the toys are stored away so only the therapist can access them. The toys can either be stored in closed and locked cabinets within the playroom or completely outside the room. This toy storage system accomplishes several things. First, it prevents children from becoming so distracted when they enter the playroom that they would rather attend to the toys than interact with the therapist. Theraplay is an excellent example of how few toys or materials are needed to create a highly therapeutic interaction between the child and therapist (Booth & Jernberg, 2010). Second, having very few toys in the playroom means the child cannot use toys as a way of avoiding the work of therapy. Given free choice, many children would much rather play a content-neutral game, such as chess or checkers, and avoid addressing their fears or problems. When the therapist can limit the toys, the child is more easily engaged in the play therapy process. Last, having fewer, well-selected toys available means the therapist will do less limit-setting. Highly disorganized or dysregulated children often move from one toy to another very quickly, creating havoc in their wake. While they may appear to be enjoying themselves, the resulting mess often makes them feel even more disorganized and dysregulated. In addition, it may put the therapist in the position of having to delay the start of the next session in order to put the room back in order. Further, for children prone to acting out in destructive or aggressive ways, the therapist can carefully limit the toys available to reduce the opportunity for the child to behave in inappropriate or dangerous ways. Although limit-setting can be a therapeutic experience, most children do better when the environment is structured in such a way as to minimize the need for limits, thereby maximizing the opportunities for play and positive interaction with the therapist.

While the toys available to a child in any given session are limited, the EPT therapist will still need to have a broad array of toys and materials available from which to select. For working with a general clinical population, a play therapist will need toys in each of the following categories: sensorimotor, pretend (body centered, transitional, toy centered), games, gross motor, construction, art, music, and educational. Then, within each category, the therapist should have toys suited to children at different developmental levels. For example, although sensorimotor toys are usually geared toward very young children, older children also enjoy toys with multisensory properties, such as sand or scented markers. In addition, play therapists will want to have an array of toys that reflect the needs or issues of specific clients or populations. Children who have experienced medical trauma often need to play with either miniature or life-sized medical supplies...
and equipment to both allow for cathartic play and to help them build a sense of mastery over their experiences. Similarly, children who have been the victims of crime often need to play with miniature police figures and vehicles or with full-sized toys such as handcuffs.

Having obtained a suitable array of toys from which to choose, the EPT therapist usually selects five to seven toys/materials to bring into a given play therapy session with a child. These toys will be selected based on several criteria, one of which is the child’s developmental level. Three developmentally based toys/materials will be selected: One toy should be a bit below the child’s developmental level and be easy to use, one should be right at the child’s developmental level, and one should provide a bit of a challenge for the child. Two to three toys to elicit content relative to the child’s treatment goals and underlying needs or issues will also be included. Finally, one or two toys might be added because they support the other materials, will promote interaction between the child and therapist, or they are relatively neutral and will allow the child to take a break from the work of therapy when needed. Although five to seven toys are typically chosen, it would be entirely feasible to conduct an entire session during which the therapist and child play together using no toys.

Following are examples of the toys an EPT play therapist might choose for a session with a school-aged child who is experiencing considerable school-related anxiety:

<table>
<thead>
<tr>
<th>Play</th>
<th>Developmental Level</th>
<th>Therapeutic Content</th>
<th>Other Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ball</td>
<td>Catch</td>
<td>At or below child’s level</td>
<td>Neutral</td>
</tr>
<tr>
<td>Blindfold</td>
<td>Blind Man’s Bluff</td>
<td>At or below child’s level</td>
<td>May stimulate a bit of anxiety the therapist can interpret as a lead into discussion of child’s school anxiety</td>
</tr>
<tr>
<td>A moderately difficult board game</td>
<td>Game play</td>
<td>Above child’s developmental level</td>
<td>Might elicit themes of anxiety related to competition at school</td>
</tr>
<tr>
<td>School supplies</td>
<td>Body-centered pretend play in which child pretends to be a student or teacher at school</td>
<td>Below child’s level</td>
<td>Directly addresses presenting problem</td>
</tr>
<tr>
<td>Miniature toy children and adults with miniature school supplies such as desks or blackboard</td>
<td>Toy-centered play in which school-related content is presented</td>
<td>At child’s level</td>
<td>Directly addresses presenting problem</td>
</tr>
<tr>
<td>White paper, markers, scissors, tape</td>
<td>Expressive play</td>
<td>At child’s level</td>
<td>May or may not stimulate specific therapeutic content</td>
</tr>
</tbody>
</table>
**Treatment Frequency and Duration**

As with most other types of play therapy, EPT sessions are usually scheduled at weekly intervals. Younger children or those with significant separation issues may require more frequent sessions, particularly at the beginning of treatment. Weekly sessions should continue for some time after the child's symptoms have abated to ensure the gains remain once therapy is completed. The total number of sessions required to complete treatment will vary significantly depending on the child's age, presenting problem, and the ability of the various systems in which the child is embedded to support both the treatment and any changes the child makes as treatment progresses. An otherwise well-adjusted 5-year-old who is experiencing some fairly age-appropriate phobic symptoms might see significant symptom reduction in just five to seven sessions. More complex situations might involve many more. Moreover, some children who are coping with chronic mental health issues might benefit from long-term supportive work. In these cases, the goal is not to achieve the absence of symptoms, but rather to foster the child's ongoing ability to cope in the face of his or her own developmental changes and natural shifts in the environment, such as changes in grade level and teachers at school. However long the treatment proceeds, the time between sessions should be gradually increased as termination approaches to allow the child plenty of time to adjust to the impending separation from the therapist, as children are even more likely than adults to have developed significant emotional attachments to their therapists.

**Pretreatment Intake and Assessment**

Prior to designing and implementing a treatment plan, EPT therapists obtain a comprehensive history and conduct whatever assessments are needed to enable them to conceptualize the case fully. The EPT intake covers all of the major systems in which the child and his or her family are likely to be embedded. *Play Therapy Treatment Planning and Interventions: The Ecosystemic Model and Workbook* (O'Connor and Ammen, 2013) includes both paper and online forms useful for obtaining a comprehensive history and completing both a full mental status exam and systems review prior to initiating treatment. While the degree to which mental health professionals will conduct assessments beyond the intake varies, two types of assessment should be considered routine in working with children: a developmental assessment and a baseline measure of the child's overall functioning and/or symptoms.

Completion of a developmental screening allows the play therapist to determine the degree to which children's symptoms may have interfered with their making age-appropriate developmental progress, as well as guiding the therapist's initial treatment planning. Many children who enter therapy have experienced such severe symptoms over a prolonged period of time that their development in one or more spheres has been inhibited. A 10-year-old boy who has been abused since infancy may still be working on the development of a primary attachment, a task usually mastered by children in their first 2 years of life. This same boy will need aspects of his treatment adjusted to suit his early developmental needs in spite of his chronological age.

The Developmental Teaching Objectives Rating Form (DTORF; Wood, 1992a, 1992b) can be very useful in giving an overall sense of children's development across four domains: behavioral, social, communication, and academics. The instrument is easy to use and provides the therapist with a list of potentially useful treatment goals. The DTORF is designed to be completed as part of a semistructured interview with adults who know the child well. While the majority of the information is usually gathered from the child's primary caregiver, the input of others, such as the child's teacher, can prove useful in determining the consistency of the child's functioning across settings. For each domain, there is a list of hierarchically arranged items covering development in that domain from birth through about age 16. Items are checked off based on the child's ability
to complete the target behavior consistently. The child's ceiling in each domain is reached when two items in a row cannot be checked because the child does not perform the behavior regularly. These two missed ceiling items then become the treatment goals. As a result, completion of the instrument establishes at least eight treatment goals for the child, two in each of the four domains.

The DTORF was designed for use in schools, which has some advantages and disadvantages when it comes to using the instrument in a clinical setting. On the plus side, the instrument was designed to be repeated at regular intervals, so it can be used to assess a child's progress over time. Also on the plus side, because it was designed to be used by teachers as opposed to clinicians, it is more user friendly than some of the more traditional developmental screening tools. The fact that the items often refer to behaviors more commonly seen in a classroom than at home is also both an advantage and a disadvantage. On the positive side, it means the goals can be readily communicated to children's schools and implemented by teachers. On the negative side, it means some of the items may be a bit difficult for a caregiver to rate. A final advantage to its having been developed for school use is the fact the DTORF can be completed online. The DTORF site (www.dtorf.com) allows the therapist to print out the child's goals as well as a customized, behaviorally oriented treatment plan and to track the child's progress over time.

TREATMENT PROCESS AND STAGES

Treatment Process
As described earlier in the section on curative elements, EPT is focused on helping children break their problematic response sets, which are here defined as ineffective and/or inappropriate ways of getting their needs met. Once the response set is disrupted, children are open to learning and using new behaviors allowing them to get their needs met more effectively and appropriately. The need to be able to break response sets on a regular basis is particularly high in children because they are undergoing constant developmental changes, which requires them to replace old behaviors with new ones. Therefore, all aspects of the EPT process are geared toward facilitating this healthy process of behavioral change and developmental adaptation.

The process of replacing children's dysfunctional response sets with newer, more functional ones is accomplished by cognitively or experientially challenging their existing patterns of behavior. All EPT sessions combine both experiential (activity/play) and cognitive (discussion and problem solving) interventions. As has been previously stated, the balance of one versus the other is determined by the child's developmental level.

Treatment Stages

Introduction and Exploration
During the Introduction and Exploration phases, children become acquainted with the therapist, the playroom, and the toys and materials. Because most children do not come to therapy of their own volition but are brought because their behavior or symptoms are troubling to others, they can be slow to warm to the idea of therapy. Depending on their past interpersonal experiences, they can also be slow to warm to a new adult, especially one who is in an authority position. On the other hand, some children come to therapy desperately needy, and they quickly cling to anyone offering support in the midst of their distress. Irrespective of how children present initially, whether they be reluctant, indifferent, or clingy, it is important to remember they rarely disclose their true selves early in the play therapy process.
Tentative Acceptance

Once they become familiar with the therapist, the playroom, and the toys, most children quickly decide they will give therapy a chance and begin to play. During the Tentative Acceptance phase, they are likely to try to avoid addressing any therapeutic content in much depth, especially if there has been past trauma. Because children inherently tend to avoid the "work" of play therapy, it is important for the play therapist to keep the treatment contract at the forefront during this stage or risk having the child see the sessions as a time for engaging in pleasantly avoidant play. When this happens, any attempt on the part of the therapist to later focus on the treatment goals can be met with considerable resistance and even a feeling of betrayal on the part of the child.

Negative Reaction

As the therapy progresses to the point that children begin to break set and see their symptoms and patterns of behavior as no longer meeting their needs effectively and appropriately, they will experience a very uncomfortable sense of being caught between their desire to change and their fear of change. This usually manifests in some form of regression or resistance, and this is referred to as the Negative Reaction phase. Adult clients may not show up for sessions during this phase as a way of avoiding both the work of therapy and the need to make any further changes. Since children are brought to therapy by others, they are more likely to show their resistance in session. Some children resist passively by limiting how much they talk and focusing their attention on the toys or the play. Other children, particularly those who have experienced aggression or violence in their past, may act out very aggressively as their equilibrium is threatened by the mere thought of change. Since the appearance of this behavior often precedes children making significant positive changes, it is important for the therapist and caregivers to see it as a sign of progress and not of regression or treatment failure. If the adults can acknowledge children's fear of change and provide extra support and scaffolding at this time, then the vast majority of children will rapidly transition to the next phase.

Growing and Trusting

The Growing and Trusting phase of therapy is where the most change occurs. Children in the phase have broken set and are now able to reframe their earlier experiences and to develop more effective and appropriate ways of getting their needs met. During this stage, most children will gradually shift from primarily experiential to more cognitive ways of processing problems and engaging in problem solving. Certainly, the degree to which this shift occurs will depend on children's developmental levels. Most preschool and early school-age children will continue to rely heavily on experiential means of communication and learning. Late school-age and preadolescent children sometimes shift to using primarily cognitive means of communicating and problem solving while relying on play as a way of relaxing and reenergizing. Toward the end of this stage, therapy should focus on helping children consolidate and generalize the gains they have made.

Termination

As children's new-found abilities to get their needs met effectively and appropriately stabilize, it is time to begin planning for the termination of therapy. Because of children's limited understanding of therapy, this phase of treatment often needs to be managed carefully. Adult clients come to therapy because they are in distress, want help, and expect to end treatment once their goals are met. Children, on the other hand, are usually brought to therapy because their behaviors distress others. Children often do not want help, and when they do, they do not usually understand how
therapy might be helpful. Children enter therapy suspicious of their caregivers' and the therapist's motives and only gradually come to first trust in, and then rely on, the therapy process and to build a powerful, emotional connection to the therapist. As things in their lives improve and they realize how much better they feel, children are often distressed by the idea of ending the very relationship to which they attribute the improvement. To many, termination is not seen as a reward for all the good work they have accomplished, but as a punishment.

The negative aspects of termination can be greatly reduced if the therapist keeps the contract and goals at the forefront of each and every session. Doing so ensures children are aware of the purpose of therapy. It also allows them to take an active role in implementing changes and tracking their progress. The therapist can introduce the idea of phasing out therapy very early on and tie the notion directly to children's abilities to maintain the changes on their own. Typically, termination begins by spacing the play sessions farther apart. Scheduling sessions once every 2 weeks, then once every 3 weeks, and then once a month helps children slowly extricate themselves from the therapeutic relationship while still knowing the therapist is not yet completely out of the picture. Ideally, when termination is finally completed, the therapist can still leave the door open for children to return to therapy at any point in the future should they so desire. In cases where this sort of slow termination is not possible, such as when therapists leave the work setting in which they were treating the child, it is best to make the child aware of termination as far ahead as possible. In short-term therapy, this might mean letting the child know how many sessions there will be right from the outset. This allows children some degree of control over how invested they become in therapy and the therapist. While this may mean the children do not engage as fully in the therapy process, it seems to be better than subjecting the child to a difficult termination process because this may make it difficult for children to make use of therapy at any point in the future, should the need arise.

**COMPLETE CASE EXAMPLE**

**Intake and Pretreatment Assessment**

Sarah was 3 years old when she was brought to treatment with Dr. Gray by her parents, Jane and Steve Williams, who had adopted Sarah when she was 4 months old. Mr. and Mrs. Williams were an older, Anglo-American couple who had adopted Sarah from a South American orphanage several years after finding out they would be unable to conceive biological children of their own. The orphanage provided the children with very good basic care, although most of the babies did not get much individual attention or nurturing. From the outset, the Williamses noticed that Sarah seemed to be perpetually hypervigilant, attending to everything in her environment with an intensely alert gaze. Initially, the Williamses had felt things were going well because Sarah showed signs of attaching to both of them during the first 6 months after the adoption. However, as time progressed, Sarah seemed to grow more and more reactive, displaying marked emotional and physiologic responses to an ever-increasing array of environmental stimuli. By the time she entered treatment, most intense or novel stimuli caused Sarah to cry and scream in obvious terror for up to 15 minutes past the time the stimulus was removed. Even after she settled, Sarah would continue to talk about the stimulus and her fear of its return. Sarah's fears made it impossible for her to interact with peers or attend preschool on a regular basis. While the family had been able to reduce their interactions with the outside world to prevent Sarah's fear episodes, it was becoming progressively harder for them to accommodate her needs and live any semblance of a normal life.
Following the intake, several assessment measures were completed. The DTORF was completed based on feedback from both of Sarah's parents. The DTORF results are listed in the Initial Treatment Goals section later in this chapter. A Marschak Interaction Method (MIM) (Lindaman, Booth, & Chambers, 2000; Marschak, 1960) was completed with Sarah and her mother to rule out underlying attachment issues as a factor contributing to the fear episodes. During the MIM, parents are asked to complete a variety of simple tasks with their child while being observed and videotaped, in this case through a one-way mirror. Throughout the MIM, Sarah tended to be more clingy than cooperative. Her mother had difficulty engaging Sarah in any of the more novel tasks or successfully soothing Sarah once she became overstimulated and started to cry or protest. Although Sarah's mother was able to leave the room for 1 minute as directed, Sarah responded by sitting motionless and screaming while her mother was out of the room. The dyad was unable to complete any of the tasks following the separation task because Mrs. Williams was unable to soothe Sarah once she had become so significantly dysregulated.

In addition, a variety of baseline measures was taken. A complete list of all of the stimuli triggering Sarah's fear responses was generated. The parents were then asked to keep a record of the triggering stimulus, the length and severity of the fear response, as well as any things they found to be helpful in bringing the episodes to a close. This data helped to distinguish three, somewhat different, response patterns the parents had previously lumped together. One response seemed to reflect genuine terror on Sarah's part. During these episodes, Sarah would cry more than scream, shake, and take on an oddly blank facial expression while clinging to her mother. These episodes were the ones most likely to be followed by Sarah perseverating on whatever had set the episode off. The second response involved more screaming than crying and was usually accompanied by oppositional behavior as Sarah would refuse to participate in an activity or complete a task she had been asked to do. The last category included fear responses in which Sarah was more likely to become very quiet but still manifested a rather blank facial expression. These episodes tended to be much briefer and were often overlooked by adults. These episodes were also most easily resolved if parents responded by providing Sarah with simple verbal reassurance paired with physical and emotional support.

Lastly, Sarah was referred to an occupational therapist in order to determine if she was inherently overly sensitive to stimuli. This came about because the parents indicated Sarah had always seemed hypersensitive to normal stimuli and rather hypervigilant to danger in her environment. The occupational therapist confirmed Sarah to be very easily overstimulated by virtually all sensory stimuli. Though Sarah was most sensitive to sound, she also tended to react negatively to sudden movement or flashes of light and to avoid unusual textures or sensations. Based on these findings, Sarah began attending occupational therapy sessions in addition to her play therapy sessions.

Ecosystemic Case Conceptualization

In reviewing the history and the various assessment results, Dr. Gray concluded that two factors had interacted and contributed to Sarah's presenting problems. One was her lack of early attachment experiences because of her time in an orphanage. While the care she received was adequate, the setting probably contributed to Sarah's hypervigilance because the behavior would have both helped her to avoid or prepare for negative stimuli and to search for opportunities to obtain care or nurturing. The other was her biologic hypersensitivity. This seemed to have both contributed to and reinforced her hypervigilance. Because of the hypersensitivity, Sarah had learned to avoid as many novel stimuli and situations as possible. Because avoidance was effective in reducing her fears, she gradually avoided more and more situations. While this had probably worked quite well
during infancy and early toddlerhood, it was becoming problematic as she got older and the need to interact with the environment increased.

In the first few months after she was adopted, Sarah’s hypervigilance had decreased in the face of the sudden and dramatic increase in the amount of attuned attention and care she was receiving. Luckily, this allowed her to create a solid initial attachment to her parents. Unfortunately, she seems to have become somewhat anxiously attached. In anxious attachment, children cling to their caregivers both because they fear losing them and because they fear the world outside of the caregiver–child relationship. In Sarah’s case, the sensory hyperreactivity greatly enhanced her fear of the environment. As her attachment to her parents increased, Sarah seemed to focus her hypervigilance on her environment and found more and more reasons to see proximity to her parents as safe and the environment as dangerous.

At the time of referral, Sarah’s need for safety was being well met in the context of her relationship with her parents, particularly so long as she was in relatively close proximity to them. However, her need for safety outside the parent–child relationship was not being met. In the face of novel situations or stimuli, she was becoming so severely overstimulated she experienced terror. This produced three patterns of behavior. The first and most obvious were the blatant terror episodes during which Sarah was virtually inconsolable. Because this first type of episode sometimes resulted in Sarah being able to avoid unpleasant tasks or demands, she had been gradually conditioned to respond to things she did not like in the same way she responded to things she feared. Finally, milder fear situations seemed to cause Sarah to revert to her older hypervigilant but withdrawn behavior. While mild, this was probably the most problematic of the three responses because it was the least likely to be noticed by adults and, therefore, least likely to result in her needs being met.

Initial Treatment Goals and Contract

Following the intake and assessment process, the Williamses agreed to a treatment contract in which both individual and dyadic play therapy would be used to increase Sarah’s secure attachment, reduce her fear responses, and increase her ability to interact positively with other adults, peers, and her environment. Given her age, the contract with Sarah was kept very simple. Dr. Gray told Sarah, “I know you feel scared a lot. Being scared feels really, really bad. My job is to make sure you spend less time being scared and more time having fun.” Consistent with the practice of EPT, some iteration of this goal was repeated at least once in every session.

Based on the information gathered during the intake and the assessment data, Dr. Gray developed the following treatment goals for Sarah.

Needs-Based Goals

Sarah will:

- Feel safe and demonstrate decreased anxiety responses in response to various stimuli, people, and situations
- Feel less helpless and develop ways of feeling as if she has some control beyond simply screaming
- Develop improved self-esteem and a better sense of achievement/mastery as her fears diminish and she is better able to function and be successful in her environment

Sarah’s parents will:

- Learn to better protect Sarah from overstimulation
- Learn to more consistently identify the three types of fear responses Sarah is exhibiting
Attachment-Based Goals

Sarah will:

- Feel more securely attached to her parents and be able to use them as a secure base for managing her fear responses as demonstrated by her being better able to tolerate separations from her parents and more regularly engaging with peers.

Sarah’s parents will:

- Master the skills needed to differentially respond to Sarah’s fear responses.

Developmental Goals

Sarah will:

- Be able to demonstrate an appropriate physical response to stimuli.
- Participate verbally and physically in movement activities with peers either at home or daycare.
- Produce recognizable single words in several activities to obtain a response from a peer.
- Use words spontaneously to share minimal information with a peer.
- Participate spontaneously in specific parallel play activities indicating awareness of peers.

Treatment Phases

The treatment goals just presented were organized by intensity and then integrated into the overall treatment plan, with the “easier” goals being addressed from the outset and the more difficult goals reserved for the Growing and Trusting phase.

Introduction and Exploration

Throughout the intake and assessment process, Sarah had responded with intense fear to the clinic setting and to Dr. Gray. Sarah was able to tolerate having Dr. Gray in the room at the beginning of the MIM. However, once she had become overstimulated and anxious while completing the MIM tasks with her mother, Sarah displayed an intense anxiety response when Dr. Gray reentered the room. This created a bit of a problem. If Sarah was allowed to leave the clinic prior to regaining at least some sense of safety, then her anxious behavior would have been negatively reinforced and she would be even more likely to display a fear response in the future in order to escape the clinic setting. To prevent this, Dr. Gray stayed in the room with Sarah and her mother while she encouraged the mother to soothe and nurture Sarah. After nearly 15 minutes, Sarah seemed not to have calmed at all. Dr. Gray left to get some M&Ms. Upon her return, she handed them, one at a time, to Sarah’s mother, who then fed them to Sarah. Very gradually, Sarah stopped screaming and began to visually follow the M&Ms from Dr. Gray’s hand to her mother’s hand. Forty-five minutes later, Sarah had still not looked at Dr. Gray, though she had stopped crying. At this point Dr. Gray said, “Sarah, I’m so glad you aren’t feeling quite so scared.

---

2 All of the developmental goals were adapted from Sarah’s completed DTORF.
3 In this section, sentences or phrases preceded by an asterisk are goals that were adapted from a Positive Behavioral Intervention Plan generated from Sarah’s completed DTORF form on the DTORF website (http://www.dtorf.com).
right now. You screamed for so long you look really, really tired. I think mom needs to take you home, get you something to eat, and then maybe the two of you can lie down and read a story so you can rest up. I'll give your mom the rest of the M&Ms so you can eat them at home. The next time you and your mom come the clinic, you can bring one of your favorite books for us to read.”

In this way, Dr. Gray acknowledged Sarah's fear, the work it had taken her to calm herself even just a little, and associated leaving the clinic with calming as opposed to screaming and set up a potentially nurturing interaction for their next meeting.

The primary goal of the first phase of Sarah's treatment was to reduce her anxiety level enough to allow her to participate in the play therapy process. Because the playroom, toys and materials, and the therapist, Dr. Gray, were all novel stimuli, it took a great deal of environmental management to keep Sarah from becoming overstimulated. To address this goal, Dr. Gray focused on organizing the schedule, routine, pace, space, activities, and time to allow Sarah to habituate to both the playroom and to Dr. Gray over time. She also kept the materials, supplies, equipment, and toys to a minimum to ensure satisfying outcomes while providing uncomplicated opportunities to use materials appropriately. In fact, in the first session, the only material used was the book Sarah and her mother had brought. Dr. Gray only increased the materials and toys present in the room very gradually, and she usually let Sarah know ahead of time when she would be adding something.

Dr. Gray also chose to include Sarah's mother in the first few sessions, though she asked her to do as little talking as possible so as to increase the chances Sarah would attend to Dr. Gray rather than her mother. For all of the activities, Sarah sat in her mother's lap while interacting with Dr. Gray. This provided Sarah with the experience of using her mother as a secure base while gradually adapting to Dr. Gray's presence. During this early period, Dr. Gray would play simple games like pat-a-cake, where the emphasis was on not just the physical contact but on trying to increase the volume of the “pats” while keeping the interaction fun. Over the course of a few sessions, Sarah was beginning to enjoy the sessions and was spontaneously leaving her mother's lap.

Tentative Acceptance

Sarah's move into the Tentative Acceptance stage of treatment was marked by her lack of any clear fear responses to the playroom, the toys, or Dr. Gray. She began to interact directly with Dr. Gray, although she still frequently displayed a freeze reaction in response to any sort of novelty or loud sounds. During the previous stage, Sarah's mother had provided Sarah with encouragement by using hugging, touching, and other nurturing sensory responses, such as cooing. During this phase, Dr. Gray began to do the same. She also began to introduce other pleasing and attractive sensory stimuli and invited Sarah to interact. They smelled the perfume strips commonly found in magazines, as well as a variety of foods. Though Sarah was unable to tolerate the use of a blindfold, she was able to close her eyes and try to guess what she smelled.

Over the course of just a few sessions, Sarah's mother began to sit quietly and read during the session and Sarah stopped checking in with her, having become somewhat secure in the new environment. After just two sessions like this, Mrs. Williams very matter-of-factly told Sarah she was going to sit in the hallway to read so she wouldn't disturb the play. With only a bit of hesitation, Sarah let her mother go. From this point on, the play sessions were split in half. Mrs. Williams would attend the first part. When new activities or materials were introduced, Mrs. Williams would directly interact with Sarah and Dr. Gray. During these new activities, she would physically guide Sarah's responses in order to teach her how to respond and avoid her becoming overwhelmed by the fear of responding incorrectly or of simply not knowing what to do. Both Mrs. Williams and Dr. Gray made sure to talk about how much fun the new activity would be in order to reassure Sarah as she learned the new pattern of behavior. In other sessions,
Once Sarah settled into using the new material or form of play, Mrs. Williams took the role of being an audience for whom Sarah could demonstrate both her growing sense of mastery and her enjoyment of the play.

**Negative Reaction**

In spite of how difficult it had been for Sarah to overcome her initial fears at the beginning of play therapy, any resistance she showed during the negative reaction phase of therapy was relatively mild. Having begun to master some of her stronger fears, Sarah now tended more toward the second type of fear response her parents had noted at the time of intake. During these episodes, it was much more difficult to tell if Sarah was genuinely frightened or was primarily motivated to avoid the task at hand. During these times, Dr. Gray primarily modeled expected behavior with simple, positive words and actions. Most of the time this was sufficient to get Sarah to return to the play. On a few occasions, Sarah did become very dysregulated. One of these occurred when she happened to hear a car backfire outside the clinic. After displaying a brief freeze response, she began to scream and moved to flee the playroom. Dr. Gray immediately pulled Sarah onto her lap and held her firmly but supportively while talking very little. Instead, she hummed and slowly rocked Sarah. Only when Sarah had stopped screaming did Dr. Gray begin to talk about both the trigger and Sarah’s response. Within only about 10 minutes, Sarah was able to return to some quiet play and Dr. Gray heavily reinforced her mastery of her fear response. She also noted how this was just what they were working to accomplish, saying, “You were so scared by that loud noise you couldn’t help but scream. But this time, you were able to tell yourself the noise was far away and to calm down. Then you were able to go back to playing. That is just what we wanted to happen: Being less scared means more play.” Following this inadvertent experience, Sarah seemed to fully accept Dr. Gray as someone who would both recognize her fears and help her learn to manage them.

**Growing and Trusting**

During the growing and trusting phase of treatment, Dr. Gray primarily engaged Sarah in a lot of play activities designed to systematically desensitize her to various stimuli. They began to play games like Blind Man’s Bluff and Simon Says. During Simon Says, Dr. Gray would include instructions such as, “Simon says clap as loud as you can” while modeling loud clapping. The vast majority of the time, Sarah was able to tolerate new stimuli when these were introduced in a game or play format. They also began to conduct more play sessions outside, where Sarah was more likely to be exposed to unexpected stimuli. Surprisingly, Sarah particularly enjoyed going on bug hunts, where she and the therapist would overturn leaves or rocks to see what they would uncover. Even though some of the bugs they found moved quickly, Sarah seemed to tolerate them because they were small and because she could always cover them right back up if she needed to. During this phase, Dr. Gray significantly increased her use of language to help Sarah recognize the thoughts underlying her fears (primarily separation anxiety) and to discuss potential coping strategies: “Sometimes, if you blow out very slowly, you can blow the fear away.” Dr. Gray also continued to use physical proximity and soothing physical and verbal interactions with Sarah in order to both prevent overstimulation and to manage it when it did happen.

**Termination**

After nearly a year in treatment, Sarah’s fear responses had decreased to the point she was able to attend preschool on a regular basis. She was still prone to freezing up in novel situations, but she was usually able to take cues from the behavior of those around her and behave accordingly.
Though she often seemed to be “acting” as if she was not scared rather than genuinely being unafraid, the imitative behavior allowed her to continue to participate in activities until she was once again having fun.

Over the course of treatment, Sarah had become very attached to Dr. Gray, who she saw as having rescued her from her near-constant fears. Because of this, play therapy was discontinued very slowly. First, Mrs. Williams returned to attending most of the play sessions. Now, instead of functioning as either the secure base or as a passive observer, she was more likely to take the lead while Dr. Gray became the observer. In some sessions, Dr. Gray would even leave the room for brief periods to allow mother and daughter their own time in the playroom. As the play sessions focused less directly on the management of Sarah's fears, she regressed a bit and began sleeping in her parent's bedroom once again. Since the Williamses were comfortable with managing this on their own, the termination process continued and sessions were scheduled for every other week as opposed to every week. After 2 months, Dr. Gray expressed her pride in Sarah's ability to manage her fears and her joy in how much time Sarah was having fun in a wide variety of settings. Because this treatment contract had been articulated regularly, she was also able to talk to Sarah about their work being nearly done and about Sarah's ability to manage on her own. Together, Dr. Gray, Mrs. Williams, and Sarah decided to move to monthly sessions. After three additional sessions, the trio decided the fourth session should be their last and should include a party to celebrate all the things Sarah had accomplished. The final party was planned entirely by Sarah and her mother. Dr. Gray took on the role of a guest at their party. As they ate snacks, they talked about all the things about which Sarah had once been afraid. Sarah displayed some amazement at how long the list was and a great deal of pride at having mastered so much.

RESEARCH

The mental health field is currently focused on two types of research when it comes to evaluating the effectiveness of any and all forms of psychotherapy. One type is used to establish an intervention or technique as an empirically supported treatment (EST). The other type is referred to as evidence-based practice (EBP) and is used to document the effectiveness of therapy with an individual client. To become an EST, the intervention or technique must be manualized and subjected to rigorous scientific testing. Theoretical models, therefore, cannot really be empirically supported because they are not narrow enough to be tested. For example, many existing empirically supported treatments are grounded in cognitive-behavioral theory, but cognitive-behavior therapy as a whole is not considered to be empirically supported. For this reason, Ecosystemic Play Therapy (EPT) as a theoretical model is not currently, and will probably never be, considered an EST. However, many of the techniques promoted by EPT could be readily manualized and tested. For example, it would be possible to determine if having an explicit treatment contract with a child and regularly using that contract to help the child understand the rationale for both specific play activities and the course of play therapy as a whole does, indeed, result in more rapid symptom reduction than is accomplished with less goal-oriented interventions.

Ecosystemic Play Therapy is intended to be implemented as an evidence-based practice and, due to its format and structure, it lends itself to ongoing evaluation of client progress and treatment effectiveness. The model requires the play therapist to establish baseline measures of children's functioning and to incorporate these into treatment planning. Further, the play therapist must regularly evaluate the child's progress in order to continue to implement well-planned therapeutic play activities. Lastly, the model encourages the incorporation of those ESTs shown to be effective in addressing a child client's presenting problems. What makes ecosystemic play therapists unique is their ability to modify established ESTs to suit the needs of children by making
needed developmental modifications and by incorporating play as both an essential tool in and of itself and as a medium for making interventions more palatable to children. For example, all eight components of Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2012; National Child Traumatic Stress Network, 2008), a well-regarded EST, could be readily incorporated into the practice of Ecosystemic Play Therapy. To illustrate, one component of TF-CBT involves helping children express and modulate a range of emotions. Color Your Life (O’Connor, 1983) is a play and expressive arts technique specifically designed for use in EPT to teach children emotion words and to provide them with a concrete, visual way of expressing the quantity and intensity of their emotional experiences.

CONCLUSION

Ecosystemic Play Therapy (EPT) is a systemically focused, developmentally responsive, goal-oriented form of play therapy suitable for children with a wide range of presenting problems. EPT puts a great deal of emphasis on understanding and optimizing the roles of the various systems in which the child is embedded and in ensuring the child’s needs are met effectively and appropriately. EPT is also a developmentally responsive model in which the case conceptualization, treatment goals, and treatment methods are all significantly modified to best suit the child’s developmental level and needs. EPT is an integrative metatheory that allows play therapists to pull concepts and strategies from many other theories and to employ a wide variety of techniques, including empirically supported treatments. EPT emphasizes the power of the relationship between the child and the therapist in helping the child break problematic response sets and replace them with more functional and flexible ways of responding to everyday problems. Lastly, EPT lends itself to the practice of evidence-based play therapy and to the use of empirically supported treatments.

REFERENCES


Prescriptive play therapy is a therapeutic approach that incorporates a variety of theories and techniques in order to customize the play intervention to meet the specific and diverse needs of individual clients. The focus is to resolve the specific problem(s) that brought the client into therapy, not to enhance the client’s general psychological well-being or personal development. Thus, the task of the prescriptive therapist is to co-develop with the client a set of achievable goals, a coherent problem formulation (an explanation based on a thorough assessment of why the presenting problem exists or what is causing it), and a treatment plan tailored to the individual client’s specific problem and situation.

The prescriptive psychotherapy approach is not new (Dimond, Havens, & Jones, 1978; Goldstein & Stein, 1976). However, the popularity of this approach has mushroomed over the past 30 years (Beutler, 1979; Beutler & Harwood, 1995) and is likely to continue to expand in the years ahead.

BASIC TENETS

Every school of psychotherapy is founded on a set of core principles, tenets, or beliefs. These serve as fundamental cornerstones of the approach. The six basic tenets of prescriptive play therapy are described in the following sections.

Tenet 1: Individualized Treatment

The overarching aim of prescriptive play therapy is to tailor the play intervention to meet the individual needs of the client so as to answer Gordon Paul’s (1967, p. 111) famous question for clinicians: “What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances, and how does it come about?” As Maimonides (Garfinkle, 1912), the famous scholar and physician, taught eight centuries ago, “The physician should not treat the disease but the person who is suffering from it.” Because what works for one
person may not work for another, prescriptive therapists seek to tailor the intervention not only to the disorder but also to the personal characteristics and situation of the client (Norcross & Wampold, 2011).

**Tenet 2: Differential Therapeutics**

Play therapy has been developing over most of its 100-year history based on the “one true light” assumption. This is basically a nonprescriptive position that holds that in the absence of evidence to the contrary, one’s preferred treatment approach is equally and widely applicable to most or all types of client problems. From this perspective, treatment is instituted essentially independent of diagnostic information. The difficulty with this one-size-fits-all assumption is that no one theoretical school (e.g., Rogerian, Adlerian, or Jungian) has proven strong enough to produce optimal change across the many different and complex psychological disorders that have been identified (Smith, Glass, & Miller, 1980).

The prescriptive approach to play therapy (Kaduson, Cangelosi, & Schaefer, 1997) is based on the core premise of differential therapeutics (Francis, Clarkin, & Perry, 1984), which holds that some play interventions are more effective than others for certain disorders, and a client who does poorly with one type of play therapy may do well with another (Beutler, 1979; Beutler & Clarkin, 1990). It rejects the Dodo bird verdict that the major forms of psychotherapy are equally effective for specific disorders (Beutler, 1991; Luborsky, Singer, & Luborsky, 1975; Norcross, 1995). Rather than forcing clients in a procrustean manner to adapt to one therapeutic modality, prescriptive therapists vary the remedies they provide to meet the different treatment needs of individual clients.

Notwithstanding the “common” or “nonspecific” elements characteristic of all effective therapies, increasing evidence has shown specific interventions work better for specific disorders or syndromes (Chambless & Ollendick, 2001). Support for the strength of specific treatment effects is seen in the findings of psychotherapy outcome meta-analytic studies. These studies have found the mean effect sizes of specific factors consistently surpass those of common factors (Lambert & Bergin, 1994; Stevens, Hyman, & Allen, 2000).

**Tenet 3: Transtheoretical Approach**

In order to effectively tailor one’s intervention to the individual needs of a client, one must be transtheoretical, or eclectic. Eclectic psychotherapists, drawing upon a three-fold criteria of empirical evidence, clinical experience, and the desires of the client, select from different theories and techniques the best therapeutic change agents for a particular client (Norcross, 1986). They reject strict adherence to any one school or system and instead select what is most valid or useful from a wide therapeutic spectrum. This stance calls for a replacement of the traditional, insular state of theoretical camps by a new and flexible approach of psychotherapy pluralism.

Prescriptive therapists believe the more remedies you have in your repertoire, coupled with knowledge about how to differentially apply them, the more effective you’ll be across the multitude of presenting problems one encounters in clinical practice (Goldstein & Stein, 1976). Using more than one modality in therapy helps therapists avoid the trap Abraham Maslow described as, “If the only tool you have is a hammer, every problem starts to look like a nail (p.15).”

According to Norcross (1987), “synthetic eclecticism” involves combining various theories into one coordinated treatment intervention. This differs from “kitchen-sink eclecticism,” which, Norcross states, is an atheoretical treatment approach. In the latter, practitioners apply techniques from various schools of thought in a manner that ignores the theory that underlies them. Such an approach, Norcross warns, is haphazard and ineffective at best, and may in fact be harmful to some clients.
Surveys of clinicians have indicated many identify themselves as eclectic, making the eclectic, transtheoretical approach the most frequently espoused theoretical orientation across disciplines and across the world (Brabeck & Welfel, 1985; Norcross, 2005; Prochaska & Norcross, 1983). A poll of play therapists (Phillips & Landreth, 1995) found an eclectic orientation to be by far the most common approach reported by the respondents. Although eclectic, transtheoretical psychotherapy (Prochaska, 1995) is still not widely taught in graduate schools, it is likely to remain the treatment of choice by most practitioners in this country and abroad (Norcross, 2005).

As Goldfried (2001) observed:

Most of us as therapists eventually learn that we cannot function effectively without moving outside of the theoretical model in which we had originally been trained, recognizing that the strength of another orientation may at times synergistically complement the limitations of our own approach (p.12).

The widespread eclectic movement reflects a decisive departure from the aforementioned purist, one-size-fits-all orthodoxy, together with a much greater openness among psychotherapists to adapt to differing contexts of the client’s life, thus tailoring their strategies to the circumstances and needs of individual clients.

**Tenet 4: Integrative Psychotherapy**

Because prescriptive play therapists are not confined by single-school theories, they often combine different theories and techniques to strengthen an intervention and broaden the scope of their practice. The term *Integrative Psychotherapy* is used to describe any multimodal approach which combines two or more theories. Thus, individual, group, and family play strategies may be integrated to treat a particular case, or psychodynamic and humanistic play theories may be combined within treatment. An integrated, multicomponent intervention reflects the complex and multidimensional nature of most psychological disorders, which arises from the fact they are caused by an interaction of biological, psychological, and social factors. Because most disorders are multidetermined, they need an integrated, multifaceted remedy. The fact there is high comorbidity among many psychological disorders, such as conduct disorder and attention-deficit/hyperactivity disorder (ADHD), also points to the need for an integrative treatment approach. Children who present with ADHD often require a multifaceted intervention that combines psychotropic medication, parent management training, social skills play groups, and individual psychotherapy. Thus, over the past 30 years, the field of play therapy has seen a growing movement toward integration (Drewes, Bratton, & Schaefer, 2011).

Clearly, prescriptive therapists need to be both integrative and eclectic; however, many prefer to call themselves integrative rather than eclectic (Norcross & Prochaska, 1988). The type of integrative psychotherapy practiced by most prescriptive play therapists is “assimilative integrative” (Drewes et al., 2011). This means they began their careers with a firm grounding in one primary orientation, typically child-centered, and then gradually incorporated or assimilated a number of practices from other schools over the course of their careers (Messer, 1992). Theoretical integration cannot be hurried because it requires in-depth knowledge and training in several theoretical orientations.

**Tenet 5: Prescriptive Matching**

Because differential rates of improvement are being found among different treatment procedures, prescriptive play therapists seek to “match” the most effective play intervention to a specific
disorder (Norcross, 1991). On the face of it, practically every therapist endorses the premise that treatment should be tailored or matched to the needs of the individual case. It makes intuitive sense. However, prescriptive matching at the optimum level goes beyond this simple acknowledgment. It differs from the typical matching procedure in the following way.

The typical basis for matching client needs with interventions is a theory of psychotherapy rather than—at the highest level—direct matching of a change agent to the cause of the disorder. In formulating a treatment plan, the prescriptive play therapist selects a therapeutic change agent that is designed to reduce or eliminate the cause of the problem. Thus, by treating not only the symptoms but the underlying cause(s), the problem will be less likely to reoccur in the future.

For example, Theraplay®1 (Munns, 2009), an attachment-oriented play intervention, would be a logical match for a child presenting with an attachment disorder. Similarly, abreaction/reenactment play therapy (Prendiville, 2014) is a trauma-focused intervention intended for children who have experienced a recent trauma or stressor. Cognitive play therapy focuses on changing the dysfunctional thoughts triggering anxiety and depression in children.

One of the goals of a comprehensive assessment prior to treatment selection is to pinpoint the underlying cause of the disorder so the therapist can then select a change agent (a therapeutic power of play) most likely to remedy the determinantal or causal factor underlying the client’s presenting symptoms. While causal therapy—therapy designed to eliminate the cause of the problem—would be the highest form of prescriptive matching, it is not always possible to identify the pathological process underlying the problem or the precipitating cause may no longer be operative. In such cases, the prescriptive play therapist turns to other bases for matching treatment to the client, such as evidence-informed matching and client–therapist matching.

Evidence-informed matching (Bohart, 2005) tailors an intervention to a client by considering three main factors: empirically supported treatments for a specific disorder, client needs and preferences, and therapist variables, such as clinical judgment and practical experience. The combined use of these three criteria has been termed evidence-based practice. Initially, evidence-based practice was determined by applying the best research evidence for treating client disorders, but subsequent versions of evidence-based decision making have required clinicians to include their own professional expertise as well client needs and preferences before selecting the best treatment plan (Haynes, Devereaux, & Guyatt, 2002; Kazdin, 2008).

Client–therapist matching involves matching the personal qualities of clients to the personal qualities of therapists, such as similar personalities, values, backgrounds, genders, conceptual levels, and so on.

In the event a prescriptive play therapist is not comfortable implementing the intervention best suited for treating a client’s problem, the therapist will then recommend referral to professionals able to provide such treatment. Thus, treatment selection for a prescriptive play therapists is systematic, intuitive, and therapist centered.

**Tenet 6: Comprehensive Assessment.**

Albert Einstein said, “If I had an hour to solve a problem I’d spend 55 minutes thinking about the problem, and 5 minutes thinking about solutions.” Play therapy practitioners are often under pressure to assess clients quickly. Because more comprehensive assessments can be costly and time consuming, funding sources, agency protocols, and parents often seek a speedy assessment

---

1 Theraplay is a registered service mark of The Theraplay Institute, Evanston, IL.
and start of treatment. However, a comprehensive clinical assessment needs to be conducted for several reasons:

- It provides the therapist with an in-depth understanding of the child, the family, and the origins of the child’s presenting difficulties.
- It enables the therapist to customize the treatment to the individual needs and problems of the client.
- It is cost effective in the long run because it reduces the duration of treatment by enabling the therapist to focus on the likely cause of the problem and thus implement the best treatment.
- It helps parents understand the origins of the child’s presenting problem.

Methods

A comprehensive assessment involves: (a) multiple informants—parents, child, teachers; (b) multiple methods—clinical interview, standardized instruments such as behavior checklists (Achenbach & Edelbrock, 1983), rating scales (Conners, Sitarenios, Parker & Epstein, 1998), direct observations of the child as well as parent–child interactions (Schaefer, 2014); and (c) ongoing assessments throughout treatment to measure progress.

Content

In a recent survey of experienced play therapists (Schaefer & Gilbert, 2012), respondents reported the following information about the problem and client needs to be obtained in the initial assessment in order to develop an individualized treatment plan:

The Problem
- Nature of the problem
- History of previous therapy
- Parents’ treatment preferences/expectancies
- Child and family’s readiness and motivation to change
- Empirically based guidelines for treating the presenting problem

The Client
- Family history
- Client strengths
- Trauma history
- Medical history
- Developmental history

Based on the assessment information, an individualized case formulation is prepared prior to the initiation of therapy. A case formulation is a theoretically grounded, descriptive, and explanatory summary of the client’s most important issues/problems (as well as strengths) and of the probable causal and/or contributory factors. This case formulation leads to the development of an individualized treatment plan—a “prescription” that specifies treatment goals and strategies. Additional assessments need to be conducted throughout treatment in order to evaluate progress and revise the treatment plan as needed.
CORE PRACTICES

In light of the basic beliefs previously described, prescriptive play therapists attempt to implement the following core practices.

Empirically Supported Treatments

In the past, the field of psychotherapy has relied too heavily on practices with little supporting evidence or, at worst, ones with poor outcomes. Therapy has been provided based on “that’s what we’ve always done” rather than on an emerging evidence base for what works. Research on the effectiveness of play therapy interventions for children continues to grow at a rapid rate (Reddy, Files-Hall, & Schaefer, 2005, 2014), but there remains a large gap between evidence-supported treatments and what is practiced in the field. One of the primary criteria employed by prescriptive play therapists to match an intervention to a disorder is scientific evidence of what works best for the disorder with which the client is presenting. This is a bottom-up approach as interventions with empirically supported efficacy are applied and subjected to further scientific validation. If empirically supported treatments have not been reported for a particular disorder, prescriptive therapists look to their own clinical experiences and/or those of other therapists to determine what has worked best in actual practice. If both research and practice are uninformative, therapists turn to the most compelling theory linking change mechanisms to the disorder.

Therapeutic Change Mechanisms

In recent years, there has been a shift away from the development of elaborate, formal theories of psychotherapy to a focus on identifying the basic mechanisms of therapeutic change—that is, healing forces not tied to any specific theory or model (Beutler & Harwood, 2000). Change mechanisms are not theories, they are descriptions of observed relationships. They are more general than techniques, and they are more specific than theories.

Perhaps the most basic question faced by play therapists today relates to the mechanisms of change in play therapy; in other words, what therapeutic forces actually produce the desired change in a client’s behavior (Schaefer, 1993; Schaefer & Drewes, 2014)! Once the active ingredients in a play intervention have been identified, the inert factors can be eliminated and a more time-efficient and cost-effective interventions can be developed (Goldfried, 1980). Therefore, in addition to outcome research, the prescriptive play therapist looks to process or component analysis research (Hunsley & Rumstein-McKean, 1999) to identify the therapeutic change mechanisms underlying effective outcomes. Furthermore, they continually search for the mediator and moderator variables that can help them understand the relationships between a specific play treatment and outcome (Shadish and Sweeney, 1991).

The major therapeutic powers of play (Schaefer, 1993) are listed next. The most well-known powers of play are its communication power (e.g., young children express themselves better through play activities than with words), its teaching power (e.g., children learn and remember better when instruction is made fun and enjoyable), its self-esteem boosting power (e.g., children gain a sense of power, control, and competency through play), and its social relationship enhancing power (e.g., parent-child attachment through playful interactions).

A. Facilitates communication

1. Self-expression/self-understanding
2. Conscious thoughts and feelings
3. Access to the unconscious
4. Direct teaching
5. Indirect teaching
B. Fosters emotional wellness

1. Counterconditioning of negative affect
2. Abreaction
3. Catharsis
4. Positive emotions
5. Stress inoculation
6. Stress management

C. Enhances social relationships

1. Therapeutic relationship
2. Attachment
3. Social competence
4. Empathy

D. Increases personal strengths

1. Creative problem solving
2. Resiliency
3. Moral development
4. Accelerated psychological development
5. Self-regulation
6. Self-esteem

The prescriptive play therapist continually seeks to acquire a deeper understanding of all the therapeutic powers of play and tries to determine the disorders to which each of these change mechanisms is best applied. Based upon their understanding of the therapeutic powers of play, they seek a prescriptive matching of these therapeutic remedies to the causes or determinants of a disorder. For example, attachment-oriented play therapy would likely be the treatment of choice for a child exhibiting signs of an insecure attachment (Benedict & Mongoven, 1997). Similarly, based on a functional analysis, Kearney and Silverman (1999) identified four main causes of school refusal in childhood: avoidance of stimulating and aversive situations, attention-seeking, and/or positive reinforcement. They found children who received prescriptive treatment (matching specific remedy to the specific cause of the disorder) showed substantial improvement. However, those who were given nonprescriptive treatment in which there was no attempt to uncover the underlying cause(s) exhibited a worsening of their symptoms. By incorporating most or all of these curative powers of play into their repertoire, prescriptive play therapists are able to offer specific treatment for a wide range of psychological disorders.

Pragmatic Approach

An overarching principle guiding prescriptive play therapists is: If it works, use it. This pragmatic approach is consistent with the philosophical writings of such prominent American thinkers as William James, John Dewey, and Charles Pierce. The central idea is that the truth of a theory or the value of a technique is demonstrated by its practical consequences—that is, its usefulness (Fishman, 1998). The best therapeutic intervention is one that gets the job done in the most cost-effective manner.

Pragmatic therapists do not let their adherence to a given theory or their prior assumptions blind them to what works and what doesn’t work for a disorder in the real world. They are opposed to the idea any one particular theory is the one right way to think about all clinical issues, or that
any technique provides the one true way of treating all clients in distress (Silverman, 1997). Thus, they are continually open to new approaches that successfully solve problems.

**Best Practice Guidelines**

The basic premise behind best practice guidelines is that enough research evidence has accumulated to provide guidance as to the interventions that have the best outcomes with specific disorders. Treatment guidelines help practitioners update their training to include the latest findings, which should not only improve treatment efficacy, but also give clients confidence that practitioners are relying on cutting-edge science. This, in turn, will encourage clients to seek and continue treatment. The treatment guidelines in Table 10.1, prepared by the authors, list play therapy interventions with strong empirical support for a number of childhood disorders. Evidence-based clinical practice guidelines such as these are typically promulgated by a task force.

**Table 10.1 Practice Guidelines**

<table>
<thead>
<tr>
<th>Childhood Disorder/Condition</th>
<th>Play Intervention With Research Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fears and phobias</td>
<td>Systematic desensitization (Knell, 2000; Mendez &amp; Garcia, 1996), emotive imagery (King, Mallory, &amp; Ollendick, 1998; Malhotra, Rajender, &amp; Bhatia, 2012; Shepard, 2009)</td>
</tr>
<tr>
<td>Aggression</td>
<td>Play group therapy (Bay-Hinitz, Peterson &amp; Quilitch, 1994; Dubow, Huesmann &amp; Eron, 1987; Orlick, 1981)</td>
</tr>
<tr>
<td>Adjustment reaction</td>
<td>Release Therapy (Brown, Curry, &amp; Tillnich 1971; Burstein &amp; Meichenbaum, 1979; Rae, Werchel, &amp; Sanner, 1989)</td>
</tr>
<tr>
<td>ADHD</td>
<td>Cognitive-behavioral play group therapy (Kaduson &amp; Finnerty, 1995; Hansen, Meissler, &amp; Ovens, 2000), child-centered play therapy (Ray, Schollelkorb, &amp; Tsai, 2007), parent–child interaction therapy (Johnson, Hall, &amp; Prieto, 2000)</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>Abuse-specific play therapy (Corder, 2000; Fenkelhor &amp; Berliner, 1995), cognitive-behavioral play therapy (Springer &amp; Misurell, 2012), trauma-focused Integrative Play Therapy (Gil, 2012)</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>Incredible Years Program (Webster-Stratton &amp; Reid, 2003, 2009)</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Cognitive-behavioral play therapy (Barrett, 1998; Barrett et al., 2001)</td>
</tr>
<tr>
<td>OCD</td>
<td>Cognitive-behavioral play therapy (March &amp; Mulle, 1995)</td>
</tr>
<tr>
<td>Obesity</td>
<td>Play group therapy (White &amp; Gauvin, 1999)</td>
</tr>
<tr>
<td>Peer relationship problems</td>
<td>Play group therapy (Nash &amp; Schaefer, 2011; Schaefer, Jacobson, &amp; Gahramanlou, 2000)</td>
</tr>
<tr>
<td>Reactive attachment disorder</td>
<td>Theraplay (Booth &amp; Koller, 1998; Munns, 2009)</td>
</tr>
<tr>
<td>Anger</td>
<td>Cognitive-behavioral therapy (Lochman, Fitzgerald, &amp; Whidby, 1999)</td>
</tr>
<tr>
<td>Autism</td>
<td>Behavioral play therapy (Rogers, 1991; Integrated play group (Neufield &amp; Wolfberg, 2010; Wolfberg &amp; Schuler, 1993))</td>
</tr>
<tr>
<td>Chronic illness</td>
<td>Filial/family play therapy (Van Fleet, 2000)</td>
</tr>
<tr>
<td>Children of divorce</td>
<td>Play group therapy (Pedro-Carroll, 2005; Pedro-Carroll &amp; Cowen, 1985), filial therapy (Bratton, 1998)</td>
</tr>
<tr>
<td>Bereaved</td>
<td>Play group therapy (Netel-Gilman, Siegner, &amp; Gilman, 2000; Zambelli &amp; DeRosa, 1992)</td>
</tr>
<tr>
<td>Foster/adoptive</td>
<td>Filial/family play therapy (Van Fleet, 1994, 2006)</td>
</tr>
</tbody>
</table>
convened by a professional organization (Parry, 2003). The task force compiles the best practice list based upon a review of the current outcome research. This is an important way to link clinical practice with scientific research (Hayes & Gregg, 2001).

The American Psychological Association’s Division of Clinical Psychology created a special task force whose express purpose was to promote the dissemination of empirically validated psychological treatments (Chambless, 1995). The task force initially identified and published 22 well-established treatments for 21 different syndromes. Hopefully, the Association for Play Therapy will soon establish such an interdisciplinary task force to develop and publish a consensus list of evidence-based play interventions.

Role of the Therapist

The therapist who wishes to practice prescriptive play therapy must become familiar with more than one theory and technique of play therapy. It would be wise for the therapist be competent in at least one directive and one nondirective form of play therapy, because both will be needed to treat a wide variety of presenting problems. Moreover, because prescriptive play therapy is, at its core, a person-centered approach, the therapist always seeks to understand and treat the person behind the disorder.

The therapist’s role in the prescriptive approach will vary depending on the specific play approach selected for each client. For example, the therapist will be directive and structured when implementing a behavioral or Theraplay strategy but nondirective when following a child-centered orientation. The degree to which support, insight, or instruction is offered depends on the approach chosen. At times, the therapist trains a child’s parents to be partners in treatment, but such parent training may be contraindicated in other cases. Thus, the prescriptive play therapy approach is best suited to therapists who are open, flexible, and pragmatic, as well as skillful in adapting a particular treatment protocol to their own personal style. Gil and Shaw (2009) presented a detailed case illustration of the application of prescriptive play therapy with a child client.

Challenges

It has been suggested that a weakness of prescriptive psychotherapy is its lack of investment in theory generation. Indeed, the main interest of prescriptive therapists is not in the development of single theories, but rather in the identification of change mechanisms underlying successful psychotherapy of all types and in the development of a prescriptive matching of change mechanisms to underlying determinants of a disorder. In essence, it is a metatheory that transcends single theories of therapeutic change while utilizing the healing forces within multiple theories.

The first challenge for prescriptive therapists is the need to be competent in more than one therapeutic orientation. A second challenge for them is the expanded training needs implicit in this approach. As part of their graduate training, prescriptive therapists typically receive in-depth instruction and supervision in one or two major schools of psychotherapy. Then they gradually expand their areas of competence through supervision and by participating in continuing education workshops and institutes. Believing that learning is a lifelong process, they gradually acquire in-depth knowledge and skills in several schools of play therapy, such as humanistic, psychodynamic, and cognitive-behavioral, as well as in the three main modalities: individual, group, and family play therapy.

A third challenge of the prescriptive approach is that flexibility can deteriorate into mindless fluidity of approaches. According to Hans Eysenck (1981), “eclecticism can become little more than a mish-mash of theory, a hugger-mugger of procedures, and a hodge-podge of therapies”
CONCLUSION

This chapter contains an overview of the basic premises and core practices of the prescriptive approach to play therapy. Prescriptive play therapists draw from a number of therapeutic approaches so as to have a wealth of change agents at their disposal. They then tailor their therapeutic interventions to the needs of the individual client by utilizing four sources of information: empirical evidence, clinical experience/expertise, client preferences/context, and likely cause(s) of the presenting problem.

Most play therapists today are becoming more and more prescriptive in their practice. This means there are few, if any, purists who strictly and dogmatically adhere to a single theoretical orientation (Kazdin, Siegel, & Bass, 1990). If the impressive growth and development the field of play therapy experienced in the 20th century is to continue throughout the 21st century, it will likely be due to the prescriptive (transtheoretical, eclectic, integrative, evidenced-informed) approach becoming more fully and widely implemented by practitioners across the world.

REFERENCES


Luborsky, L., Singer, B., & Luborsky, E. (1975). Comparative studies of psychotherapies: Is it true that “everyone has won and all must have prizes?” *Archives of Abnormal Psychiatry, 32*, 995–1008.


Prescriptive Play Therapy


PART 3

Core Techniques
CHAPTER 11

Sandtray/Sandplay Therapy

LINDA E. HOMEYER

“Children think with their hands.”

—Margaret Lowenfeld

A tray with sand, small toys, miniature objects, and perhaps some water—who knew such simple items would be so powerful in the hands of those who need to be understood, and those who seek to understand? These simple items are the basis for sandtray therapy.

THEORY

The use of sandtray components in a therapeutic setting is practiced widely with a variety of clients, in various settings, and for a wide spectrum of clinical issues. This technique originated with Margaret Lowenfeld in the 1920s. Lowenfeld (1979, 1993) wanted to find a way for children to express their emotional and psychological inner worlds in a developmentally appropriate manner. She wanted to “help children to produce something which will stand by itself and be independent of any theory as to its nature” (Lowenfeld, 1979, p. 3). Rather than impose an external theory or construct onto the child, she sought to learn from the child and understand what the child was experiencing. In this sense, Lowenfeld was atheoretical; her sandtray approach, called the World Technique, was developed from children building their worlds, which informed her clinical experience. She stated that clinicians from other theories—Freudian, Adlerian, or Jungian—would find in any World Technique components and constructs that support their theoretical views. This occurs, according to Lowenfeld, not as “merely a result of wish fulfillment” but “because they are almost certainly to be present there” (Lowenfeld, 1979, p. 7). Indeed, this is what makes sandtray therapy work so valuable: It can be successfully utilized by mental health professionals from all disciplines and all theoretical and clinical approaches. We find in the clients’ worlds meaning that fits how we conceptualize clients’ and their issues, just as we do in verbal therapy. The World Technique continues to be used, primarily in the United Kingdom and it is now seen as one facet of Lowenfeld’s work, which is known as Projective Play Therapy (T. Woodcock, personal communication, February 27, 2013). Dora Kalff (1971),
who espoused Carl Jung’s analytical psychology, developed sandplay after an initial time of studying with Lowenfeld in the 1950s (Ryce-Menuhin, 1992). Sandplay is widely adopted and has been the primary form of sandplay therapy used worldwide. For four decades following the 1950s, sandplay was the predominate form of sandplay therapy published in the professional literature. Current sandplay authors include John Allan (1988), Lois Carey (1999), Joel Ryce-Menuhin (1992), Barbara Turner (2005), and Estelle Weinrib (1983).

To set Lowenfeld’s and Kalff’s work in the context of the play therapy movement, Anna Freud (1928) and Melanie Klein (1932) were busy developing psychoanalytic play therapy during this same time. It would be a couple of decades until Virginia Axline (1947) developed what is now known as child-centered play therapy.

As mental health professionals began using sandplay therapy from a non-Jungian perspective, a wider scope of professional literature began to be published. Examples of this include Violet Oaklander, who wrote about her Gestalt work using sandtrays in child therapy (1978); Terry Kottman’s Adlerian perspective (www.encouragementzone.com; 2011); Steve Armstrong’s humanistic work (2008); and Barbara Labovitz-Boik and E. Anna Goodwin’s general approach (2000), among many others. Linda Homeyer and Daniel Sweeney first wrote about a transtheoretical approach to sandplay therapy in 1998, with a second edition in 2011. They define sandplay therapy as “an expressive and projective mode of psychotherapy involving the unfolding and processing of intrapersonal and interpersonal issues through the specific use of specific sandplay materials as a nonverbal medium of communication, led by the client(s) and facilitated by a trained therapist” (Homeyer & Sweeney, 2011, p. 4). They suggest mental health professionals incorporate the use of sandplay therapy into their ongoing approaches and work with clients, integrating it into their therapeutic process with clients.

For the purpose of this chapter, unless otherwise noted, the term sandplay therapy will be used generically for the entire spectrum of sandplay/sandplay therapy use, regardless of theory, unless the specific use of an approach or a theory name is required for clarity and specificity.

PROCEDURE

Sandplay therapy provides the mental health professional with an expressive, experiential technique to use in an intentional, purposeful manner to move therapy forward. The counseling theory or approach used by the mental health professional will directly affect when, why, and how a sandplay experience would be used. For the cognitive-behavioral therapist, it might be to help a child practice, through use of the miniatures in the sandplay, how to deal with the bully at school. For the Adlerian therapist, it might be to help the client obtain insight into his or her private logic or show his or her early recollections. Sweeney, Minnix, and Homeyer (2003) used sandplay therapy for lifestyle analysis. For family therapy, it might be used for the caregiver subsystem to understand the perspective of the child subsystem. Taylor (2009) describes using sandplay therapy with solution-focused therapy. For the transtheoretical or integrative therapist, it might mean selecting any of the above, or another of the vast applications of sandplay therapy, based on assessment of the client’s uniquely presenting issues.

Therapist Qualifications, Training, and Characteristics

Sandplay therapy is used by a variety of mental health professionals. In the United States of America, this requires a minimum of a graduate-level mental health degree, clinical supervision, and appropriate licensure or certification, along with continuing education requirements to maintain
licensure/certification. Other countries may have similar or different requirements for the legal practice of mental health.

All the ethical codes of the various mental health disciplines agree that one should not practice outside the scope of one’s training. Therefore, education, training and supervision to establish competency is essential. The Association for Play Therapy (APT) in the United States of America (U.S.A.) has specific requirements to be a Registered Play Therapist (RPT). APT sees sandtray therapy as a part of the broader field of play therapy. Mental Health Professionals choosing to add the use of sandtray therapy to their work, could use that specific training and supervision, clearly identified within the play therapy movement, as part of the criteria to be a RPT. The criteria to be a RPT can be found at www.a4pt.org. Similar organizations in other countries may have their own credentialing standards.

One hundred seventy-seven graduate programs at universities in the U.S.A. have specific play therapy and sandtray therapy courses (APT, 2014). Graduate course work presumes a robust didactic and clinical experience that meets university-level standards through a university-approved curriculum process. Twenty-two APT (2014) approved centers of play therapy education established at universities further expand the quality of play therapy and sandtray therapy education, training and supervision.

Several sandtray therapists offer certification programs for their particular methods of sandtray therapy. These programs can provide a sequential, thorough, and in-depth experience. Typically, there is a supervision requirement as well. These training programs might be very helpful for a practicing mental health professional who desires in-depth preparation to a specific sandtray approach.

The professional association for sandplay, the International Society for Sandplay Therapists (ISST), has several national branches and state chapters in the U.S.A. ISST has both practitioner and certification levels (http://www.isst-society.org). Each level has specific requirements for training, personal experience, and supervision.

The Association for Sandplay Therapy (AST) is a new international professional organization (www.SandplayAssociation.com). It is following the tenets and teachings of Dora Kalff. They have two levels of registration: Registered Sandplay Therapist (STR) and Registered Sandplay Therapist – Supervisor (STR-S) both with criteria for training, personal experience, and supervision.

Even if credentialing is not a goal, requirement, or desire, these and other national and international professional associations are sources of viable best practice standards.

**Client Characteristics**

One primary value of sandtray therapy is its applicability to a wide variety of clients. The client might be a child, preadolescent, adolescent, adult, caregiver–child dyad, pair of partners, or family. Sandtray therapy groups have been used across the lifespan from children to the elderly. Settings for use include private practices, schools, community agencies, hospitals, nursing homes, businesses, residential treatment centers, and juvenile detention centers, among others.

Abstract thinking skills are necessary to benefit from the typical procedure of sandtray therapy: to have the client build a scene in the sandtray using various miniatures and then have the client reflect on the meaning of the scene through a verbal discussion with the therapist. This generally requires the client to have a cognitive developmental level of at least 12 years old. Younger or regressed children are unable to reflect on the meaning in this manner and will use the tray and the toys as traditional play therapy in miniature. For these younger or regressed clients, the client plays in the sand with the toys in an ongoing, dramatic manner, just as he would play in a
more traditional play therapy room. It is not developmentally realistic or appropriate to expect young, developmentally delayed, or regressed children to create a scene in the sandtray and then sit still to verbally discuss it. That said, young clients can communicate a great deal through their interactions with the sandtray and materials. For example, a young girl in kindergarten was referred to the school counselor for her newly inattentive behavior in the classroom. The child completed a sandtray of chaotically placed buildings, vehicles, people, and animals, all jumbled together. Several items were positioned on others, some on the edge of the tray. The second tray created a few days later looked much the same. The level of chaos concerned the school counselor, who knew this reflected the child’s internal world. Only after the school counselor’s consultation with the child’s mother did the full meaning of the tray reveal itself: The parents had not yet disclosed an impending relocation to another city to their daughter. The girl had picked up the information her life and home were about to change, and she could not manage the thoughts of what that might mean. She faced a new life experience with no reference points or information. She was distracted in the classroom, trying to think about what the move could mean, and she was unable to manage the resulting emotions. The school counselor recommended the parents inform their daughter of the upcoming move, and she helped with suggestions of ways to reduce the child’s anxiety. The third and final tray completed several days later was remarkably simple and organized: a house with a streetlight nearby, a baby bed, and a grouping of family figures. She was again focusing in age-appropriate ways in the classroom. Although this child did not talk about her created worlds, she clearly communicated to the adults in her world, who took the necessary steps to attend to her needs.

Indications and Contraindications

Some clients will love working in the sand, but others will not. Even Lowenfeld wrote about some children loving it and others not so much (1979). Those therapists who regularly use sandtray therapy know this is true. Some clients will plan from one session to the next what they will build, arriving at subsequent sessions with plans for the next tray. Others may look longingly at the shelves of miniatures, yet cannot bring themselves to complete a tray, being quite self-restrictive and self-censoring. Others use the movement of their hands through the sand as an anxiety-mediating, tactile-soothing, self-care activity while building and talking about their creations in the sand.

In cultures in which sand is seen as inherently “dirty,” many clients may not find its use acceptable or pleasurable. In these cases, if experiential activities are desired, the selection of other modalities is recommended.

Very few diagnoses or symptomology preclude the use of sandtray therapy with clients. Psychosis is one exception. Should the treatment focus be to assist the client in maintaining contact with reality, any experiential technique that inherently uses fantasy or symbolic representations is countertherapeutic. Turner (2005) writes that specially trained and very experienced sandplay therapists may be able to use sandplay in the reintegration phases that follow psychotic episodes (2005, p. 282). However, Turner recommends the sandplay therapist be extremely cautious of the use of sandplay with clients with fragile psyches or who are experiencing psychosis.

Some highly anxious clients may find the tactile interaction with the sand and miniatures overwhelming, whereas other anxious clients might find it a soothing and an emotionally organizing and expressive medium. This is where the training, supervision, and clinical experience of the sandtray therapist become essential. As with any experiential activity in the therapeutic process, it is the therapist’s assessment of the appropriateness of the medium, the readiness of the client, and the therapeutic intent that becomes critical for ethical and successful treatment.
LOGISTICS

A certain amount of material is needed to offer the sandtray experience to clients. At a minimum, a tray of sand and a set of miniatures are necessary. These take up space regardless of the wide variety of possible office arrangements. Many play therapists have their sandtray and miniature collections in their traditional play therapy playroom. This arrangement is perhaps both philosophical as well as practical. Some therapists, such as school counselors, may only have room for a sandtray and small collection of miniatures, having insufficient space in a school for a full playroom. If working in a primary or elementary school, they are continually doing play therapy in miniature. Other therapists may provide sandtray therapy in foster homes or other in-home service settings. They may travel with the miniatures boxed by categories, all loaded in a wheeled suitcase, and they may store a lidded plastic box with sand in the home of each of their clients. Alternatively, some therapists have a specific room only for sandtray therapy, with shelves filled with a huge collection of miniatures lining the walls and several options for sandtrays. The power of sandtray therapy is seen in clients’ abilities to work effectively in any of these settings.

Sandtray Therapy Room Setup, Toys, and Materials

The sandtray therapy room has three primary elements: a tray with sand, a miniature collection, and water. The size and shape of tray varies by theoretical approach. Sandplay therapists use a standard rectangular size of 28.5 × 19.5 × 3 inches (Kalff, 2003; Turner, 2005). As Kalff stated, this “size confines the player’s imagination and thus acts as a regulating, protecting factor” (2003, p. 8). Turner writes that the rectangular shape for use in sandplay provides “a place in which the central archetype of the Self can manifest,” indicating that if the tray is square or round (archetypal configurations), “the pull for grounded conscious awareness would be absent” (2005, p. 289). Other approaches might use the typical rectangular tray of the same or similar dimensions, or octagonal or round trays of various sizes (Homeyer & Sweeney, 2011). Some therapists have smaller round trays that clients can perch on the corners of the larger rectangular trays. School counselors might use take-out food containers as small, individual trays for students during classroom guidance experiences; this allows all the children in the classroom to have their own small trays for simultaneous work. Similar options are used in sandtray therapy training experiences. Regardless of shape and size, most agree that the inside of the tray should be painted blue, to represent water on the bottom and a skyline on the sides (Homeyer & Sweeney, 2011; Turner, 2005).

A spray bottle with water allows the therapist to control the amount of water used during the session, while giving clients the freedom to use as little or as much as meets their needs. If one uses a sandtray several times a day, then each client would be offered a spray bottle with smaller amounts. This controls the total possible saturation of the sand by the end of the day, and most damp trays will dry out overnight. Kalff and others recommend having two trays available, one dry and one wet, allowing clients wider flexibility (Turner, 2005).

Selecting miniatures is a focal and enjoyable task for most sandtray therapists. Once the selection process begins, it is often difficult to hold back. The key is to have some depth of variety within each category of miniatures. One suggested list of categories by Homeyer and Sweeney (2011) includes the recommendation to have several items from each category to develop a balanced collection with depth as well as breadth:

- Mystical/spiritual: religious figures, crystal balls, gold, chalice, pyramid
- Fantasy: wizards, wishing wells, dragons, unicorns, cartoon characters, children’s movie characters, treasure chests
People: family groups, occupations, different stages of life, historical figures, soldiers, various racial and ethnic peoples

Animals: prehistoric, wild/zoo, farm/domestic, birds, sea life, insects

Transportation: cars, trucks, helicopters, planes, motorcycles, covered wagons

Buildings: houses, schools, castles, forts, lighthouses, churches/temples/mosques

Vegetation: trees (with and without leaves), bushes, cacti, flowers

Fences/gates/signs: barricades, railroad tracks, traffic lights, traffic cones

Natural items: seashells, rocks, fossils, twigs, brambles

Landscaping and accessories: sun, moon, stars, caves, tunnels, monuments, bridges, mailbox

Miscellaneous items: household items, tools, weapons, medical items, alcohol bottles

Sand tools to smooth and move the sand: spatula, brush (pp. 21–24).

Sandplay therapists recommend similar categories, but include archetypal figures, elements (fire, ice, waterwheels, windmill, etc.), and shadow and death figures (Turner, 2005). While most sandtray therapists continue to add to their collections over time, an initial set of 300 or so is sufficient for clients to do their work (Homeyer & Sweeney, 2011). Many therapists find it irresistible to continually acquire miniatures while walking the beach, perusing airport gift shops, checking out thrift stores, or browsing conference vendors. Options are everywhere. While this is enjoyable for the therapist, remember to keep the collection balanced and not overwhelming for the clients.

Depending on the therapeutic space available, the miniatures can be displayed on shelves or stored in boxes. Most clients find shelves the easiest to maneuver when locating the miniatures they want to use in the tray. Miniatures should be arranged by category on specific shelves. This provides the clients with ease of finding the ones they want, and the therapist can return them to consistent places after the session. Those who need to have their sandtray materials in a multiuse room might use a cabinet with doors to close them from sight and secure them. The cabinet might have tubs in which items are organized by category. For those with even less space, or those who may travel from place to place, plastic boxes can hold miniatures, again organized by a category or two per box. Boxes can be carried in wheeled suitcases, making transportation easy. Others who move from room to room within a facility can use boxes on a wheeled cart. The cart may also have a sand tray built into the top. Many configurations are possible. It is recommended that however the miniatures are displayed, a consistent placement or organization is used. This provides the clients with ease of selection.

The sandtray itself may sit on a tabletop or be part of a wheeled cart for ease of movement. There should be two chairs, so the client and the therapist can sit together while talking about the creation of the tray. The sandtray should be positioned near the collection of miniatures, with clear space for the client to move both around the tray and to and from the collection to the tray. The therapist is seated near, but not too close, to the tray. This allows the therapist to be part of the psychological building of the tray without being intrusive or physically in the way of the client’s movement (Homeyer & Sweeney, 2011).

A clean paintbrush can be used to dust sand off the miniatures before returning them to the shelf or other storage area. This is especially helpful if damp sand clings to the item. Some therapists put items in a sifter or sieve and give them all a good shake to remove sand. Mixing sections of wet and dry sand together after a session may result in sand that is only damp, which is acceptable for use by the next client. Mounding the sand in a volcano-like shape overnight gives more opportunity for the sand to dry well if it gets overly wet during the course of several sessions during the day. Careful monitoring of the water bottle is important. The availability of a second
sandtray is also useful, especially if working with young children. A deeper, plastic box assists in containing sand from spilling out during the more active play of young children. It also provides a sandtray that can hold a great deal of water for any age client.

**Treatment Frequency and Duration**

The frequency of use of the sandtray experience with clients depends on the needs of the client and the therapeutic intent and approach of the therapist. Therapists may choose to use the sandtray consistently in every session, from intake through termination. Others will use it selectively, for a specific purpose, within the overall therapeutic plan. There is no indication for limitation of its use, as long as the therapeutic intent is being met and the client remains engaged in the process.

Homeyer and Sweeney (2011, p. 34–43) suggest a six-step protocol for a session:

1. **Room preparation:** Have the sand tray near the collection of miniatures, with ample space for the client to walk around it freely. The therapist should sit off to one side, but close enough to observe (and interact, if that is consistent with the therapist’s approach). The miniatures should be appropriately located on the shelf. Do a final check before clients arrive to be sure the sand is clear of any buried items and relatively smooth, providing a neutral space for clients to begin their work.

2. **Introduction to the client:** Provide an appropriate prompt, either directive (“Show me what it is like to be bullied”) or nondirective (“Build a scene in the sand”). The prompt will be directly related to the therapist’s purpose in using the sandtray. The prompt should be clear and communicated in an age-appropriate manner. Children, and some adult clients, function from a very concrete perspective. These clients may benefit from a more directive approach: “Select three items that are like the bullies in your life” or “Select three items that represent your fear.” When that is done, say, “Add more items to tell the story.”

3. **Client creates the scene in the sandtray:** During the time the client works in the sand, the interaction depends on how the therapist works. Some approaches are very interactive during the building of the scene; others will prefer the client to complete the scene, then jointly discuss and process the tray. If the latter is the case, it is helpful to say to the client at the beginning of the session, “Please build your scene, let me know when you are done, then we will talk about it together.” That is usually just enough direction to add the needed structure. The age of the client may also impact how the session is structured. For young children, it is developmentally appropriate for the therapist to verbally track while the child is playing, as one would do in more traditional play therapy.

4. **Postcreation:** For those sessions in which the therapist prefers to wait until the client completes the sand scene, the therapist first takes a moment to look at the tray from the client’s perspective. If possible, the client and therapist sit at the same side of the tray from which the client built the tray, taking a moment to be with the tray and peruse its meaning. Badenoch (2008) and Kestly (2014) both recommend taking time to help the client bridge from working in the creative, symbolic, emotional, right-brain hemisphere to shift to working in the logical, sequential, verbal, left-brain hemisphere. Then, let the client unfold the story and the meaning of the tray with artful and inquisitive questions from the therapist.

The tray may change during this discussion step. A clients may decide to add, move, or change out symbols as she talks about the scene. The therapist might ask the client to select another symbol to add to the tray, for example, if the client is talking about an important concept evoked by the tray but that is not already represented there.
At other times, the therapist might see an opportune moment to take the discussion of the content of the tray and the client to another, deeper level and request a change or a new scene. This can provide a dynamic, powerful way to work with the client.

5. Sandtray cleanup: Again, therapists vary in whether the client should assist in cleaning up the tray. Adlerians, for example, will typically have the client join them in removing the miniatures and returning them to the shelves. It’s part of the egalitarian relationship and development of social interest. Others, like Jungians/sandplay, prefer to leave the sandtray scene intact, both to honor the work and to have the client leave with the scene still intact psychologically. This provides the client with a visual image in his mind, and this often results in the client discussing it further in the next session, having continued to think about it between sessions.

6. Documenting the session: Like all therapy sessions, clinical notes to document the content of the session are an ethical and legal requirement. Most sandtray therapists prefer to photograph an overhead view of the completed scene. Others like to add a view from the client's perspective, perhaps even taken by the client. Many children like to have their picture taken with the scene. Cell phones provide an easy way to document this visual form of therapy. The therapist is cautioned to keep cell phone photos secure and confidential. The remainder of the session notes would match other formats used by the therapist: issues presented, key or repeating symbols or metaphors, meaning of the tray to the client, and so on.

**TREATMENT STAGES AND STRATEGIES**

The flexibility of sandtray therapy provides mental health professionals with numerous varieties of possible applications. As previously stated, therapeutic intent and purposefulness are the deciding factors for the selection of when and how to use sandtray therapy with a client. This impacts the initial treatment planning. The use of the sandtray may meet some of the original treatment goals and can be included in the initial treatment plan. An example is using sandtray therapy as a relationship-building technique. This would be helpful for nonvoluntary clients, such as teenagers or court-ordered clients. The use of the sandtray is also helpful in relationship building for those clients who have been excessively lectured about their problems, shamed by the presenting issues, or simply have difficulty with verbal expression. For example, a special education high school counselor used sandtray therapy at her three assigned high schools. All of her student-clients were on parole or probation. She found using sandtray to be very effective because these adolescents were very hesitant to connect or talk with any authority figure, even a school counselor. She discovered it was critical that no one else knew they were playing with toys. She also found she needed more than the typical number of police cars and police officers. A securely confidential working space was absolutely necessary to ensure no unexpected intrusions, which are unfortunately too common in school settings.

Treatment plans may change as client dynamics and clinical needs unfold during the treatment process. Sandtray therapy can provide a strategic change in the intervention modality. This has been a useful change of pace after many talk therapy sessions with adults. It can be a method by which a client can go deeper, or explain further, what has not been accessible in verbal interaction only. An experience with a sandtray might also be helpful for those who have participated in a great deal of counseling and would benefit from being engaged in a new and different way. It is especially useful for those who have learned therapy lingo and appear to be working, when in reality they are deflecting or resistant. Some adult clients more effectively access deep emotional pain and distress through the use of experiential techniques and activities such as sandtray.
Involuntary clients, especially adolescents, who often appear to lose touch with their emotional language, find a new way to communicate. Sandtray therapy is very effective at strategic moments such as these and others during the course of treatment.

**Parent–Child Dyad Sandtray Therapy**

When a child is being seen in traditional play therapy, it is often informative and facilitative to have the caregiver and child work together in a standard-size sandtray. It can be used to assess new parenting skills that might have been taught during previous caregiver consultations or to assess improvement in interaction and communication. For example, a socially developmentally delayed 10-year-old, Janie, who was being raised by her grandmother, was being seen in the play therapy room. Janie was working on anger issues, based in her grief over the death of her step-grandfather (her father figure) and additional highly stressful family disruptions. Her grandmother, Grace, was having difficulties of her own with the death of her spouse; the loss of her job, which occurred within days of the death; and the same family issues. Grace was having problems maintaining boundaries and setting limits with appropriate consequences. Working with Janie within the natural boundaries of a tray appeared to be an opportunity for Grace to view those issues in a very here-and-now experience in the presence of the therapist, who watched the issues unfold visually and therefore could more fully comprehend what was occurring.

The therapist made a separating line in the sand with her hand to designate an equally sized space for each. The goal was to offer each of them a designated space should they want separation, but one that was easily "erased" away if they decided to build one large shared scene. The prompt was simply to "build a scene in the sand of what your world looks like." The prompt was broad enough for individual creativity, but focused specifically on them. They both worked from the same side of the tray and each began to select miniatures off the shelves. Grace selected a house, placed it in the corner nearest her, facing into the tray. She added some vegetation, then a single piece of picket fence in front of the house. Janie began to fill the space nearest to her with animals: lions, tigers, giraffes, gorillas, zebras, and others. As she placed her items, she noticed her grandmother adding the piece of fence by her house. Janie immediately added fencing all along the side of her space, to separate her side from her grandmother's. In placing the fencing, she enlarged her side from the initial half of the tray to about two-thirds of the tray. Grace noticed, but said nothing. It appeared clear that Janie took up more than her share of space in their shared world, and she felt free to move the boundary.

As the session continued, Grace added a giraffe to her side, across from the small piece of fence that was in front of her house. It appeared she was joining with Janie's love of animals, and sharing similar interests. (A few weeks earlier, they had spent Christmas day at the zoo, rather than at home, which seemed so empty due to the death of the husband/grandfather.) Janie soon traded out Grace's giraffe with one Janie had earlier placed on her own side. It seemed Janie knew she could simply take whatever resources from her grandmother that she wanted. But Janie did leave her grandmother with another, if not as desirable, resource. Janie controlled the exchange without request, permission, or even a statement. Without comment, Grace finished up her world with a few more landscaping items. Janie appeared to be done building as well, but in a final rearranging of items, she moved the fence that separated her area from her grandmother's closer to the grandmother's house. Janie appeared to not only want more space, but she was also intrusive into her grandmother's space, without any request or negotiation. Grace made a comment to Janie about her now-smaller space, but she set no limit to keep it from occurring nor did she request that Janie move it back, and Janie did not change her behavior of resetting the fenced boundary.

Later, talking with the grandmother alone, the therapist noted Janie's behavior of continuing to take up more space. Grace kept staring at the scene in the sandtray and finally whispered, "She
takes up all my space … and time … and energy. It’s like I have no space left to breathe.” After this session, Grace seemed reenergized and had more internalized power to work on the new caregiver techniques to set limits on Janie’s behavior before it escalated. With similar limit-setting by the therapist with Janie in the play therapy room, overall progress began to speed up and interactions at home seemed to stabilize in a more healthy way. They also began to attend a local bereavement center that had separate groups for children and adults. This helped them acknowledge their grief more openly with each other, while providing the group process and support.

Group and Family Sandtray Therapy Sessions

There are several configurations for doing group or family sessions. The first is to have each family or group member work in his or her own individual trays. The other, and perhaps a second step after having family/group members work in their own individual trays, is to have everyone work together in a large tray. The large group sandtray could be custom built. However, one easy way to have a movable, nonpermanent large tray is to use four, 3-foot long 2 × 4 inch pieces of wood for the sides; builders squares to hold the wooden side pieces together (found at the home center store); and a large blue painter’s cloth draped inside. Just pour in the sand. This goes together quickly and is easily disassembled for storage under a sofa, in a closet, or in another place. This provides a 9-square-foot area for working with families and groups. If working with a large number of people, the size of the miniature collection may need to be expanded, but it does not need to be significantly larger. How group/family members deal with limited resources can be informative to the therapist, and it can help develop useful skills for the participants.

For family sessions, the therapist may want an enmeshed family to work in separate sandtrays to learn how to have separate thoughts and actions. Individual trays are also useful for disengaged families who need time to learn to relate to one another again. The decision to move to a large tray is dependent upon the clinical understanding of the process and need of the clients. Sometimes the shift to the large tray begins with areas in the sand segmented for each family member. Other times, working together without artificially designated boundaries is more therapeutic. For couples, this same kind of work can occur, with each beginning with his or her own tray. The two individuals can then transition to building together in one regular-sized tray. Higgins-Klein (2013) provides a cohesive example of how sandtray therapy is used in her model of mindfulness-based play-family therapy. Carey (1999) and Gil (1994) also provide many examples of using sandtray therapy with children and families. These authors and others expand on the use of sandtrays in family therapy from a variety of perspectives.

Kestly (2001, 2010) writes about friendship groups in schools. This is an effective format for working with individual children in a group setting. It allows the group process and dynamic to work effectively, while allowing the children to use a primarily nonverbal form of self-expression. After ample time for the children to create their individual trays, time is provided for each to share the story of his or her tray. This builds self-confidence, a sense of belonging, and therapeutic space to work on their issues. Later in this chapter, two research projects are described that use, in part, Kestly’s group format.

Group sandtray formats can also be used with work groups, support groups, supervision groups, faculty/staff groups, and others. One very large sandtray, 3 feet by 9 feet, was used at an all-day sandtray therapy training event. Throughout the day, all the 200 or so participants could go and play in the sand. The evolving and growing creation over the course of the day not only infused a sense of playfulness, creativity, and belonging into the training day, but also resulted in many hypotheses about the final creation.
Play Genograms

Play genograms, promoted and taught by Gil (2003), are an interesting and useful way to use the miniatures outside the sandtray. The client begins by drawing her genogram on a large sheet of paper (18 × 24 inches works well). Next, the client selects a miniature symbolizing each person and places it on the appropriate part of the genogram. A discussion of the play genogram can reveal a great deal about the client’s perception of self and others in the family system. A second step, if time allows, can be to have the client add items to reflect the relationships between the family members. Interesting items are used to symbolize relationships: chains, coins/money, bridges, swords, “magic” rocks, and others. This process provides the therapist with a great deal of family information, the client’s perspective of the family, and client awareness into multigenerational issues. Play genograms can be used with individuals working on family-of-origin issues, couples doing premarital counseling, sibling groups, and other configurations.

Parenting Genogram

This same process can also be used as a parenting genogram. The client uses miniatures as symbols of how the person parents and was parented. The same kind of processing can focus on the multigenerational impact of parenting, what worked and didn’t work, and possible changes needed. Looking at two or three generations of parenting can also reveal family secrets and aid in the realization of how difficult it can be to change parenting methods and styles.

Focus Time

Often, when a client enters the room, we may casually ask, “How was your day?” or some other such innocuous question to bridge from the external environment to the clinical setting. Another way of doing so, while assisting the client in focusing on therapeutic issues, is the focus experience. Provide the client with a set of markers and a sheet of construction or drawing paper (12 × 24 inches works well). Next, ask the client to pick one miniature that particularly interests him at the moment, place it anywhere on the paper, and draw an environment for it to live in. This provides the client the opportunity not to have to begin verbal work immediately and engages the left brain by providing a nonverbal, creative manner in which the client can be reengaged. This exercise appears to work as well for the client who rushes in and needs to physically and mentally slow down, or for the student after (or in) school who might already be tuned out. It provides the client with physical, emotional, and psychological space in which to transition into the therapeutic process.

NEUROBIOLOGICAL CONSIDERATIONS

Also critical to understanding the effectiveness of sandtray therapy is the implications of neuropsychology. With the growing body of research and its application to the mental health field (Badenoch, 2008; Gaskill & Perry, 2013; Perry, 2006; Perry & Pate, 1994; Siegel, 1999; van der Kolk, 2006), it is critical to stay informed in this area. Badenoch (2008) explains the neuropsychological processes involved in the client’s interaction with the sand and miniatures. Touching the sand and miniatures activates the lower brain. The limbic system receives the information from the brain stem and identifies an emotional reaction to the sand, passing the message on to the neocortex, which decides the meaning to attach to it and integrates it (van der Kolk,
Anxious clients may spend extended periods of time moving their hands through the sand, letting the sand fall through their fingers, or burying their hands in the sand. If the client’s limbic system finds the tactical experience pleasant and soothing, it quiets the amygdala (Siegel, 1999).

For example, a 9-year-old client, referred for anxiety, builds well in the tray and talks easily about his scenes. Throughout the entire session, during building and talking, he continually moves both hands through the sand. Sometimes he moves the sand from one end of the tray to the other or covers and uncovers his hands with the sand. This often provides the client sufficient anxiety reduction to allow for left-brained logical, sequential verbal processing. In more severe cases, as neuroscience has informed us, the Broca’s area of the brain, which controls expressive speech, can be deactivated by too much blood flow (resulting from memories of trauma, for example), shutting down the ability to talk (van der Kolk, 2006).

For many clients, their trauma is based in early life experiences of neglect, deprivation, and/or abuse. Trauma is stored as implicit memories. Implicit memories, with their sensory components, are stored in the lower right brain (Siegel, 1999). Steele and Raider (2001) state “before traumatic memory can be encoded, expressed through language, and successfully integrated, it must be retrieved and implicitly externalized in its symbolic (iconic) sensory forms” (p. 3). Sandtray therapy provides the therapeutic intervention that allows clients to externalize and communicate such implicit memories. The wide variety of sandtray miniatures used by clients to build a scene in the sand allow for just such symbolic and metaphorical representations. “Grounded in the body, sandplay unfolds through the limbic region and cortex, and spans both hemispheres as the symbolic unfolds into words” (Badenoch, 2008, p. 220). Badenoch indicates that processing the creation in the sandtray “with verbal conversation … stimulates bilateral integration … [and thus] develops the regulating experience” (2008, p. 227). Implicit memories become explicit creations in the sand that are verbally and cognitively processed and understood. The resulting image is then re-stored and recontextualized in the right brain. This reflects the right–left–right brain experience discussed by Kestly (2014) and McGilchrist (2009; 2010). McGilchrist articulates this right-left-right movement experience as “something that arises out of the world of the right hemisphere, is processed at the middle level of the left hemisphere and returns to the right hemisphere at the highest level” (2009, p. 126).

Through the use of neuropsychology and neuroimaging research, van der Kolk (2006) reports traumatized clients have difficulty with “sustained attention and working memory, which causes difficulty performing with focused concentration, and hence, with being fully engaged in the present” (p. 280). An experiential activity, such as sandtray work, may assist in providing a visual image created by the client that provides a stable idea or metaphor that can then be discussed at a pace sensitive to the client's needs and abilities. The creation in the sandtray, like the play in the playroom or art created by a client, is an externalized form of content that provides the client the distancing needed, making the abstract concrete. Clients therefore process their trauma through the use of sandtray therapy, allowing the therapist to use sandtray therapy as a trauma-informed intervention.

**RESEARCH**

Being aware of the efficacy of any mental health treatment is important. It assists the therapist in the selection of the treatment which will result in the best outcome for the client. Outcome research in the use of sandtray therapy is extremely limited. Although there is a large body of work comprised of published case studies, theoretical articles, and general practice literature,
well-designed outcome-efficacy studies are few. As a technique, sandtray therapy can easily fit into other counseling theories that are empirically supported treatments. For example, therapists who use cognitive-behavioral therapy (CBT) can integrate sandtray therapy as a technique to assist clients in working through the various phases of the treatment protocol. The advantage of sandtray therapy is that it is a technique that can be utilized within an existing treatment protocol.

There are two well-designed outcome studies regarding group sandtray therapy by Flahive (2005) and Shen (2006). Their results are reported using the Cohen’s d effect size (Cohen, 1977). Flahive conducted a pretest/posttest control group research project. Fifty-six 9- to 12-year-olds were randomly assigned to either the experiential or control group and were stratified by gender and ethnicity. The students were referred by classroom teachers for disruptive classroom behaviors, peer interaction problems, and symptoms of anxiety, sadness, or being withdrawn. The treatment groups consisted of three students each, and met weekly for 10 weeks. Pre- and posttreatment data were collected from caregiver- and teacher-completed forms of the Behavior Assessment System for Children (Reynolds & Kamphaus, 1992). The Homeyer and Sweeney (1998, 2011) six-step session protocol was followed by all the group therapists. Each group member made a nondirected sandtray with the prompt of “create a world in the sand.” When completed, each group member had the opportunity to share the story of his or her tray. There were significant differences in the total problem scale (d = 0.52) as reported by the teachers. While the students in the treatment group had slight improvement, the control group displayed worsening behavior. The teachers also reported significant changes in internalizing behaviors between the groups (d = 0.59). Externalizing behavior showed significant changes as reported by both caregivers and teachers (d = 0.54 and d = 0.63), respectively (Flahive & Ray, 2007).

Shen (2006) studied 37 seventh-grade girls. She also used a pretest/posttest control group design, studying changes in self-esteem. Pre- and posttreatment data were collected using the Self-Perception Profile for Children (Harter, 1985). Shen’s treatment groups consisted of four girls, that met twice a week for a total of nine sessions. The girls completed directed trays focused on specific topics important for self-esteem, such as relationships, social acceptance, and physical appearance. The resulting analysis of the data revealed the girls in the self-esteem group improved on measures of scholastic competence (d = 0.64), physical appearance (d = 0.52), global self-worth (d = 0.83), and behavioral conduct (d = 0.46) (Shen & Armstrong, 2008).

Additional research is critical as the mental health field continues to be influenced by the medical-model requirements for empirically supported treatments. Kestly suggests (2014) the fields of play therapy and sandtray therapy begin advocating the use of mental health treatments as science-informed, which would honor the scientific method but give credence to the promising practices informed out of the neuroscience field. Certainly, as mental health practitioners, we must use treatment interventions which are efficacious. At the very least, best practices that are developed out of well-grounded and accepted theory, professional literature, and empirical research should be used and well-articulated.

REFERENCES


INTRODUCTION

Metaphor, storytelling, and play therapy are tools with which a play therapist can access the inner world of a child, help the child make sense of that world, connect to others, and discover solutions to problems. Stories illustrate the universality and contextual normalcy of human conditions.

Storytelling is an age-old tradition. Aesop’s Fables, fairy tales, and Native American legends teach memorable lessons, while movies such as Schindler’s List preserve and pass on important history to the next generation. Milne’s book Winnie the Pooh provides lessons in life, while Pastis’s comic strip Pearls Before Swine and Trudeau’s comic strip Doonesbury offer social commentary (Pernicano, 2014). The Harry Potter series offers symbolic meaning about life versus death, love versus hate, and good versus evil (Oldford, 2011).


The themes of play are coherent metaphors in and of themselves and may include triumph/conquering, fearlessness/courage, power/control, dependence/independence, abandonment/separation, safety/security/protection, chaos/instability, grief/loss/hopelessness, forgiveness/revenge, and mastery/competence (Drewes, 2010; Erickson, 2011b).

According to Jeff Zeig (2008), when a treatment provider connects the dots for clients, clients do little more than use their left brain, the logical side, to follow the dotted line of compliance. Metaphor and stories guide clients to use the right brain, the creative side, to connect the dots of their own lives in meaningful ways. Children engage in nonconscious, symbolic processing and realize solutions as they listen to stories, so storytelling, like metaphor and play, allows communication on multiple levels (Gil, 2013). During a workshop at the 11th International Erickson Congress, Betty Erickson (2011a) pointed out that the language in stories is layered, and listeners
consciously hear surface meanings while responding to deeper meanings: “We know what we know without knowing how we know” (p. 2).

In *Using Trauma-Focused Metaphor and Stories*, Pernicano (2014) states:

The impact of therapy stories is both cognitive and emotional, some metaphors hypnotically going in the back door to tap into right-brain emotional and sensory processes. It is often during the reading of a story or in the weeks following this that a family, child, or caregiver experiences a breakthrough, gains and acts on new insight, or experiences emotional growth. Attachment (sensed safety, love, and felt security) develops in the right-brain limbic areas, particular in the amygdala, and therapy stories seem to have the power to emotionally trigger interpersonal awareness and relational change. (p. 20)

Metaphor is the language of play. “Through metaphorical communication, children can reveal their concerns, demonstrate their desires, express their emotions, gain a clearer understanding of their experiences, and create solutions to problems” (Snow, Outts, Martin, & Helm, 2005, p. 63). According to Gil (2013), therapeutic stories and metaphors change representation, enhance memory, explain or illustrate a point, open up strategies, and challenge something seen only one way. Play allows the child to protect the self while projecting experiences onto another object; during play therapy, the play therapist must pay close attention to the symbolic meaning of the child’s play. After hearing a story, a child’s play may indicate wishes and fears of the child that remain, as yet, unspoken. Children, in their transparency, identify with story characters; reveal confusion, painful memories, and feelings; and seek solutions to their problems. Stories set the stage for and springboard the client toward change.

**THEORY**

Metaphor and stories may be used within any theoretical orientation, including client-centered, cognitive-behavioral, Adlerian, narrative, family, Gestalt, Jungian, psychoanalytic, object relations, and psychodynamic, and the clinician’s theoretical underpinnings guide the manner in which the material is utilized. Depending on the play therapist’s theoretical orientation, metaphor and stories are used to discover, change, or create meaning; teach or model concepts; see change; alter schemas; change behavior; utilize the child’s language and themes; induce hypnotic trance; access unconscious processes; strengthen parent–child relationships; change or construct personal narratives; trigger “aha” moments; or reduce defensive and resistance. Solution-oriented treatments (Cauffardi, Scavelli & Leonardi, 2013; Selekmam, 2005), hypnotherapy (Austin, 2011; Erickson, 2011a, 2011b; Linden, 2007; Oliness & Kohen, 1996; Yapko, 1990, 2007), acceptance and commitment therapy (ACT) (Hildebrandt, Fletcher, & Hayes, 2007), Adlerian approaches (Kopp, 2007), Ericksonian therapy (Close, 2004; Garcia-Sanchez, 2007; Mills, 2007), filial therapy (Homeyer & Morrison, 2008; Landreth, Bratton, Kellam, & Blackard, 2008), narrative therapies (Perry, 2007; Smith & Nylund, 2007; White & Epston, 1990), mindfulness approaches (Kabat-Zinn, 2011), cognitive-behavior therapies (CBT) (Blenktron, 2010; Friedberg & Wilt, 2010), clay therapy (White, 2006), art and expressive therapy (Malchiodi, 2005, 2008), sand work (Homeyer & Sweeney, 2010), and a variety of play therapies (Bratton & Ray, 2000; Drewes, 2009, 2010; Drewes, Bratton & Schaefer, 2011; Duffy, 2011; Gil, 1994, 2006, 2013; Malchiodi, 2008; Reddy, Files-Hall & Schaefer, 2005; Schaefer & Cangelosi, 2002) all utilize stories or metaphors. In client-centered play therapy, the therapist follows the lead of the child, which provides an opportunity for the therapist to observe the child and both interpret and utilize the metaphors that emerge during play (Axline, 1974).
Milton Erickson’s work, described by Haley in *Uncommon Therapy* (1993) and by Rosen in *My Voice Will Go With You* (1991), advocated for the use of stories and metaphors in child and adult therapy. Carlson (2001) and Esparza (2001) provide excellent summaries of Erickson’s work and this school of thought. Erickson believed the unconscious was a positive energy source, malleable and affected by experience. He posited that a therapist influenced a client’s unconscious experience by providing new information, arousing feelings, and creating new experiences through stories. Gil (2013) refers to Erikson as having been a master storyteller; his quirky stories and quick metaphors gave clients freedom to create meaning, yet the stories he told were not necessarily the stories they heard. The stories often used in hypnotherapy move the listener to a vulnerable, receptive state of readiness; for children this is a readiness to play. Young children, with their propensity for magical thinking, suspend reality and respond to nonlogical aspects of metaphorical stories as if they are real. The stories often used in hypnotherapy move the listener to a vulnerable, receptive state of readiness; for children this is a readiness to play. Young children, with their propensity for magical thinking, suspend reality and respond to nonlogical aspects of metaphorical stories as if they are real. At a 1993 workshop on solution-oriented hypnosis, Bill O’Hanlon demonstrated how individuals see things differently in trance states and experience the “aha” of insight that propels them toward change.

Children experience problems when the narratives they are living do not match reality; in effect, past life experiences (and their impact) carry forward, and children behave as if those experiences are still true. They live as if what they experienced has not changed and cannot change. They develop beliefs and feelings about themselves and others (based on experience) that need to be examined and challenged in order for them to develop new narratives (White & Epston, 1990). A child in therapy has a story to tell about himself and his experience; so the play therapist and client co-construct a metaphor or story of the child’s experience, and the child reveals his or her contextual world in the play (Cattanach, 2009; Chazan, 2002; Meichenbaum, 1993). Clients develop new assumptive worlds (beliefs and attitudes about themselves, others, and the world) through therapist reframing, validation, empathy, and co-construction, resulting in new narratives that are coherent and make change “conceivable and attainable” (Meichenbaum, 1993, p. 5). Oldford (2011) describes making narrative use of fairy tales and the Harry Potter stories to help clients reauthor, reinterpret, and integrate their past. Play therapy allows children to deconstruct and reconstruct their narrative understanding of what they have experienced. Kathryn and Marc Markell (2008) further describe how the Harry Potter series and other familiar stories may help children cope with grief.

Psychoanalytic theory posits that when children are exposed to stories that reflect their, at least in part unconscious, struggles, they engage in identification and projection. They identify with the needs, wishes, and frustrations of the character most similar to them, hopefully the protagonist (Carlson, 2001). The children then go through abreaction and catharsis, during which they experience emotional relief (verbally or nonverbally). Finally, they achieve insight and integration, with increased self-awareness and understanding.

Ultimately, a child’s play reflects neurodevelopment, including the capacity for emotional regulation, cognitive functioning, and interpersonal competency.

As we continue to learn more about neurobiological pathways and right-brain contributions to trauma and attachment, we better understand the ways in which stories have the capacity to open up right-brain processes, activate sensory memories, trigger strong unresolved emotions, and stimulate the “aha” of insight that propels behavior change. (Pernicano, 2014, p. 19)

Gabbard states in Meares’s *The Metaphor of Play* (2005), “despite the hard wiring of neural networks, new networks can be formed” in therapy. Cozolino (2010) writes about the therapist as neuroscientist, wherein integrative narratives (which emerge within the therapeutic
relationship), resonance (triggered by brain mirror systems), movement (activation of balance and motor systems), attunement (sensing the emotional states of others at a brain level), and empathy facilitate attachment and therapeutic change, allowing clients to experience themselves differently. Therapy is, from this point of view, a brain-to-brain connection that results in neurobiological change.

Narratives often arise out of implicit (emotional or sensory) memories that are long forgotten and difficult to process, yet contribute to rigid or disorganized coping, and an attuned, empathic therapist can help the client cope in a more integrative manner. Cozolino describes the case of a 60-year-old man who was socially isolated and quite regimented and inflexible. As it turned out, he had been separated from his parents while hidden from the Nazis in a friend’s home. He was a “good boy,” and in the small hiding space, he silently and repetitively rode a tricycle in small circles, sometimes for hours. He later reunited with his parents and “forgot” the experience. Cozolino and the man realized that he still felt trapped and paralyzed by fear. In the story they co-created, the man became a child again and eventually rode an invisible tricycle out of the hiding place through the walls of his “prison,” freely and without fear. For that moment in time, he experienced being a child again, with all the emotions that entailed, but now he was free to move where he pleased. At a trauma conference in Niagara Falls, and in his books The Mindful Therapist (2010) and The Developing Mind (2012), Siegel (2013) spoke about the neural integration that takes place through shared play, emotional resonance, and sensitive attunement, whereby a client “feels felt,” develops coping skills, and changes his or her views of self and other. From Siegel’s perspective, the attuned, brain-to-brain connection between therapist and client results in top-down, right–left, inner–outer brain integration and functioning. Play therapy, with its many tools, is a set of activities that facilitates brain integration. What better tool than a metaphorical story to guide the client into the right brain (to activate sensations, memories and emotions) and then use language to give meaning to what is played out?

RESEARCH

Clinicians and researchers have sought to identify the specific elements inherent in play that make it a therapeutic change agent (Reddy et al., 2005). Some of the main factors are its power for communication, teaching, abreaction, and rapport-building. Studies over the past two decades indicate a moderate treatment effect for play therapy, and two factors related to positive outcome are parental involvement in the child’s therapy (such as in Filial Therapy) and the duration of therapy (Ray, Bratton, Rhine, & Jones, 2001). Regular communication with and involvement of parents in the storytelling and play strengthen parent–child relationships, improve parent understanding of child issue, and ensure better follow through at home. Homeyer and Morrison (2008) describe a number of play therapies that have been shown to be effective across a variety of presenting issues, and they also stress that using client-centered or nondirective play therapy, along with the involvement of significant others such as teachers and/or parents, increases efficacy.

PROCEDURE/TECHNIQUE

There are many books, chapters, and articles written about the use of storytelling, metaphor, and narrative techniques in play therapy—too many to cover in detail. Kopp (1995), Burns (2005, 2007), and others have written extensively about the use of therapist- and client-generated metaphors and stories. Mutual Storytelling, an early use of therapeutic stories, provides a structured, psychodynamic approach to help children process wishes and “real-world” reality (Gardner,
Metaphors and Stories in Play Therapy 263

1971). The Squiggles game, developed by Winicott in 1971, was later adapted by Claman in 1980 when he incorporated Gardner’s Mutual Storytelling technique (Schaefer & O’Connor, 1983).

During a presentation at the 2011 Erickson Congress, Consuelo Casula stated, “In the story we insert suggestions to elicit wonder and curiosity, reframe negative beliefs, emotions and attitudes; to overcome transitions; to prepare and consolidate changes; to reinforce or loosen bonds; to transmit joy of life, to enhance and empower resilience.” Through play, the child begins to experience him or herself as capable, creative, and efficacious.

A therapeutic story (a) has a goal, (b) carries a message that incorporates the goal, (c) is often fun, (d) teaches and instructs, and (e) normalizes the situation (Erickson, 2011b). During storytelling, a conversational trance (a shared state that is more right-brained and provides easy access to implicit memory and sensory/emotional states) occurs when the therapist is intently focused on the listener, the voice is paced and leading, and there is a strong interpersonal, attuned connection conveyed by the therapist’s sincerity, honesty, vulnerability, and openness. Most people shift smoothly between conscious (more left brain) and creative unconscious (more right brain) trance-like states of mind throughout the day. During play therapy, the therapist somewhat purposefully shifts or guides the client into the creative, unconscious (right brain) state using imagery, therapeutic language (metaphor/story), play, or hypnosis. In this state, children process information differently, and they can access new understanding and resources. Reality can be somewhat suspended and new possibilities awakened.

Therapeutic stories touch the hearts of their listeners and stir up emotions in even the most guarded of clients, and conversational trance increases the likelihood of this taking place (Erickson, 2011a). It can be very helpful to guide the client to describe the problem in the form of a metaphor, then together clarify it using descriptive details and sensory language, as this will help identify solutions for the metaphorical problem (Austin, 2011). In Family Play Therapy: Assessment and Treatment Ideas, Gil (2013) points out that the right hemisphere uses symbols, metaphors, fantasy, and play to process information. Early in treatment, it is effective to stay with right hemisphere activities as long as possible, as these amplify the impact of the metaphor and leads to reflection. Left brain cognitive evaluation is useful once the right brain work is done. This is particularly important when doing trauma work because stories and play activities are less likely to trigger a state-dependent meltdown or a fight/flight response during trauma narrative work, and they help with cognitive and emotional coping. Pernicano (2014) offers trauma guides, many stories and activities to use with traumatized children aged 9 and older, and their caregivers.

Drewes (2009) includes an overview of play therapy research in her edited volume on the integration of play therapy with CBT, and Cattanach, in this same volume, reviews narrative approaches. With regard to story development, Kottman and Ashby (2002) suggest setting the story in the past or future to help the child suspend reality and engage in projection. The play therapist and client then co-create a detailed character description, emphasizing physical, emotional, and mental characteristics. It is important to include visual, auditory, olfactory, kinesthetic, and tactile information in the story to engage the child’s senses.

Blenkiron (2010) published a one-of-a-kind volume on the use of stories and analogies in CBT. He provides an overview of treatments in which metaphor and stories are used and diagnostically distinct interventions (metaphors by problem type). Intended more for work with adults, the metaphors and stories contained in the book could be easily used in conjunction with play therapy to treat children, adolescents, and families.

The Fairy Tale Model, an evidence-based model of trauma intervention, uses a fairy tale as a change metaphor (see www.childtrauma.com; Greenwald, 2009). A Fairy Tale, a comic book written by Ricky Greenwald and illustrated by Katrina Jones Baden (Greenwald & Baden, 2007) for use in trauma work, is available for purchase at the website, as is Slaying the Dragon, a self-help
book about trauma for laypeople (Greenwald, 2014). Slaying the Dragon includes interventions such as motivational interviewing, cognitive-behavioral therapy, parent training, attachment work, trauma resolution, and relapse prevention/harm reduction; however, the comic book and metaphor can also be useful within child and adolescent play therapy. Greenwald’s Treating Problem Behavior: A Trauma-Informed Approach (2009) includes the fairy tale and a detailed description of Greenwald’s trauma-informed treatment model for use by therapists.

Any creative play therapist can use metaphor and stories in play therapy using the following guide (Pernicano, 2014, pp. 26–27):

- Select or create a story that parallels or pulls for the client’s problem, the client’s characteristics (attitudes, beliefs, feelings, or behaviors), the goal or purpose of the treatment session, and/or the phase of treatment.
- The story should allow the character to resolve the conflict and achieve a desired outcome (Gil, 2013).
- Match the story to the child’s developmental level so the material is within the child’s zone of proximal development (i.e., contains skills the child has not yet mastered but that are attainable with the play therapist’s help) (Carlson, 2001).
- Tell or read the story with the child and/or caregiver. If the child is able to read, take turns reading. Shorten or paraphrase the story for a younger child or a child with a short attention span.
- After reading, see what comes up spontaneously before offering observation or interpretation. If the opportunity arises, help the child link the story to his or her life experience, perceptions, or feelings.
- Show curiosity: Accentuate the metaphor, theme, story process, and outcome. Ask questions to clarify child and/or caregiver perceptions: “Why do you think this happened?,” “What advice do you have for the character?,” or “What do you think led to this?”
- Move into a planned or client-directed play therapy activity that follows from the story or the client’s response to the story and addresses a theme, schema, or feeling state in the story.

Therapeutic stories can be preselected or developed and told spontaneously as metaphorical themes emerge. Stories may provide psychoeducation (normalize a problem, educate about symptoms, teach about an issue such as domestic violence or trauma); trigger identification with a character in the story; reduce defensiveness or cut through denial (the story “pulls” the client into the right brain and bypasses rational processes helping the client access emotion and connect to past feeling states); trigger insight; and/or introduce coping skills or resolution (the story’s character engages in an evidence-based technique or the character comes to a new understanding). Child therapy books are available for such problems as trauma recovery, domestic violence, attachment, grief and loss, divorce adjustment, depression, obsessive compulsive symptoms, anxiety, bullying, anger management, fear of the dark, attention deficit, adoption, and foster care, among others. Relying on someone else’s stories is a time-saver, but any play therapist can learn the art and skill of story development or teach children how to make up their own stories.

Pernicano (2014) describes ways in which play therapists may develop their own stories and use them in child and family treatment. With regard to character development,

If the main character will be an animal, it must have characteristics that fit the presenting issue and create a helpful response set in the child. The character’s problem has to be significant so that there is a strong need for problem solving. For example, an eagle
should not be afraid of flying, and an obsessive compulsive frog would soon starve if he could not eat flies without washing them. A peacock can easily be seen as a show-off, and there is a perceived aggressive energy to dragons, lions, and alligators. The child character can be a victim or the person in charge that offers wise advice. Either approach can be helpful when the client perceives him or herself as a victim and needs to develop self-efficacy. A perpetrator character has one or more of the characteristics of someone that hurt the child: dangerous behavior, untrustworthiness, selfishness, arrogance, self-centeredness, cruelty, or disregard for others. The action of the story will remind the child of something he or she experienced. (p. 21)

Stories are good tools within family play therapy, as parents hear and accept things from story characters they would not accept from a therapist, and they disclose things in play they would otherwise guard against. A play therapist can provide a metaphor or ask the family to choose one. In Play in Family Therapy (1994), Eliana Gil spells out creative ways to involve families in storytelling, art, and puppet play.

During family therapy with a boy and his critical mother, “First Things First” (Pernicano, 2010a) proved to be a helpful story to illustrate the impact of the mother's negative behavior on her son. In the story, a know-it-all monkey allows his friend to flounder in quicksand while he lectures and criticizes her means of trying to stay afloat. He has a rope in his hands but does not use it. As I read to the mother and child, the mother looked sheepish, laughed, and said, “oh my god, that’s just like me and his dad. The next time I act like that, I’m going to see that picture of the quicksand and the monkeys!” The child exclaimed, “Mom that’s just like you. I do wish you would give me just a few more compliments when I do something good.” During their next session, the boy mentioned he was getting “more good chips” and more positive attention from his mother.

It is important for the story to fit the age and functioning of the client. With younger children (preverbal, preschool, and those with limited language abilities), it is best to tell a short and simple story. The play therapist actively engages the child while telling the story, asking questions about the characters, the action of the story (“Guess what happens next?”) and the outcome (“I wonder why he is doing that?” or “What can we do to help him/her?”).

Enactment of the story, especially with puppets or action figures, engages a young child well, and it is very important for the play therapist to mirror the intensity of the child’s affect. After the story, the therapist moves the child into a directive (planned, structured) or nondirective (child selects the play materials) play intervention. For example, a toddler who witnessed her mother’s murder was having nightmares and had stopped talking in anything but a whisper. She had regressed and would not separate from her caregiver. “Little Butterfly and the Bad Thing” (Pernicano, 2014) was written for trauma intervention, but the concept of a “bad thing” may also be used with other types of child issues. This story depicts a butterfly who has nightmares and whose wings no longer work after witnessing a “bad thing.” The story guides the child to share and wrap up bad memories and stick them on a large spider web in the play therapist’s office. After reading the story, the child’s therapist asked, “What is the bad thing you and I can wrap up?” The child whispered, “Bloody hands.” For several sessions, the girl and her therapist drew pictures of bad things, wrapped them up in duct tape, and stuck them on a web in the therapist’s office. She began speaking up more and was sleeping better at night. She had come to therapy emotionally frozen, and the story provided a gentle thaw.

Young elementary-aged children enjoy directive play using watercolors, games, the sandtray, molding sand, the dry-erase board, and puppets. Nondirective play involves the child using the toys or materials in a playroom to engage in “metaphorical construction” of his or her own
Preteens and teens readily respond to play techniques such as Squiggles stories, role playing or psychodrama, expressive art or music, sand creations (molding or dry sand), and creative writing (writing poetry, a play, or a sequel to the metaphorical story). A boy had been abused in the past and was having daily “meltdowns.” He was very interested in Star Wars themes and characters, especially Obi-Wan Kenobi, Yoda, Luke Skywalker and Darth Vader, and he really liked to draw on the dry-erase board. The play therapist selected the story “Climbing the Mountain” (Pernicano, 2013) to reduce arousal/agitation and give him a sense of control/empowerment. The story has been used effectively with adults and children to establish psychological distance from pain, anger, anxiety, fear, and distress, and it provides a coping tool during exposure work. In this story, the client builds a cage at the foot of the mountain, locks the “bad guys” (or pain, memories, distress, anger, etc.) in it, provides “guards” of his/her choice, and “climbs” the mountain in a manner of the client’s choice (cable car, ski lift, escalator, stairs, pathway, jet pack, etc.). On the way up the mountain, the client stops three times to look down, paying close attention to the reduction in arousal and the increasingly small size of the cage and its contents. When appropriate, the differences between “then” (at the foot of the mountain) and “now” in terms of time and space are noted. Relaxation or trance-induction may be facilitated before beginning the guided imagery. This allows clients to hypnotically alter sensory and emotional triggers (unpleasant sounds can be tuned out the higher you get, feared persons look like ants at the peak, the higher you climb the farther you are from the painful memories). While climbing the mountain, the client gains psychological distance and mastery over whatever is at the foot of the mountain. At the first lookout, there is the opportunity to practice relaxation, reduce anxiety, and gain control over arousal in the face of still-distinct cues. At the second lookout, the cues are less intense and the client experiences much less anxiety. At the top, most clients feel successful, empowered, and safe to discuss what lies at the foot of the mountain and they feel less emotional impact.

As he finished the exercise, the boy was invited to draw his own scene based on what he created in his mind. The instructions for this directed play therapy task are: (a) draw or build a scene where you (b) lock the bad guys in a strong cage of your design at the foot of a mountain;
(c) identify the number of locks needed to keep the bad guys, feelings, or memories safely in the cage; (d) identify the guards (animals, people, or both); and (e) create a way of your choice to move up and down the mountain (cable car, escalator, path, ski lift, etc.). The rest of the details are up to the client. The boy drew the cage with a huge guard standing on a fire-proof perch outside the cage. The cage was locked with 85 locks, and only he and the guard had the keys. He put a giant spider in the cage to “suck their blood out if they try to escape.” The cage hung by chains, suspended over a pit of fire. He wrapped his perpetrators in duct tape. Deadly snakes were coiled around the chains, “just in case” the bad guys ever got out. He placed him and his siblings in a fire-proof, jet-propelled car (like on a ski lift) above the cage. The children propelled themselves up and down over the bad guys and yelled at them. He was intensely engaged in the activity and grinned as he manned the controls. It was a powerful depiction of his fear and strong need for safety, protection, self-control, and autonomy. Using guided imagery, he was encouraged to slowly go higher and higher while looking down on the bad guys in the cage, noticing that the danger was increasingly far away and the fire and bad guys could not reach him. Following this session, the frequency and intensity of his angry meltdowns decreased, and he continued to process past abuse.

His younger sister created quite a different scene, although the instructions were the same. Her cage had over 2,000 locks. A lion guarded the cage from the left, “to grab them by the throats if they escape,” and a poisonous snake guarded it from the right. An eagle guarded from the top “to carry them off,” and a poisonous spider was inside the cage. She said, “We [children] are safe on top of the mountain. They are mean. We are throwing lion, eagle, and snake poop down on them.” She put blindfolds on them and added, “They don’t deserve to see this beautiful place,” then duct-taped their hands, feet, and mouths “so I won’t hear their mean words.” In a later session, she used play to reenact this scene using a small birdcage, puppet guards, and doll house dolls she thoroughly wrapped in duct tape.
The following section provides detailed examples of specific ways metaphor and stories may be used in play therapy. The cases, stories, and techniques are my own, to serve as examples, but there are endless other possibilities to be found in the literature. There are five main ways stories are used in play therapy.

1. The play therapist uses a metaphor introduced by the client and selects or creates a story that uses the client’s metaphor.

An adult client experienced fear and vigilance in spite of now living in a safe place. She said with a laugh, “I’m looking for land mines.” I smiled and said, “Yes, in Disneyland.” I wrote “Looking for Landmines in Disneyland” (Pernicano, 2011) and read it to her in the next session. She drew and labeled her land mines (people and significant past and present life events), then she began talking about ways to detonate or deactivate the remaining land mines so she could enjoy Disneyland.

A teenager engaged in cutting behavior used the word damaged in her self-description. We read “The Cracked Glass Bowl” (Pernicano, 2010b, 2011), a tale of brokenness and healing “from the inside out.” She came to the next session with a beautiful work of art, a colorful drawing of a bowl with cracks. The bowl had gouges as well as deep and shallow cracks. It was labeled with events that and people who had left her feeling “damaged” or “broken.” We discussed what sorts of “heat” she might use that would be powerful enough to melt her pain and soothe her strong emotions. We decided the necessary heat (anger, righteous indignation, determination, self-pride, forgiveness) might come from self-care, journaling, and talking about her feelings. In the course of treatment, she eventually drew her “new creation” bowl and framed it. No cracks appeared on that bowl; instead, she had written her strengths and the kinds of heat that helped her avoid cutting.

2. The play therapist introduces a metaphor that illuminates the client’s issues and tells or reads a story including the metaphor.

A young boy who lived with his grandmother was “mad at the world.” During intense daily meltdowns, he would bite, yell, and fight. He ignored adult directives, and at school he hid under a desk when he thought he was in trouble. Early in treatment he would not greet me in the waiting room; he made no eye contact and played alone, mostly in silence. His play was aggressive and he sometimes said he wanted to kill others. I was concerned about his poor mood regulation and attachment difficulties. At the end of each session, he went to the sand tray where a battle ensued and the bad guys won. Eventually, I suggested the good guys might work together and find a way to win—after all, no one should fight their battles alone—and I read him a story about a small fish abandoned by parents who pretended to be a shark to scare everyone away and be safe. Later in the story, a real shark “sniffs him out” as an imposter and nearly eats him. A large school of fish surrounds and rescues the small fish, reminding him “there is safety, and friendship, in numbers.” After listening to the story, the boy asked to use the puppets to play this story, and he invited me to join him. He played the shark and asked me to play a small frog (for lack of a fish puppet).

During the next session, he asked if we could use the puppets again to play the fish story. Again, he played the shark and I played the frog. When the shark tried to bite/eat the frog, I suggested we work together to protect the frog and he agreed. As we played, he said the shark was like his mother’s ex-boyfriend. He finished by inviting me to help him put the shark in jail to protect the small frog. Not too long after this, he invited me to fight bad guys with him in the sand tray, and without even looking at me he stated, “Everyone needs a friend, like you said.” He set up medieval characters and two sides of the battle. He directed the play, and my involvement, and for the first time, the good guys won.
During the next family session, he set up a new kind of scene, filling the sandtray mostly with frogs and snakes. He made good eye contact, smiled, and informed me and his grandmother, "This is good-guys day. Only friends allowed. Like you said, everyone needs friends." He set up the sandtray with the rubber dollar in the middle as the main character. He invited me to join in with, "You can be the biggest frog. I'll be the dollar," and proceeded to surround the dollar with friends.

It only took me a minute to make the connection between the frogs and the earlier play sessions with the frog and the shark. He had started to master his fear, and his trust in our relationship allowed him to invite me into his world. The progress that occurred over a period of several months of weekly sessions was also seen in his functioning at home and at school. He was having fewer meltdowns, was less aggressive, joined Cub Scouts, improved his eye contact, and was starting to engage with others and participate in the classroom. The story of the fish had hooked him; it allowed him to trust me, feel safe again, and believe in himself.

3. Select a story for the purpose of diagnostic clarification.

An 8-year-old girl was disengaged and hard to connect with, according to the foster parents. She stared into space and sometimes did not respond when spoken to both in sessions and at home. There was no known history of abuse, but it seemed likely given her family circumstances. She engaged well in play therapy using stories, puppets, and art, but she remained emotionally disengaged. In the middle of one play session she announced, "My memories come through my brain like a river. They float in and I try to catch them. Sometimes I catch one and can hold it for a moment, but then it is gone," and then went back to her play. I decided to assess specifically for dissociation.

I told her a shortened version of the story "A Safe Place to Call Home," about a girl who finds herself in a house where all the doors are locked. She does not have the key but hears voices of different ages coming from the rooms; they claim to know her. Eventually she finds the key and unlocks the doors. She invites the others to talk with her and share their stories. She looked at me with surprise as I finished, and she said, "Those others are all parts of her, aren't they? Like her
memories?” I told her how smart she was to see that. We moved into play and about 10 minutes later, she stopped abruptly and said with a smile, “I have imaginary friends you know.” She added, “Did I ever tell you I hear voices? Other kids think I’m crazy.” I reassured her she was not crazy at all, that many abused kids hear voices and have imaginary friends. This brief intervention helped clarify her diagnosis and guide further treatment.

4. Introduce a story to gently challenge magical thinking, a blind spot, or denial in the child or parent.

When I asked a 5-year-old why she was coming in for play therapy, she said, “My daddy lied to me. He promised to let me go home and then he kept me. He hurt me and mommy when she tried to get me back.” The girl’s mother confirmed this took place a couple of months ago. Since then, the child would not sleep alone, had nightmares, wet the bed, and did not want to separate from her mother. She thought it was her fault he hurt her mom, saying, “I should have let him take me; then he wouldn’t hurt my mommy.”

We started family play therapy focused on anxiety reduction and trauma recovery, and they made good progress. I read the story “Monkey in the Middle” (Pernicano, unpublished), then suggested we use puppets to act it out. The girl directed the action and played the monkey puppet. Her mother pulled on one arm and I, as her father (the alligator puppet), pulled on the other. She became very emotional and told the alligator to stop, that he was hurting her. Her mom and I “saved her,” and she wrapped duct tape around the alligator’s mouth. She told the alligator, “You need to go to jail!” Right before the little girl put the alligator in jail, she said, “He has an anger problem. He is mean. He needs to calm down!” I suggested she teach the alligator puppet how to breathe and relax using the stone meditation she had learned a week prior. During this activity, the child selects a special stone, and the therapist suggests that the child can send stress from his or her body down an arm into the stone. The child is told that when it works, the stone becomes warm. That is a sign that the child is calm and relaxed. We listen to a Tibetan ringing bell bowl while we hold the stones and breathe. The rule is that whenever we hear the ringing, we close our eyes and listen to the sound until it is gone.

The child gave each of us one stone to hold, then said indignantly, as only a 5-year-old girl can, “He needs FIVE stones!” She angrily shoved five stones into the alligator’s mouth. She taught the alligator how to breathe and let go of anger while holding his stones; then she put him in jail. Once he was in jail, I suggested she tell the alligator how his actions made her feel. She shook her finger at him and said firmly, “You are mean! You hurt me and mommy! You need to control your temper.” Five minutes later, she asked, “Do you think we can take the tape off his mouth and let him out of jail? Maybe he is ready to be nice.” I said, “I know you love him and want your daddy to change. You want him to be nice. [Pause] But he has to want to control his temper. He has to want to change. Do you think he is ready?” She said, “I don’t know.” She asked her mother, “Do you think he wants to change? Do you think he will be nice if I tell him to be nice?” The mother held her daughter’s hands, looked her in the eye and said, “I don’t think he wants to change, and I don’t think he is going to change. He has been this way his whole life. He doesn’t think he has a problem. I won’t let him hurt you again. I will keep you safe.” The child looked at me and said, “I think he needs some more time; let’s leave the tape on and keep him in jail.” Through the use of metaphor, a story, and play techniques, this child addressed her ambivalent feelings toward her father and accepted her mother’s protection. She started sleeping in her own bed, and there was a parallel reduction in her nightmares and anxiety.

5. Select a story to teach a specific technique (problem solving, cognitive coping, mood management, etc.) demonstrated in the story.

Sometimes a character in a story models a therapy technique for the client to learn and practice in play therapy. A 6-year-old boy came in with phobias and separation anxiety.
Cognitive-behavioral play therapy was the treatment of choice, using relaxation, modeling of coping skills, role playing, cognitive restructuring, exposure to feared situations, and behavioral rehearsal. I selected a story that demonstrated exposure, cognitive restructuring, and anxiety reduction about an eagle who was buying tennis shoes to walk to Tennessee because he was afraid of flying.

After reading the story, we “taught” the eagle puppet relaxation and breathing skills and practiced with the puppet. We discussed risks and benefits of flying, helped the eagle get off the ground, and ensured he had a successful flight. Next, the child practiced being brave, using Hulk gloves to touch things he was afraid to touch and roaring to show his “power.” We played Spider-Man (his hero), who had to conquer his fear of heights to climb and hang upside down to help others. The boy spun webs from his hands as we practiced and played. His mother joined some of his sessions, and they practiced at home between sessions. His parents reported a big reduction in avoidance and phobic behaviors and an increase in confidence within previously feared situations.

**Therapist Qualifications, Training, and Characteristics**

To use metaphor and storytelling, a play therapist needs to have basic understanding of child development and some training in play therapy. The play therapist needs to be able to evaluate play skills, attention span, language ability, cognitive development, and emotional understanding because story and play intervention must be matched to the child's development. Metaphor and storytelling require a fair amount of flexibility, spontaneity, and creativity. The play therapist must observe the child's play and listen carefully to the client's language in order pick up on emotional or thematic material connected to the child's background and history.

**Client Characteristics and Indications/Contraindications**

Anyone can play, and stories are a familiar activity for children of all ages. But stories are not one size fits all, and play therapists need to match the story and delivery to the client. The use of a story that arouses painful emotion too early in treatment, before there is a therapeutic alliance and the child has coping skills to manage arousal, is contraindicated. This can retraumatize a child and result in premature termination, increased symptom intensity, decompensation, or even dissociation.

Siegel (2013) discusses the importance of using interventions that promote neurobiological integration. A child with poor brain integration may use overly rigid (too organized) or overly chaotic (disorganized and disharmonious) coping behaviors. Some children live more in the left brain, with black and white or concrete thinking, rigid logic, rote play, overcontrolled emotions, and low arousal. Such children are not in touch with their own or others' feelings. Other children are easily overwhelmed and find it difficult to think clearly due to excess emotional arousal and sensory overload in the right brain. The overly rigid client may engage in ritualized, overcontrolled play; may seem “too adult” for a child; or may display obsessive compulsive or autistic spectrum–type symptoms. The overly chaotic child may experience mood dysregulation, hyperactivity, or excess arousal. Stories, in combination with play therapy, can help children improve brain integration by increasing activation and flexibility in those children with rigidity or low arousal and calming/regulating those children with high levels of distress.

**Logistics, Toys, and Materials**

The use of metaphor and storytelling does not require a playroom and can be made portable for those who have smaller office spaces or work in settings such as schools. A play therapist's office
can easily hold a set of stories, some molding or dry sand, a dry-erase board and erasable markers, puppets that match story characters or “pull for” different roles, drawing paper and washable markers, stones or objects for relaxation or mindfulness, and even a bell bowl. The author refers readers to other resources for sandtray (Homeyer & Sweeney, 2010) and clay (White, 2006) techniques.

Treatment Planning and Treatment Stages

Early in treatment, children’s metaphors and stories indicate their perception of the problem, and play activities can reveal the intensity of their concerns, their cognitive coping styles, their feelings about self/others, and their capacity for emotional expression versus control. Stories used by the play therapists early in treatment need to be only minimally to moderately emotionally triggering and more global in nature. These types of stories might address coping skills, avoidance, decision making, the courage to move forward, and barriers to change. Later in treatment, selected stories can challenge, elicit painful emotion, build new coping strategies, and change the child’s view (of the past, self, and others).

The Transtheoretical Stages of Change model (Prochaska & DiClemente, 1982) is helpful in planning treatment. A client in precontemplation does not think he or she has a problem, and stories cut through denial better than others. Someone in contemplation is aware there is a problem, but not yet sure he or she wants to change, so stories point out the risks and benefits of change. Once a client is in preparation and planning to make a change, stories help with planning and moving forward. Active change stories are focused on specific problems or symptoms, and maintenance stories address risk or relapse prevention. Carefully chosen stories can help a client reach goals and move to the next phase of treatment (Pernicano, 2011).

CONCLUSION

In sum, metaphors and stories arise in play therapy with clients of all ages, regardless of the play therapist’s orientation or preferred treatment modality. Metaphor is the language of play. Metaphors and stories are brain-integrative, and when used carefully during treatment, they drive change through noncognitive, sensory, and emotional processing. These tools invite identification with characters and story themes and springboard clients toward a better understanding of self and others, cognitive restructuring, and behavioral change.

REFERENCES

Austin, A. T. (2011). Helping a client explore their metaphor for their problem to discover a solution. Presented at the 11th International Erickson Congress, Phoenix, AZ.


Drewes, A. (2010). How to respond to the child’s play through metaphor. Rome, Italy: Italian Association for Play Therapy.


Erickson, B. (2011). Constructing therapeutic metaphors and stories, Workshop handout presented at the 11th International Erickson Congress, Phoenix, AZ.

Erickson, B. (2011b). Telling stories where they belong, Workshop handout presented at the 11th International Erickson Congress, Phoenix, AZ.


Gil, E. (2013). Family play therapy: Assessment and treatment ideas. Presented at the CTAMFT Annual Conference and Meeting, Groton, CT.


Siegel, D. J. (2013). Resiliency and neural integration: Harnessing the power of relationships and reflection to cultivate and maintain well-being. Presented at Trauma and Attachment Conference through the Attachment and Trauma Treatment Centre for Healing, Niagara Falls, Canada.


Pthomegroup
CHAPTER 13

Expressive Arts in Play Therapy

JULIA GENTLEMAN BYERS

For those who play, the source of satisfaction lies in the play itself.
—Knill, Barba, and Fuchs (1994, p. 24)

The use of art, music, dance, drama, poetry, storytelling, and other expressive modalities has been broadly applied in play therapy. While often used as artifacts or as instruments within the play therapist’s repertoire of play interventions, they rarely have been articulated as an integrative form of expression. In the above quote by Paulo Knill, the act of play is the source of satisfaction. It could also be said that for those who play in the context of a therapeutic relationship, the satisfaction lives in the play as well. Knill et al. (1994) state, “it is the nature of play to engage the imagination” (p. 24). Using the Latin root of imagination (imago or image) or the broader Paleolithic root, “mirrored thing in the water,” to play is to engage the image within us. If play and image are thought of as verbs, they can serve to express the role of the expressive arts play therapist as someone who engages his or her clients in the process of gazing at the reflections of a higher sense of who and what they aspire to be in the world. Using play and image as both verbs and nouns creates the opportunity to embody the in-between space or frame of the therapeutic environment. The in-between space referred to here and throughout this chapter refers to the space in which a person can test out new shifts in perspective, similar to Winnicott’s notion of the transitional phenomenon (Winnicott, 1971) or Betensky’s notion of the as-if phenomenon (Betensky, 1973), which creates a therapeutic space for clients to creatively integrate therapeutic issues. Clients’ need for self-expression is satisfied and reenacted in their play and use of toy objects. This chapter focuses on the use of specific expressive arts and play interventions within play therapy sessions.

THEORY

Within transdisciplinary research, the use of responsive methodologies (Leavy, 2011) suggest each discipline (including the human services field) should look for ways to be more informed
as “a way of being alive” (MacDonald, 2000). In contrast, problem-centered approaches encourage researchers and participants to explore only the presenting problem or issue, rather than focusing on the greater picture or the person as a whole. When using play therapy as a central counseling-psychology technique in integrative or holistic health care, it is important to include discussion of the field of expressive therapies, as play therapy often employs the use of expressive therapy techniques. Because one of the key principles of play therapy is flexibility, it allows for an easy transition between various expressive therapies techniques that enable the therapist and the client to freely explore issues and emotions.

As Landreth (2012) so aptly illustrates in Play Therapy: The Art of the Relationship, “perceptions are changed as a result of meaningful relationships” (p. 71). Beyond the empathetic stance of observing the client in a passive process, the role of the therapist is to be mentally and verbally engaged with the client in an active, action-oriented stance. In anticipating a client’s natural abilities and by being sensitive to the “flow” of the play therapy process (Csikszentmihalyi, 1990), the therapist can improve the chances of the client feeling more empowered and competent to face life challenges. The question may be asked, “Why bother making a distinction between counseling-psychology approaches and expressive therapy approaches towards play therapy?” In an expressive therapies approach, it is the actual doing or playing and creating of something new, beyond manipulation of the play toys, that enhances the client’s experience and provides tangible evidence of therapy beyond the sessions themselves.

Typically, the expressive arts play therapist endorses a more nondirective approach (Axline, 1971; Moustakas, 1992) and looks for opportunities to enhance the therapeutic space. In this context, the “therapeutic space” refers to both the physical and emotional connections between the therapist and client, not simply the actual physical space in which a therapy session takes place. When using the expressive arts in play therapy, the therapist seeks, at all times, for ways to marry play therapy and the expressive arts together. The notion that creating something adds a depth of self-exploration to therapy distinguishes expressive arts in play therapy from most other play therapy approaches in which play and interaction between premade and available toys or supplies is the more central focus. The opportunity for genuine engagement in the therapeutic process through the use of the arts and play is emphasized in expressive arts in play therapy, and the successful use of art materials in the playroom has been widely documented (see Green & Drewes, 2013; Norton & Norton, 1997; O’Connor, 2000; Schaefer & O’Connor, 1983).

RESEARCH

While there has been research into the use of drama, art, music, dance, movement, and intermodal expressive therapies as primary tools in play therapy, there has been little research addressing a stronger emphasis on the use of expressive therapies within play therapy.

Over the past couple of decades, there has been an increase in play therapists adopting expressive art therapy techniques for use within play therapy sessions. Eliana Gil (2012) and Cathy Malchiodi (2008), the leaders in employing expressive arts in play therapy with traumatized populations, have published several instructive books on the value of combining art and play therapy techniques in helping clients dealing with anxiety and loss, and developing mastery, coping skills, resilience, and self-regulation to achieve individual, family, and community restoration. In the area of family therapy (family psychotherapy, systemic therapy, and art therapy for children), Lowenstein (2010) edited a book entitled, Creative Family Therapy Techniques: Play, Art, and Expressive Activities to Engage Children in Family Sessions. She included documented therapeutic
approaches collected from over 20 Registered Play Therapists (RPTs), in which both art and play modalities were used:

- Trudy Post-Sprunk used the “create-a-family” collage to help families visually express their emotions about their family dynamics and to increase family members’ awareness of one another.
- Lois Carey integrated miniature objects into a family genogram. Genograms are widely used within the expressive therapies, social work, and counseling-psychology to illustrate the roles and relationships of family members. The addition of miniature objects provides clients with an extra element of control and offers the possibility of manipulating or changing the relationships depicted.
- Connie-Jean Latam described using animal miniatures in sessions to express characters and relationships in the child’s play.
- Angela Cavett adapted a traditional scavenger hunt, making it a creative game to increase positive experiences within the family.
- Karen Freud used a box of memories to visually depict family relationships.
- Darryl Hastram encouraged families to make family sculptures with puppets to deepen the awareness of family dynamics.
- Jennifer Olmstead made a “nighttime protection potion” in her sessions with abused children so the children could carry the potion with them to create a sense of safety.
- Sueann Kenney-Noziska created “farewell fortune cookies” for use as transitional objects during the termination process.

In these examples, a generous, playful spirit is incorporated within the development of the therapeutic relationship. This includes a frequent use of creative approaches (such as art, music, dance) with the clients in the therapeutic sessions. The play objects were used to promote playful expression and progress toward the therapeutic goals.

In the area of group play therapy, Chapman and Appleton (1999, p.179–191) bring together the work of other group play therapists, including Landgarten (1981), Riley (1999), and Rubin (2005) in using art media in therapeutic sessions. The collection focuses on structured or unstructured group play and how the directives would meet therapeutic goals. By integrating art into group therapy sessions, it provides an opportunity to visually identify and understand the roles (leader, mediator, or follower) participants reenact within the group process. The group setting allows for a safe space and the in-between space for the group members to try out new attitudes and shift their perspectives.

TECHNIQUE

Therapist Training and Qualifications

Over the past 50 years, the practice of play therapy has grown nationally and internationally, allowing for the creation of training programs and the development of a registration process through which professionals can document their training. In most play therapy training programs, both national and international, play therapists are required to have a graduate degree in social work, counseling, psychology, or a related human service field, with additional specific play therapy coursework. The coursework may include an overview of the history of and specific techniques in play therapy, advanced professional training in population specific applications, and ongoing supervision of specific play therapy interventions. Because of the growing interest in play therapy, the Association for Play Therapy has created standards for becoming a Registered Play Therapist (RPT) (www.a4pt.org). They require registrants to have a graduate degree in
one of the fields previously mentioned and to be licensed mental health practitioners who have a minimum of 150 postgraduate hours of play therapy instruction and at least 50 hours of supervision while accruing their play therapy experience.

As an example of a play therapy training program, Lesley University (Cambridge, Massachusetts), developed a Certificate in Advanced Graduate Studies in Play Therapy to bridge the disciplines of counseling-psychology and the expressive therapies. Coursework includes specific techniques in play and advanced play therapy, with a particular focus on multicultural implications for play therapists adopting an integrative approach with expressive therapy techniques (art, dance, music, drama, etc.).

In the integrative field of the expressive arts and play therapy, therapists may also choose to become Registered Expressive Arts Therapists (REATs). The International Expressive Arts Therapy Association (www.ieata.org) requires a REAT to obtain a graduate or doctoral degree in expressive arts therapy or a related field with training in expressive arts, 500 hours of internship work, and 2,000 hours of postgraduate expressive therapies experience, plus 100 hours of supervised clinical experience. Graduate courses required to obtain the REAT include approaches to expressive arts therapy, individual and group expressive arts therapy process, ethics, psychopathology, and human development.

Client populations for expressive therapies in play therapy include children and adolescents in schools, rehabilitative centers, or clinics for the treatment of abuse; children in medical and hospital settings; and incarcerated youths and their families. There is also an increasing need to offer adults and seniors expressive approaches to deal with aging as well as medical and psychiatric issues and conditions. For certain adolescents, adults, and seniors, the use of play or expressive media may be seen by the clients as infantilizing. Therefore, sensitivity must be applied to meeting clients where they feel they can address their own positive memories of play in order to reengage with life. Also, for children with specific sensory disorders, the use of certain art materials, instruments, fabrics, and other sensory-stimulating materials may be counterindicated.

Logistics

Whether the playroom is in a traditional clinical setting, counseling center, or some other location, what remains constant is the play therapist’s conceptualization of what constitutes play and play therapy. The more varied the settings in which one practices and the presenting problems of the children with whom one works, the greater the need for flexibility on the part of the play therapist. In the remainder of this chapter, various techniques that use the expressive arts in play therapy will be illustrated through multiple vignettes.

First, how to conceive and create an appropriate playroom setup is illustrated by a graduate class within the Certificate of Advanced Graduate Studies in Play Therapy at Lesley University that employs experiential learning. Second, a crisis intervention community model is illustrated by examining therapeutic work with Ugandan girls and women who experienced violence and loss due to abduction and torture by the Lord’s Resistance Army (LRA). Third, a local, open-studio approach provides a case study of adults dealing with anxiety, depression, and related behaviors characteristic of arrested adult development.

In each of these settings, the emphasis is on the role of expressive media in creating, amplifying, and making meaning of the play therapy experience. This process may remain at the level of metaphorical symbols or reach the level of a dialogue in which the client is able to explore some restorative psychological work. In each example, the following techniques are “in play”:

- The process of making or creating a new toy
- The process of using an existing toy that evokes an integrative response
- The blending of different self-expressive art forms for catharsis and to reconnect with the community beyond the container of the therapeutic space
Further, each example illustrates how the boundaries of the therapeutic experience are expanded beyond the frame of a traditional play therapy session.

**Playroom Setup, Toys, and Materials**

General playroom setup should include a large room that allows enough space to move about but not so much that clients feel overwhelmed. Making sure there is enough privacy allows clients to feel safe in revealing their emotions and information. The following items are also helpful: a table or flat workspace for the client and therapist to use for games, art, or play, and shelves to store supplies, games, puppets, and other toys, as well as any artwork or homework the client creates (Kottman, 2011). In addition, the expressive therapy supplies may include natural objects (shells, twigs, sand, rocks); recycled objects (wire, string, cardboard, tin cans); general art supplies (paint, markers, paper, clay, glue, tape); scarves; musical and percussion instruments; commercial toys; and/or relational figures (dolls, action figures, animals).

**The learning environment**

Training future play therapists in how to bring the expressive arts into their play therapy work requires providing them with direct experiences using the materials and techniques. These experiences can and should include self-exploration; reflective analysis; field trip observations; small group role-plays in and outside of class to help students learn; experiential techniques such as mirroring, tracking, and restating of feelings (Kottman, 2011); and instructive integrative readings. Instructors might choose to equip a graduate classroom with a portable trunk of standard play objects (see Kottman, 2011), basic art materials, and items such as paper, felt, or fabrics that offer various textures and tactile sensations. Finally, students can be encouraged to bring donations of toys and materials to class to leave for future generations of budding therapists.

A directive I often use with my play therapy classes is one in which I ask the students to imagine their ideal play therapy room and to create a blueprint of what the space would contain. Drawing their ideal space invites them to express what they think is essential or most important. After placing all the images in a common space, I invite participants to review what appears to be most significant in all of the works. We explore practical elements such as storage, light, entrances, water, and work spaces suited to the different needs of special populations, such as hiding places and comfortable rest places for when a child is overwhelmed or messy and neat sections of the room where clients are able to experience the different stages of the therapeutic relationship. Using concepts from expressive art therapy practices that focus on the central area of the paper as one that contains the most important elements of the author’s central awareness or concerns, we look carefully at the center of each image. Observations are made regarding the center's clutter, colors, structure, or lack of these elements. It is important to point out to students the possibility of leaving the center of the blueprint as an open white space to represent the importance of the therapist–client relationship as the central element in play therapy, and indeed, most psychological processes. What students bring to the discussion is the openness of their playful spirits tempered by their concerns about how to trust their inherent skills.

**The “portable” playroom**

Sometimes play therapists do not have access to traditional, fully equipped playrooms. This is often the case for play therapists who work in nontraditional settings such as schools, hospitals, or in rural communities. For these play therapists, a portable playroom may be the best option.

As Cattanach (1997) discusses in “Settings and Materials for Play Therapy” in *Children’s Stories in Play Therapy*, “it is very important to define the playing space as a specific area in the environment so that the child can play and not-play in the same larger environment” (p. 37).
Because there may not always be brick-and-mortar walls, shelves with art supplies, and bins of puppets and blocks, the play therapist must be in tune with what truly makes up the “walls” of the playroom. For example, very simple portable playrooms were employed when working with Ugandan girls in their small, remote village of Lira. The outdoor environment, in this situation an area located under a tree, provided the symbolic walls of the therapeutic space. Materials were brought from the United States of America and were left behind for the clients to continue to use. While the therapist may provide various playroom objects, twigs, leaves, and pebbles might be just as effective and much more available. Further, in some cultural contexts, natural objects are often the materials most used to exchange ideas. As the sessions proceed, the interior therapeutic in-between space of the client and therapist is held by honoring what is created and sustained in the imagination, without the use of traditional playroom walls.

*The open play/art studio*

An open play/art studio is another alternative to the traditional playroom. Such a space can be particularly useful in adult or senior settings when play and art need to be made more accessible, approachable, and age appropriate. One such play/art studio was established in an abandoned factory warehouse in a rural community in central Massachusetts. A local, nonprofit organization had rented the space to run day programs that encouraged disenfranchised elders (65 and older) to participate in “creative play” as a therapeutic way of reengaging with others isolated in the community. Many of the older adults suffered from disabilities ranging from multiple sclerosis and brain injuries to mental illness. Homeless adults also sought refuge in the center. The large warehouse had old wooden beams and creaking wooden floors. Play/art materials were placed on tables made with sawhorses for legs and wooden tops covered in newspaper. Heaps of broken toys and recycled materials were contained in clearly labeled plastic bins. To the untrained eye, the scene looked more like a junkyard or toy repair shop than a therapeutic space. Some of the participants had their own containers for play cars, wheels, trucks, and other vehicles; dolls of all descriptions and sizes, including many with disjointed limbs, feet, hands, and heads; natural elements such as stones, branches, shells, and dried fruit; recycled items, wood, and fabrics; and even a bin for discarded super heroes. Every session involved spontaneous play with the toys and objects, often evoking patients’ memories of TV shows, movies, and heroes they had grown up with. The spontaneous play and memories evoked would lead to discussion between clients and therapists either right there in the studio or later in individual sessions.

Within the practice of expressive arts in play therapy, anywhere and everywhere can be a playroom as long as the therapist is able to maintain a psychological safe space for the client, be it a graduate student classroom with ample materials at one’s fingertips, a tree in the middle of a Ugandan village with just nature and imagination to create the play, or an old warehouse that looks more like Santa’s workshop of broken toys than an play/art studio. Play can be in play anywhere and with anything.

*Treatment Frequency and Duration*

Treatment may be as short as a single, hour-long session, or it may take years in an intensive, inpatient residential facility. The frequency and duration often depends on funds, protocols, or in some cases, geographic location. While working with the war-traumatized girls in Uganda, Dr. Jody McBrien and I stayed in the area for several weeks at a time, on four different occasions, over the course of 3 years. We worked primarily with the girls from three schools in the area.
to address the issues of trauma, depression, PTSD, and HIV. During our visits we attempted to meet with each cohort of girls at least three times. Each session lasted approximately 1.5 hours. In some sessions our focus was on interviewing the teachers, staff, and students to assess their current well-being. In others, we implemented specifically designed expressive art play sessions with the 12 girls in each group. When not in Uganda, we have remained in regular contact with the resident teacher and counselor, who received her graduate degree from a Ugandan university, to supervise her ongoing work with the traumatized girls, children who have HIV, and/or orphans.

The open studio for adults in Massachusetts was loosely affiliated with the local hospital and outpatient mental health clinics. Creative play sessions were offered for 1.5 hours once a week over a 1-year span. In addition, several retired artists and/or therapists worked in the studio on a daily basis. On average, approximately 20 clients participated in the studio each day. These adult clients who had issues coping with arrested psychological and social development had been referred to the program in the belief that they would benefit from a community-based intervention program.

**Pretreatment Assessment**

Assessing clients’ needs requires sensitivity to local mores. In the worst cases, the therapist must be able to remain present in the face of horrific stories and the direct evidence of traumatic death, dismemberment, violence, and the physical and psychological scars of those left behind. New therapists will often experience vicarious trauma and secondary symptoms associated with the severe emotional and environmental stress. In the case of my work with Dr. McBrien in Uganda, we were two White women working in an all-Black women’s school. This necessitated an awareness of, and active attempts to minimize the preconception of, domineering attributes associated with White privilege and power. The emphasis of all interactions had to be an acknowledgment of the common humanity of suffering and on collaborating to achieve resilience and resolution. While for the purposes of this chapter the details of working with severely traumatized populations are not elaborated, it would be irresponsible to downplay the complexities associated with interventions conducted by “outsiders” in such vulnerable and fragile communities.

As espoused by Landreth (2012), pretreatment assessment should happen first within the training and self-reflection of neophyte therapists. The process of assessing a person’s emotional state and readiness for exposure to new ideas and shifts in perspective occurs first in the classroom with the student therapists themselves. Once they have received the training and have self-reflected, the neophyte therapist can successfully go on to assess his or her patients for the same readiness for new ideas and shifts in perspective. In the field, assessment for the use of expressive arts in play therapy may be different depending on the setting and situation. In working with the girls in Uganda, the resident counseling psychologist at the girls’ school completed an assessment through which girls were identified who would most benefit from the brief expressive therapies in play therapy interventions. The assessment included evaluations of medical conditions, educational and social development, symptoms of PTSD, and symptomatic coping mechanisms. In the play/art therapy studio, clients were referred to the program by their psychiatrists, psychologists, social workers, case workers, or nurses. Having been assessed using the standard mental status evaluation upon admittance to the program, each client was interviewed by the therapist to review his or her expectations of the program, appropriateness for group work, and creative history. Treatment plans were individualized based on the client’s psychiatric history and interest in the creative arts. Basic interview topics included a psychosocial history of coping mechanisms, willingness to engage in play, a complete timeline history of the client’s childhood experiences with play, and subsequent adult hobbies.
Treatment Planning

Context, context, and context are three of the most powerful words in understanding the goals and treatment processes across cases. What remains constant is the inherent ability of therapists to ensure the therapy is playful as they search for possible ways to encourage client self-expression. Taking context into consideration, treatment planning is usually done in conversation with therapists, treatment teams, case workers/social workers, and hopefully, the patients themselves. Whenever possible, treatment planning with input from the patient can help create a more realistic plan in which the patient gains a sense of control over his or her future and the outcome of his or her work. Generally, treatment plans are created at the onset of treatment to give sessions a trajectory that both patient and therapist can agree on, and is reviewed at various times throughout treatment.

Doing crisis interventions around the world following natural and manmade disasters poses unique challenges and there are complex, changing dynamics on the ground when compared to work in developed clinics in Western society. Flexibility becomes paramount. The goal of the treatment plan for the girls in Uganda was, even within a short period of time, to increase communication skills within the community, raise the girls’ self-esteem and sense of self-worth, and provide increased resiliency skills. Ever careful not to retraumatize the girls, care was taken to wait for clues and to bear witness to their stories rather than jumping ahead to ask intrusive, probing questions. Against this backdrop, the introduction of play objects proved invaluable to enabling the girls to express themselves more freely and to build their self-esteem. More importantly, expressive arts in play therapy techniques proved fundamental as a successful mode of expression. The girls could experience a cathartic release while feeling held and heard within a supportive community, allowing them to build and/or rebuild strong ties with and support for each other.

In the play/art open studio, the treatment goals focused on the introduction and maintenance of positive coping skills to enhance areas of arrested psychological and social development. While individual clients attended the sessions, families and the general community were encouraged to celebrate the clients’ creative expression pieces via a public, community exhibition. To some, it may seem unnecessary for adults to develop mastery in an art or craft. However, in this population of adults, the use of play/art tools encouraged problem solving and gentle risk-taking behaviors that enabled the participants to shift away from negative ritual behaviors. Healthier, sustained practices of well-being were practiced with a resulting improvement in the quality of the clients’ lives.

Stages of Treatment

The Case of Carrie

Carrie was a 13-year-old who lived in Uganda and was one of the girls with whom Dr. McBrien and I worked. Carrie, whose fragile thin body looked as if she might only weigh 40 pounds, had been conceived when her mother was raped by an LRA soldier, and she was born with HIV. The teachers at St. Katherine’s School were trying to integrate the now-orphaned girl into the community. Emma, the school counselor, suggested that Carrie, who had few friends and exhibited severe depressive symptoms, would benefit from the expressive art in play therapy sessions. Though the school had several hundred students, we were only able to provide services to the most needy of them, due to limited
time and resources. After the girls had been assessed and chosen for treatment by Emma, we started with a community-building activity of sharing local songs and learning the meaning of each girl’s given African and Christian names. Afterward, I invited the 13- to 18-year-olds to find a branch, leaf, stone, or other object within the school compound with which to express themselves and how they felt about the mzungi’s (White women’s) visit and the special after-school time. They were then invited to depict their chosen objects on paper with paint and paintbrush. Carrie picked up a small paintbrush and began to paint a picture of a leaf she had found. She enlarged it on the paper, showing the veins and pathways of the interior leaf in bright colors on her paper. She would periodically look up at the other girls and smile. The older girls, who tended to isolate her, became interested in her new-found talent in expressing herself.

Next, using Model Magic clay and red clay found in the ground, the children gathered to make miniature local animals: goats, monkeys, giraffes, lions, rabbits, and so forth. This activity was chosen because the children basically had no toys at school or at home, and we wanted them to create something to have as a transitional object after we were gone. For practical purposes, making the animals in miniature provided more materials for others. At the same time, creating miniatures served to metaphorically empower each youth to feel more attitudinally in control over her creative choices and metaphoric life where in reality, there was little choice. We next encouraged the girls to get into triads and create a story about the animals they had made. The “embodied play” of both making the animals and acting out/creating stories expanded the girls’ experiences of their inner and outer realities through the sensory exploration of the materials (Cattanach, 1997). The metaphoric expression of the animals’ characteristics portrayed how the individuals were feeling, their coping strategies, and the implications of getting along with others who were outwardly or inwardly different. In this way, more confidence, self-esteem, and validation were established to inspire playing alone and together beyond the sessions.

Caught by a sudden deluge of rain during our play, we quickly ran to an abandoned clay building structure. Though the roof leaked, it provided us with more shelter than the tree outdoors. As we hovered together, two older girls took Carrie under their wing and encouraged her to participate in a story. Together they created the following tale:

Once upon a time, there was a turtle and a bird. The turtle told the bird that he wanted to fly. The bird glued wings onto the turtle. As he started to fly, the glue started melting. He soon fell onto the stones below and cracked his back. That is why turtles now have cracks on their backs.

Emma and I were able both to support their courage in creating the story and also to draw attention to the support the community of girls had begun to provide one another. Carrie went back to her leaf drawing and drew the paths the turtle had gone on. An older youth gently put her arm around Carrie, saying they were all on the same path now. Everyone knew and felt the grief of the traumatic experiences that were expressed, and as therapists we could gently guide the stories in and through the interaction.
One year later, when I returned to the girls’ school, the counselors were concerned because Carrie had been refusing to take her HIV medicine. When she heard the expressive play/art group and the White lady were coming back, she indicated she wanted to be part of the group again. In another series of sessions, Carrie gently participated, surrounded by the renewed friendship of the group. She saw the positive attention she again received from the others and vowed to resume taking her medication. The girls renewed their commitment to look out for her beyond the foreigner’s visit. Perhaps metaphorically, the turtle and the bird of the girls’ tale had merged. We sat again under the tree and spoke of the future Carrie wanted. Therapeutically, I reflected her choice and validated that she truly made a difference in the group and beyond. She discovered, or rather rediscovered, a playful attitude in the cracks of life and the nature of “toys” found in the local vegetation.

The Case of Normal

At the community center in Massachusetts, Norman, a 68-year-old Caucasian male of average height and a solid build, looked a bit disheveled and appeared despondent. His parents had died of medical illnesses when he was in his 50s, and he had no siblings. Norman had recently lost his job as a machinist. He was divorced as well as estranged from his two adult children who lived in California. He had also lost his driver’s license due to frequent binges of alcohol abuse and drinking while driving. He was referred to the community center by his social worker, who was concerned about his isolation and alienation from a sense of community because he lived in a remote country area in a disordered home he had inherited from his parents.

During his first session in the play/art studio, Norman sat, agitatedly spinning and flipping plastic shapes that were on the table. A small smile drew across his face as he noticed a pile of Tiddlywinks and remembered playing with his cousins in his youth. He saw a jumble of wire, which he turned into a homemade Slinky, a toy known for bouncing independently and moving on the staircase if one angled it right. By the second session, Norman was found playing with the Corgi and Dinky toy cars, lining them up, especially the beat-up old cars, grunting that the cars looked like him. Perhaps his most notable activity occurred during his eighth visit, when he actively started searching for toys rather than art materials, almost as if to find something that had been lost long ago. When he came across a certain box, Norman sat with tears in his eyes, fixed on something that seemingly had meaning. Gently interrupting his gaze, I asked what had caught his eye. In a choked voice, he pointed at a mechanical robot he hadn’t seen since he was 10 years old, when his father came home with a special box for his birthday. He remembered that day as one of the best in his life, when his father actually took time with him, even though he was working three jobs. He remembered his father telling him that he was in control of the robot and could make his own choices with it. Now, Norman decided it was time to take charge of his life rather than being told what to do, as he had for most of his life. With new determination, he solicited help from another man in the group to make a soap-box derby car, which ended up being quite a lengthy process. Over the next few months, he found parts and used paint to create the “Super Mechanical Robot Man Car.” He kept the production going, eliciting nearby children in an after-school program to make cars of their own to compete in a challenge day. Clearly, Norman had chosen life.
Treatment Strategies

Ultimately, the integration of expressive art media into traditional play therapy enhances the level of interaction between clients and therapists in therapeutic relationships. In the classes, blueprint sketches of their ideal playrooms created by neophyte therapists stimulate them to engage in useful and necessary internal reflections about their expectations of what a playroom is. When discussed, the playroom blueprint can provide neophyte therapists with feedback about how they are metaphorically ready and capable of being therapeutically present for their clients.

In the case of the Ugandan girls, soft sculpting materials, as well as natural, found objects, allowed them to create miniature, portable animals they used to give voice to songs and stories of adventures to provide them a sense of safety. The movement and sharing of the creation of the sculptures created a closer intimacy between the facilitator/therapist and the group. These types of expressive activities using play objects—whether human-made or natural—attest to the utility of their inclusion in the play therapist's tool box. When clients have exhibited prolonged dysfunctional symptoms, such as grieving or loss, providing them with options for expressing themselves through symbolic art materials, natural objects, and toys can help them move on in the healing process. Having the flexibility to employ the concept of “self as instrument” (Knill et al., 1994) aids in creating a compassionate therapeutic relationship. My therapeutic presence with the Ugandan girls, via the symbolic nature of their soft sculptures, enabled me to understand and explore with them the projected characteristics of the animals that laughed and cried.

In the open art studio, seeing Norman’s pride as he sent a youth off in one of his constructed derby cars brought home the value of honoring in our clients the best of who they are. Play is used not only to assess and facilitate growth in others, but also to provide therapists with a paradigm for assessing themselves with an open, inquiring mind and fostering their own growth. As Brown and Vaughan (2009) remind us, “play shows us our common humanity” (p. 199). Through his spontaneous play and his creations, Norman was able to see himself as a whole human being instead of a person with substance abuse and clinical depression.

CONCLUSION

In summary, the expressive nature of expressive arts in play therapy requires additional skills and familiarity with the aesthetics and methods of the arts to enhance the play therapy encounter. Given there are increasingly more opportunities to work with clients outside of the traditional office frame of therapy, an increased understanding of the imaginative arts in conjunction with play objects produces unique possibilities for psychological integration. Making meaning from the integration of the sounds, sights, tastes, and textures of created or borrowed play objects can enhance the repertoire of a play therapist. The introduction of expressive therapy techniques (art, dance/movement, music, drama, etc.) into traditional play therapy enables the therapist to achieve a deeper understanding of the client’s internal dynamics. The process of creation, unlike solely playing with toys, makes available to the therapist and client a metaphoric and symbolic understanding of what is going on with the patient. Whole new layers of meaning come into play.

REFERENCES


CHAPTER 14

Using Drama in Play Therapy

STEVE HARVEY

THEORETICAL RATIONALE

Several authors have pointed out how crucial pretend play is to child development, especially in the ability to understand and communicate social experiences (Garvey, 1990; Russ, 2004; Stagnitti & Cooper, 2009). Role-playing and dramatic enactments are a central part of the pretend play abilities children naturally develop as they reach school age. By the time children are 5 years old, they usually can spend hours creating, directing, and acting in improvisations with peers and family members. While different theorists may emphasize various aspects of dramatic play, the central purpose and benefit of these episodes is the development of social communication and the ability to co-create relationships and meaning with others. This dramatic pretend play both reflects and is influenced by a child’s attachment history, experiences with trauma and separations, understanding of how intimate relationships work, family situation, and social/emotional development. The degree to which children develop the ability to engage in dramatic pretend play contributes to the quality of their later interpersonal relationships, social creativity, experience of positive emotion, and resilience when confronted with challenge. Dramatic play provides a natural stage in which children find ways to negotiate their emotional experiences in response to and with others. When these enactments are successful, children are able to transform their emotional responses to the people who are important to them in a creative manner and to bring these skills into their day-to-day lives. When children have difficulties, the central goal of dramatic play is to help them develop or restart this natural problem-solving ability.

Some theories and concepts related to children’s development of intimate trusting relationships as well as their development of the ability to engage in dramatic and pretend play are central to understanding how the natural benefits of dramatic play can be applied in play therapy (Harvey, 2003, 2005, 2006). These concepts include attachment, attunement, and the development of pretend play and dramatic expression.

Attachment and Attunement

Several of the primary authors in the field of dramatically oriented play therapy have emphasized attachment theory as central to the dramatic expression of children and families (Cattanach,
Attachment refers to the lifelong, significant emotional bonds arising from the interactive communications between children and caregivers during infancy (Ainsworth, Bleher, Waters, & Halls, 1978; Bowlby, 1972; Cassidy and Shaver, 1999). Early on, this interaction centers on how children express distress and the way caregivers are able to respond to these expressions. When this sequence is successful, more often than not the caregiver is able to soothe the child and a secure interaction style develops. However, when a caregiver is unable to calm the child, insecurity results. As children mature, their essential security/insecurity is reflected in the dramatic expressions and the scenarios they play out. Harvey (2000a, 2003) suggests important family emotional communications are influenced by these basic patterns of interactive security/insecurity, and this can be seen in the dramatic play among family members. James (1994) describes how the experience of psychological trauma impacts attachment interactions and, in turn, negatively impacts ongoing family interactions. These influences can be seen in dramatic play enactment as well.

Attunement is another concept related to the emotional communication between children and caregivers. Attunement refers to the clarity of the interactions and the degree to which each is able to read and effectively respond to the other (Stern, 1985). These patterns develop in the moment-to-moment flow of communication, especially in the nonverbal context, around specific emotions a caregiver and child share while co-creating intersubjectivity between them. Intersubjectivity here refers to the state in which individuals share feelings, intentions, and motivations. Harvey (2006, 2008a) and Kindler (2005) use the concept of affect attunement (Stern, 1985, 2004) to describe the importance of dramatic communication in a play therapy context.

These patterns of attachment and attunement are reflected in all the elements of the dramatic expressions of children and their families. Play techniques can be used to recognize and address this intimate social communication within dramatic play metaphors. Harvey and Kelly (1993) report on a long-term case study in which a young child's attachment and attunement patterns from his second and third year were known and documented. Records from child protective services indicated this boy had been both physically abused and abandoned during his infancy. Observations of the interactions between the boy and his mother demonstrated clear attachment insecurity and virtually no attunement between them. Several years later, when he was seen in a family-oriented intervention with adoptive caretakers to address periods during which he showed high intensity anger in the home, this child's dramatic story and his use of roles and characters were clearly related to this history. One character in particular the boy created in sessions was a large bear (soft animal) that had spiders in his stomach. This character presentation appeared to fit the insecure style of attachment interaction he had displayed with his abusive parent several years earlier. Dramatic elements like these were then used to co-create scenes of emotional safety in a successful dramatically oriented, family play therapy intervention.

Development of Pretend Play

Children's abilities to pretend within their play also emerge during their early years alongside their abilities to engage in intimate social communication. Children are motivated to pretend within play because it is intrinsically pleasurable. Pretending occurs as children begin to substitute one object for another, attribute a property or characteristic to an action or object, and make references to an absent object or place within the play (Stagnitti, 1997; Stagnitti & Cooper, 2009). At about 20 months of age, children's dramatic play begins to include scripts based on personally experienced events from their home life. At 2 years old, children can begin to logically sequence simple actions and can combine separate play actions. In their third year, pretend play sequences employ the use of an object, such a doll or puppet, as an active participant in the
pretending. By 4 years old, children are able to expand their play scripts to include both personal as well as fictional events, and they can negotiate the content of the play characters and story with peers or family members. Plots become logical, preplanned, and complex, even when highly imaginative. Objects such as dolls or puppets have a life and character of their own. Children are able to develop several roles and are able to substitute any object for an intended purpose within the action. By 5, children are able to assign roles to others, negotiate a story and play scenes that include interaction, and use a large variety of objects as set and prop pieces to move the action forward. These scenarios can sometimes be played for several days or longer, and they are often filled with a variety of characters. With the emergence of this level of pretend play, a child uses a range of cognitive abilities, social interaction, problem solving, and emotional regulation skills (Russ, 2004). These natural developments serve as mechanisms for social/emotional growth.

Development of Dramatic Play

Jennings (2010, 2011), a drama therapist, created the Embodiment-Projection-Role (EPR) model in which both a child’s attachment/attunement interactions and the emergence of pretend play are integrated into a theoretical understanding of the development of dramatic play. This model charts the progression of dramatic play from birth through age 7. According to Jennings, an initial element of dramatic play emerges during a mother’s pregnancy as she begins to visualize/imagine herself interacting with her child and then communicates with her neonate even though she cannot see the child. Within the EPR model, babies are born with the capacity to dramatize as demonstrated in their capacity to respond to their caregivers with imitation and to initiate their own innovative interactions. During these interactive episodes, infants and their play partners can co-create “as if” responses or scenes with each other. Here, as if refers to a state in which participants’ expressions involve more than literal, concrete reality. Interactive face play and games such as hide-and-seek incorporate physical action to clearly represent and co-create shared meaning and positive feelings between parent and child that go beyond basic physical behavior.

In the first year of life, children’s dramatic expression develops through physicalized interactions. Gradually, it becomes more complex as the child explores the world beyond the body, bringing objects and imagination into projective play. By the age of 5, children begin to use roles in their dramatic play (Jennings, 2010). Jennings refers to the emergence of role playing and all the complexities that come with the creation of pretend characters as the dramatic response and sees it as essential for the development of empathy and communication. Children’s dramatic responses incorporate both their history with attachment and intimate communication and the development of their ability to pretend. Children who are not able to spontaneously use enough of the important dramatic elements within their play will have or will develop social/emotional difficulties (Jennings, 2010).

Jennings reports on a project in which EPR concepts were used to evaluate and provide a week-long intensive intervention for a group of nine children ages 7 to 11 who had special learning and social/emotional needs due to problems within their family situations. Most of the children had been exposed to domestic violence. During the week, the children were introduced to physically oriented play activities as a group (embodiment). These activities included actions such as creative movement involving balance and repetition, sensory experiences, and parachute play. This was followed by art work with crayon drawings of hand and body outlines, using clay, and making collage pictures (projection). Finally, they attempted to introduce several role-playing activities such as puppet play, story enactment, and dramatic playing (role). However, none of the children could productively engage in this level of action. When the leaders persisted in trying to structure role-related activity, the children became angry, ran in circles,
hid, or tried to escape through the windows. Any storytelling they were able to produce involved violence and aggression solutions.

Based on the EPR model, this lack of role taking was significant. These children were able to engage in dramatic play that was more physical/embodied or consisted of projection using objects. However, no role taking or dramatic response play developed naturally. Jennings suggests that this expressive immaturity typifies the dramatic play of children with emotional or behavioral problems and suggests evaluations could be designed to identify developmental gaps in children’s dramatic responses. Intervention could then be developed to address such gaps.

Gallo-Lopez (2012) uses a case study to report the progress made by a young boy with the diagnosis of autism spectrum disorder (ASD) made during a long-term, dramatically based play intervention. Children with ASD have significant impairments in social interactions, show difficulty having empathy for others, and have difficulty understanding that other people have different thoughts and intentions. Such children may also show a significant gap in their ability to use pretend play and show restricted, repetitive, stereotyped behavior and interests that can impact pretending (American Psychiatric Association, 1994). Even though this boy had not experienced the same psychological or family problems as the children described by Jennings, his play lacked a dramatic response. However, during the intervention, he was able to use sensory and then projective play while interacting with his therapist. After several sessions, he was able to begin enacting roles in simple scenarios during which the therapist guided him step by step into more developed and mutual dramatic play.

These concepts of attachment, attunement, play development, and dramatic play development all provide clues as to the ways in which play therapists can use dramatic expression to plan play interventions.

**Ingredients of Change**

The emergence of dramatic expression naturally offers children an avenue to engage in social communication with people who are important to them about topics and themes they find meaningful. Typically, these themes are related to intimacy, emotional security and safety, and emotional experiences they find overwhelming. The mutual participation in the process of dramatic improvisation through role playing and the enactment of imagined characters serves to co-create an immediate sense of relationship, meaning, safety, and problem resolution. Beyond the development of social communication, when dramatic play is performed in such a way as to be satisfying for the players, it contributes to the children’s experiences of positive feelings, sense of security, catharsis, regulation of high levels of distress, and resilience. Each of these elements has been identified as being among the inherent therapeutic powers of play (Schaefer & Drewes, 2014).

Drama becomes particularly relevant for young children given their relative inability to use complex verbal communication. Drama is even more important when children experience overwhelming experiences associated with trauma and the intense feelings that can occur in response to family distress. Additionally, dramatic expression lends itself to the experience of heightened affective states and the increased awareness that emerges when the roles, stories, and metaphors take on intersubjective meaning during improvised interactions. Hoy (2005) refers to this shift of emotional intensity as surplus reality. In this context, surplus reality refers to strong and highly personal emotional experiences that typically go unspoken or unacknowledged in daily interactions. One of the intentions of using dramatic play is to facilitate a child’s (or a child and family’s) expression of these internal experiences using such methods as spontaneous role-playing. When a therapist is aware of such moments and is able to join the client’s dramatic expression, important moments of experiential change can occur (Kindler, 2005). Harvey (2011b) refers to such experiences as pivotal moments of change.
Dramatic play can be used in interventions with both individual children and with families (Harvey, 2000b, 2003, 2006; Oxford & Weiner, 2003). While the use of role-playing, character development, and interactive scene work need to be adjusted for family applications, the general theory and techniques of dramatic expression still apply. In general, work with families requires the therapist to do more planning and to verbally direct the intervention, especially with the caregivers, than do sessions with children alone.

PROCEDURES AND TECHNIQUES

The use of role-playing in all its aspects is the main contribution of dramatic play to practice of play therapy. The end result of using this core technique is for a child (or child and family) to spontaneously use roles to establish a dramatic scene in some way related to the preseting problem. In-session dramatic episodes often relate to an emotional conflict that is hard for the child and/or family to verbalize effectively. Often these emotional conflicts are related to the child’s (or family’s) felt sense of attachment insecurity, high levels of anxiety related to trauma experiences, and lack of caregiver/child attunement that contributes to feelings of isolation.

Using dramatic play in the therapy context involves incorporating several of the elements adapted from creative dramatics, such as character development, use of costumes and sets, dialogue, and storytelling developed through actual enactments. At times, scenes are developed using short rehearsal, though most of the central scenes in an intervention are created using improvisation. When using dramatic play, the therapist engages in both directive as well as nondirective techniques and tends to be more involved in the play action than in other play approaches. For example, the therapist does teach and coach all of the dramatic aspects of the play to facilitate and extend the child or family's basic initiatives. However, the goal of any intervention is for the child to be able to freely use his or her natural dramatic ability as a mode of expression with the therapist participating as an audience, witness, or willing actor in the core scenes that emerge. (See the case example later in the chapter for an example of a therapist's multiple use of self.)

When children have problems, their spontaneous dramatic play becomes disrupted in some way. This is especially true when children have developed problems related to insecure attachment, reexperiencing of feelings related to psychological trauma, or from the isolation and loneliness related to disruptions in emotional attunement with significant people. Some problems can include role-playing dominated by frightening and helpless/ineffective characters and an overabundance of scenes with tragic endings. At other times, the whole process of the drama lacks any character or plot development at all, or the drama simply stops and does not proceed when themes are distressful. The play can lose the pleasure of improvisation. In the case of children who have developmental disorders, dramatic play may not emerge at all. When such problems occur, the play therapist can identify the dramatic elements best suited to developing and extending the child's dramatic response and develop interventions to address those causing difficulty within the play itself.

The specific dramatic skills that are useful to focus on in play therapy include a child's ability to (a) adopt roles; (b) improvise interactive scenes both independently and with others using negotiations, directing, and the enactment of roles with a variety of characters; and (c) create a sense of a plot or story using settings and props. These skills can be taught by the therapist in a directive manner if the client is not able to perform them. When needed, this teaching is usually done in the beginning part of an intervention.

Elements of the process of drama-making can also be used within play therapy. This process if usually best developed though spontaneous improvisation. This improvisation is similar to play
therapy in general, in that children are encouraged to generate drama in the ways they determine as they are able to use roles, role-playing, and plot development. Dramatic play is clearly different from the literal reality of daily activity and has an “as if” metaphorical quality in which anything can happen. The activity becomes filled with creative extensions of typical life and can have imaginative aspects that can become totally fanciful. Most children also show a pleasurable immersion in their play activity, and this positive feeling fuels players to continue their improvisations. Dramatic play therapy can be set up to emphasize these elements as a central expressive form of intervention. Once the child (or family) creates a dramatic response, observations can identify how the participants resolve conflict regarding distress/security (attachment-related themes) and emotional isolation (themes related to attunement mismatching) within the story.

The following two case examples illustrate how clinical observations of the role-playing, plot development, and the “as if” imaginary quality of the children’s unfolding play revealed their difficulties and how these observations contributed to the therapist interventions.

**Case 1**

A 6-year-old, Tim, was referred for mental health intervention due to difficulties sleeping, excessive worries, and conflict with his siblings. His mother reported there were strong, ongoing conflicts among several related adults in the extended family. The boy had also been exposed to domestic violence for much of his life. During his initial dramatic play session, Tim set up a group of large figurines (dinosaurs and scorpions) around a Lego castle. He said the figures were dangerous and he showed them clearly engaged in attacking actions. Tim placed a few knights and the king inside the castle. The castle and its inhabitants were much smaller than the dinosaurs and scorpions. As the scene developed, the king and his knights came under an increasing threat from the much larger group of animals just outside the castle walls; then Tim stared to fly the king as if he were plane. He, as the flying king, then shot and defeated the attacking force to end the scene. The roles the boy played out, of larger predators and a smaller hero/protagonist who could rise to a challenge and defeat his adversaries, emerged quite naturally, as did his use of an action plan or plot line. During the action, the therapist was able to join the scene by adding dramatic lines and action after Tim had cast her as one of the king’s helpers during the counterattack while the battle went on. A short while later, the boy invited the therapist to chase him around the play room. During this movement play, Tim invented commands to have her stop when she moved too close and then to have her continue the chase in a stop-and-go manner. This extended the toy play into the interactive roles of a chaser and one who is chased but who can exert the commands. Tim expressed positive feelings and said he was having fun. These good feelings seemed to propel him onward in improvised action and plot development.

The emotional difficulties Tim was having in his family were clearly reflected by the dramatic action in his free play. The roles of the large attacking figures surrounding the king and the story of the counterattack followed by the boy’s use of the roles involved in the game of chaser and chased also reflected a type of genuine creative solution to the challenge of the family’s conflictual emotional environment. Even though the drama suggested very strong aggressive emotional content, the boy remained calm, engaged, and even appeared to be enjoying the expressive activity. Both he and the therapist interacted in a cooperative and reciprocal way and created attunement between them during this play episode. Despite the family’s reports that Tim’s anxiety and anger were significantly impacting his life, these problems were positively transformed during these dramatic enactments.
Case 2

Hayden and his mother, Kylie, were referred for a mental health intervention by Hayden’s court-appointed attorney. Child protective services and the family court had been involved with Hayden and his parents since his birth due to ongoing domestic violence and the father’s physical punishment of Hayden. The father had also frequently threatened and verbally demeaned him. His mother had made several suicidal gestures, such as cutting her wrist or lying down in front of her partner’s moving car, both while Hayden was present. At the time of this referral, Hayden was living with his mother with court-ordered monitoring by his attorney. Prior to the referral, Hayden was showing ongoing aggressive outbursts at school, and he was making comments to his classmates that he wanted to kill himself.

During one of the initial sessions, Hayden and Kylie were asked to develop a story about a family using a variety of puppets. They were told they could also use several large pillows to create a house and a village. As the story unfolded, the boy had several of the puppets die in some way. The spider was bitten by the snake. A bird was poisoned. The therapist asked Kylie to leave for a short while to allow Hayden to develop a story by himself. During his story, the boy continued to enact the deaths of the puppets until they all were killed. He then went into the pillows and had them fall on top of him saying an earthquake had destroyed the house and he had been killed. When Kylie came in, she cast herself as a rescue worker and tried to help her son. In their joint action, however, he remained “dead,” buried among the rubble of pillows.

At this point, the therapist took on the role of the lead rescue worker and guided Kylie’s character to more effective action to find and dig her son out of rubble pile of pillows.

The themes of dying in his dramatic play were clearly related to this family’s history. The limited dramatic action and the difficulty both he and his mother had in developing a more positive ending to the play scene were troubling. As Hayden developed this drama, he displayed very little emotional expression or concern about the direction the narrative was taking. After he enacted his death in the earthquake, he closed his eyes and became very passive, despite Kylie’s efforts as the rescue worker. Her role performance was half-hearted, and she gave up shortly after she attempted to join the scene. The end of the enactment lacked an imagined reality and the sense of enjoyable improvisation was lost.

Such enactment and thematic material indicated Hayden and his mother likely had joint experiences with insecure attachment as well as trauma. Following these enactments, the therapist, Hayden, and his mother were able to use the scene they had just played out to identify and talk about the many complex problems they had encountered all of the boy’s life. They could then begin to plan how they might develop more positive alternative scenes for the therapy that lay ahead. Such scenes included the possibility of developing positive roles and endings.

These case examples illustrate how roles, scene and story making, the development of imaginative metaphors, and the level of enjoyment of creative improvisation are reflected in the dramatic play as they naturally appear in a clinical situation.

In the first case, the young boy was able to create the roles of both a protagonist and an antagonist, develop scenes and the setting of a battle between them, and create a story with a resolution while he shifted into an imaginative state he clearly enjoyed. In this situation, the therapist became a play partner, enacting the complementary roles into which he had cast her while she
validated his metaphorical world. In this session, he was able to transform himself from a boy in a very troubled state to a hero who could master a variety of large challenges in a world he co-created with his willing therapist, who accepted his imaginative expression. Both shared a genuine pleasure of being together in the real time as well as in the imaginative world of their mutual co-creation. They co-created an experience of emotional attunement together.

In the second case, the boy and his mother were also able to generate roles and play out a scene of a victim and rescuer. However, their enactment and role performance became constricted and both the boy and his mother lost a sense that they were co-creating an imaginative scene together. The emotions from their traumatic and insecure pasts intruded into the drama. Both the mother and boy lost the pleasure of becoming immersed in improvisation. They could not find a creative ending to their story. In future sessions, the therapist could become a more directive coach and director to help this parent-child dyad develop scenes that held more interest for them in finding more creative enactments that could become more emotionally satisfying.

The end result of incorporating dramatic elements in play therapy is the creation of a therapeutic stage upon which participants can play out their private emotional worlds within the theatrical structures of characters and storytelling. Adding dramatic play into play therapy enables clients to achieve their highest possible levels of expression, facilitating heightened communication in which the players' inner emotional experiences are shared in an accepting environment. This allows the child to experience the creative regulation and rearranging of these inner worlds.

**Therapist's Role**

The therapist’s central job in dramatic play therapy is to facilitate the development and use of dramatic expression so the children’s expressions are relevant and genuine to their lives. To accomplish this, the therapist generally needs to acknowledge the child’s initial dramatic attempts and respond to them. However, the therapist may be cast in several roles within the child’s story, may shift to an audience member, and at times may need to take on more of a directorial role when the role-playing and plot break down (Gallo-Lopez, 2012). This was the case in the first case example, when the therapist both initially observed the scene of a boy enacting an attack on his castle only to soon after take on a role of a defender. Later, the therapist was cast as a “chaser.”

Harvey (2005) has identified the therapist as being a “master player” to account for the potential need to take several roles to help the child’s improvisation proceed. When the therapist is cast in a drama, Irwin (2014) suggests that the therapist use a “stage whisper” and ask the child/protagonist for instruction as to what to say in the next line and for other stage directions. At other times, and in some techniques, the therapist needs to take a more active part in directing the scene. This is usually the case when the child (or family) is unable to continue a story, the drama requires structure to continue, or participants need help in developing a character or role. This often happens when the child has a history of insecure attachment and poor attunement.

The second case, involving the boy and his mother, is an example of the therapist offering this kind of direction. At one point during an enactment of the boy’s death, the mother was unable to become a rescue worker in a way that moved the scene forward. Both she and boy actually began to reexperience extreme fear related their very violent past in the present moment. The therapist stepped into the improvisation at this point to help direct a more positive ending using the actions of a new character. The therapist became another emergency worker alongside the mother so they could work together to save her son from the house destroyed by the earthquake. He then led a discussion about the rescue and saving metaphors as they related to this family’s past. In this case, the dramatic improvisation had moved into the realm of the reexperiencing of a painful past event, and the therapist needed to join the action in a proactive way.
There are also times when the therapist needs to use direct teaching to create an aspect of dramatic play for a child. This is especially the case with families who are used to a conflictual communication style. This teaching helps the participants learn how to create a role and engage in role-plays that are productive and creatively responsive to each other while they can remain in an imagined or “as if” state in an enactment. In this situation, the therapist can begin a program to instruct a child and/or family to be able to enact a role in a step-by-step fashion. Interactive scenes can be developed in a similar way. The therapist might also cast him/herself as a storyteller to reflect the feelings of the participants. However, even when taking on these more directive roles, the therapist attempts to respond and use the participants’ feelings (in the case of storytelling) or encourage the clients to develop their own version of the roles and/or scenes when they are able.

TREATMENT STAGES

Dramatic play therapy begins with the intake (as presented later in the chapter) in combination with a semistructured dramatic play session with the child (when conducting individually oriented treatment) and caregiver–child or family dramatic play sessions (when conducting family interventions). Usually these sessions involve open-ended dramatic tasks the therapist sets up to introduce the clients to the expressive modes and to view their dramatic abilities and the initial dramatic themes introduced by the clients. Often these initial scenes contain themes directly related to the central issues that brought the child/family to therapy. This is followed by a stage in which a therapeutic alliance is built and the therapist helps facilitate the child’s and family’s use of role-playing and scene development. Often the therapist uses more direct coaching during these activities. Once the participants can sustain dramatic improvisation on their own, the therapist usually is involved as an audience member or witness or, when asked, takes on various parts within the episodes that develop in therapy. Dramatic rituals and storytelling can be co-created to address family events related to strong feelings and to resolve the central issues of the intervention. The final stage involves helping the child and family summarize treatment, generalize the gains they have made, and terminate from therapy. Assigning home-based activities can facilitate this final stage (Harvey, 2006). These stages have been presented more completely with longer case examples in Harvey (2000b, 2003, 2006, 2011a) and Gallo-Lopez (2005a, 2012).

Dramatic elements are used in each of these stages to facilitate the integration of drama into the play therapy. Specific examples of how dramatic techniques can be integrated into play therapy are described in the activities in the following section. Readers interested in more information about any of the techniques or their implementations, as well as additional case examples, are encouraged to consult the recent citations listed for each activity.

ASSESSMENT ACTIVITIES

Puppet Interview

In the puppet interview procedure, the child is provided with a large range of puppets, including royalty puppets (king, queens, prince, princess), a “bad” family (witch, ogre, skeleton, and pirate), scary puppets (dragon), and occupation puppets (doctor, police officer) (Irwin, 1983, 2000, 2014; Irwin & Malloy, 1975). The child is then asked to select a few puppets and make up a story he or she has never seen or heard before. The therapist helps set up the action and then becomes the audience. Once the story is over, the therapist then interviews the puppets who were the main characters in the story action. The child is asked to respond in role while the therapist inquires
about the characters, plot developments, and possible motives in the story. Then the child can be asked who in the story he or she might like to be and who he or she would not like to be. The purpose of this interview is to allow the child to project emotional responses and fears onto the puppets and into a dramatic story. The puppet interview can also be used with families. Family members are asked to select and develop a story together. The therapist can then interview the various members as they stay in role to further elaborate the inner thoughts and feelings of the enactment. The initial scene between Hayden and Kylie reported earlier in the chapter was set up with this beginning semi-structured form. Hayden and Kylie's improvisations then took the puppet show in an unexpected direction. The resulting story development offered a view into possible emotional experiences of this family.

**Family Scenes**

In the family scenes, activity the family is asked to use the various props to make a house and develop and enact a story about a family (Harvey, 2000b). After an initial period of approximately 20 minutes, the caregivers are asked to leave the room and the child is asked to continue to act out her own story. The caregivers are then asked to return to continue the action. The content and roles used during the enactment, as well as the expressive process used in each scene, can be compared to one another. In relatively normal situations, each of these scenes is related and builds on the other. The children are able to continue their own similar story from the opening scenes the whole family initiated. The children welcome the caregivers back after they have left in a positive reunion, and the caregivers easily rejoin the action and generally resolve any outstanding problematic themes. However, when the family and child have unresolved feelings, are in conflict, or have a history of attachment insecurity or an experience of trauma, these scenes become disjointed and may break down all together. The resulting scenes provide a view of how the family shows such emotional difficulties, especially related to loss and separation, in a dramatic form. These forms, themes, and characters can be used in future sessions to build more fully developed and positive scenes. A case study using this technique is presented in Harvey (2000b, 2003).

**Development and Use of Roles/Characters**

Roles can be introduced into expressive action if the child or family shows difficulty in spontaneously developing the dramatic response. The therapist can direct the players to use specific roles in their improvised dramatic action to build a more successful scene, or when they are unable to play any role at all. One technique is for the therapist to ask the child (and family members) to play out a role related to the presenting problem. This also helps develop the role into a metaphor with immediate relevance. This type of technique can be particularly useful in addressing oppositional behavior and anxiety. These techniques are different from those presented in the assessment section as they are more often used after the intervention sessions have begun. The purpose of these activities is to facilitate or develop dramatic action after the therapist has a better idea of the strengths and difficulties the client or family has. The assessment activities are more helpful in the initial sessions to observe the beginning of a child's or family's initial dramatic play ability and content they bring to therapy.

**Mr./Ms. Opposite**

One common problem that younger children present is opposition to direction from their caregivers. Often these children also have difficulties developing a role or character in their play and can show lack of interest in mental health interventions. In these situations, the therapist can
direct them to play Mr./Ms. Opposite (Harvey, 2010, 2011a). In this activity, children are asked
to do the opposite of what the therapist (or caregiver) asks. For example, if the adult asks the
child to go slowly, he/she should actually go fast. The commands can then be made more com-
plex. Once the child and adult can play each role comfortably, the scene can be extended into
more dramatic interaction with role reversal (the adult taking the oppositional role). A system
of points can be awarded for the best opposite response to add a game-like drama, and this can
increase the motivation for the child through the use of competition and gamesmanship. The
“umpire” can keep track of the points on the white board and add emotionally related reflections
within the discussion concerning the performance of each role. While the therapist is usually the
initial umpire, the role can be played by all participants at some time.

Monster

Monster is an interactive role-playing game that can be appropriate to use when a child presents
with significant anxiety and fear-related behavior (Harvey, 2001). The activity is usually best used
in a caregiver–child or family session. The caregiver is cast as a protector. The caregiver and child
are then asked to make a “safe house” and to develop physical/dramatic ways to work together to
chase away a monster using actions such as singing songs or throwing items (e.g., scarves) while
the therapist uses a large soft animal or puppet and pretends to be an approaching monster. In
this game, the monster is never able to get into the house and the caregiver and child are always
able to chase it away. However, the action can become dramatic even with this predetermined
ending. (See Harvey, 2003, for a more complete case example.)

Superheroes

In the superheroes activity, the role of a superhero is used in a dramatic scenario to introduce the
topic of mastering extreme threats (Haen and Brannon, 2002; Gallo-Lopez, 2005a; Haen, 2011).
The therapist can introduce the superhero by having the players draw a figure that represents
the specific strengths the character should have and then extend it by having the player make
costumes and masks to bring the character to life. When needed, the therapist can also stop
the action of a scene and introduce a superhero character to help influence the outcome of the
action. At times, the player will introduce the superhero spontaneously. Haen (2011) provides
an overview of the current thinking concerning the place of the superheroes in the fantasy life
of children. Both Haen (2011) and Gallo-Lopez (2005a) present clinical examples more fully.

Interactive Scenes

Sometimes children (and caregivers, in family interventions) have difficulty developing the inter-
active action in drama expression, even if they can take on a role. In this case, the therapist,
as director, can help by setting up simple interactive activities and then developing a cast of
characters to match the action. The therapist then guides the action so it becomes more person-
ally relevant to the clients using techniques such as role reversal or doubling-speaking the inner
thoughts and feelings of the player (Hoy, 2005). The therapist might also speak as the narrator
to frame the action in a narrative. Interactions that work best are those that are easy to do and
can be sustained by the players, such as tug of war, hide and seek, throwing soft scarves at each
other, pillow fights, and so forth.

World Wrestling Federation (WWF)

This WWF technique is a good example of using a child’s interest to develop a dramatic interac-
tion (Harvey, 2011a). Many boys are quite interested in the WWF wrestling matches they watch
on television. The therapist/director can ask the boys to prepare a ring and select and name a few soft animals as opponents in order to begin various kinds of wrestling contests. At this point, the therapist becomes a TV announcer and calls the action. While announcing the action, the therapist also begins to spontaneously interweave the feelings the boy and/or the stuffed animal might be having in the moment as they are thrown around and win or lose the matches. The announcer can also interview the various characters before and after the match. In family interventions, the caregivers can be included as tag-team partners with the child. The therapist can use both the dramatic actions of the caregiver and child, in combination with what he or she knows about their real-life interactive patterns, to create an overall story. Role reversal and other dramatic techniques can then be used to extend the scene beyond the initial starting place. A more complete case example is presented by Harvey (2011a).

Developing the Story

Dramatic interactions can be extended into more complete dramas by using a story to develop and resolve conflict. Alternative media such as art and video can be especially useful as tools to engage the children and family in this process.

TV Show Storyboard

In the TV show storyboard activity, the child (or family) is presented with six blank pieces of paper. The players are asked to create a television show with a name on the initial board (Gallo-Lopez, 2001). The players then develop a welcome and introduction and go on to create more scenes they depict on each board. The therapist helps coach the story’s development. When completed, the story can be performed and, if possible, videotaped, so it feels more like the players are really making a television show.

The Scarf Story

The structure of the scarf story activity is similar to that of the TV show storyboard, in that the child’s enactment is organized into a series of scenes (Harvey, 1997). The scarf story is done with at least one caregiver. In this activity, a child is asked to begin by being still under a scarf that the therapist and caregiver place over the child’s body. The action begins with the adults raising and then lowering the scarf. While the scarf is up, the child can move freely, and he then is asked to stay still again when scarf is lowered. The therapist, as narrator, begins to tell a story, beginning by describing what the child is doing. The narration then adds the feeling content and finally becomes a story with content that unfolds in a step-by-step fashion from the stop-and-go action of the scenes. A more complete case example is presented in Harvey (1997).

Narrative Play Therapy

Cattanach (2006, 2007) presents a way of helping a child develop a dramatic story using several narrative play techniques. In this way of working, it is very useful for the therapist to be a comfortable with storytelling. To begin, the child is provided with a range of toys and asked to tell a story. The therapist and the child then discuss and enact the drama that emerges. The therapist can add additional stories from well-chosen literature sources or stories are improvised by therapist to be congruent to the child’s initial offering.

Ritual

There are often events in children’s lives that are extremely overwhelming and difficult to discuss in any way. These events include such things as the death of a family member, divorce (which
can be considered a death of sorts, as it means the end of the birth family), major psychological trauma, and adoptions. These events can be addressed in family-oriented dramatic sessions using ritual enactments. Rituals are planned for and consist of basic actions symbolically representing the central meaning of the event. Often a dramatic setting with basic interactions and characters are used to enact the preset scene.

One such ritual, called the emotional courtroom (Harvey, 2000b), is used to address a child who has been victimized in some way and the perpetrator was somehow determined to be not legally responsible during the court process. In this situation, the child and the more protective caretaker often are left feeling revictimized by the legal proceedings. This ritual involves the enactment of a courtroom scene with the therapist playing the judge and the child and his caretaker playing the role of petitioner and/or lawyer who present the child's emotional reaction to the original traumatic event. The perpetrator is cast as a large stuffed animal. The judge/therapist role is to interview the child and caretaker about the feelings they have experienced related to the assault that occurred. The judge/therapist then assigns an “emotional” sentence to the perpetrator (with the help of the child) in order the find the right emotional balance. This conversation between the judge and child is expected to take negotiation involving a dramatic scene.

A case example is presented more completely by Harvey (2000b) and addresses a 10-year-old girl who had been abandoned by her birth parents when she was a toddler. Both she and her adoptive mother, who was acting as her lawyer in the ritual, agreed with the judge after much discussion about what she had experienced emotionally and declared that the parents should be sentenced to “never have the love of a child again.”

In situations related to loss, the family is asked to work together to create drawings representing the lost person or place and then to bury the picture in the office or outside in a place of the family’s choosing. The in-office burial could be done using pillows or other play props. Each family member is encouraged to say or perform actions that have been discussed and prepared for in the play sessions prior to the ritual. Enactments related to the past life or person can also occur during this ritual. A case example is presented in Harvey (2003).

The ending of therapy also is a time for ritual. The therapist and family can create art work to exchange as gifts in the last session. The goal of this exchange is for both the therapist and the child to present and tell stories about the important memories of their time together as they produce art to symbolically represent these events.

Case Example of a Core Scene

When children (and caregivers in family intervention) are able to successfully develop their own dramas, the therapist can become more of an audience member or participant/witness to the scene that naturally emerges from the improvisation. These episodes often develop spontaneously around the important emotional issues that are central for the child and include metaphorical references to trauma and attachment. A short example follows, and a more complete case is presented in Harvey (2003, 2005).

Sarah, a 9-year-old girl, was referred for mental health intervention by her school after she expressed significant suicidal ideation, reported difficulty sleeping due to extremely frightening nightmares, and depressed mood. She had also recently been observed stealing things and behaving dangerously around the fire at home. At the time of this referral, Sarah was living with her older sister and her mother, Jenny. Sarah and her sister had lived with her father after her parents had separated, when she was 5 years old, due Jenny’s drug use.
While this arrangement originally appeared to benefit the girls, the father became violent toward them. He was also not protective and left them in situations in which Sarah was sexually assaulted on several occasions. Though some of these events were witnessed by other family members, the father became physically aggressive with Sarah because he did not believe the reports. Sarah then changed her reports when she was interviewed by the police and the assaults were not legally substantiated and no child protective action was taken.

After one of these events, Sarah began showing more externalizing behaviors in her father's home and he returned both girls to Jenny because she had stopped using drugs and had become more stable. At the time of the referral, Sarah had only recently returned to her mother's home. Sarah and her older sister began to tell Jenny about the assaults a few months they after they arrived in her home. Though Jenny did believe her daughter, she did not know how to respond to her, especially given Sarah's multiple problems. These issues were discussed during the intake. Sarah, however, did not, and may not have been able to, address her emotions related to her past in these more verbal conversations.

Following the intake, Sarah and her mother were seen together in play therapy. In the first session, they were coached to develop short, interactive scenes using the techniques of creating, drawing, and then enacting various storyboards. They were encouraged to address themes of mastery and to correct some of Sarah's cognitive errors, such as self-blame. In one session, Sarah drew a cartoon in which she showed herself thinking she was at fault and a bad girl in a thought bubble above a picture of herself with her father spanking her. In a discussion a few minutes after this, Sarah revealed that this drawing was of the event in which her father had used physical punishment after she had reported that his male housemate had sexually assaulted her in the bathroom. Unfortunately, the father had not believed her and was punishing her in an effort to have her change her reports to the police. In this session, the therapist and the mother were able to help add additional thought bubbles that Sarah was not a “bad girl” and that she had many feelings she would become able to express.

Once Sarah and Jenny could maintain a dramatic improvisation together, Sarah was asked to develop a story with her mother. This story was introduced after a night when Sarah reported particular difficulty with nightmares and suicidal thoughts. While Jenny required some coaching to follow her daughter's dramatic ideas, Sarah was easily able to develop a scene with characters for her mother, the therapist, and herself using the puppets.

In this enactment, Sarah cast herself as a snake who had been hurt in an accident. The snake had become very angry toward humans and wished to bite them. Then, in a second scene, the snake met another person, played by the therapist. Using Sarah's stage directions and lines, this new person (a doll) tried to talk the snake out of future attacks; however, the snake remained unconvinced. Sarah then introduced her mother into the scene by casting her as a doctor. Initially the snake bit the doctor. The bite was harmless, however, and finally the snake became convinced of the doctor's good intentions. The snake and the doctor became friends and travelled to another country to help other snakes learn not to bite people unnecessarily. The scenes ended with Sarah asking everyone to play music and learn to dance like the snake following her lead.

Both Sarah and Jenny were able to be quite engaged in the dramatic and emotional flow of the session. The metaphors helped them communicate the complex feelings related to their history that they had not been able to address prior to the session. As the improvisation developed, Jenny could become a significant supportive figure for her daughter, as if she were an emotional “doctor” who could withstand “snake bites.” And Sarah could
change from a snake that was misunderstood and mistrustful of important people to an ally with and helper to the doctor. The dramatic enactment became a special stage where the characters and exchange provided heightened intimacy that they were not able to achieve in more normal verbal conversations. This positive emotional exchange occurred within the enactment and did not require interpretation or further discussion to help Jenny and Sarah change their relationship. Jenny and Sarah were encouraged to continue to develop storytelling with each other in the week following at home.

In the days following this enactment, Sarah was able to disclose much of what had occurred during the previous abusive events, and her mother was able to respond supportively. While Sarah and her mother were seen for other sessions, this enactment was the turning point when their situation became more positive. Sarah’s suicidal thoughts stopped shortly after this, as did her stealing and fire play. Her mood also became more positive, and the nightmares ended. Jenny became more active in Sarah’s school and home life. This enactment facilitated several changes the family was able to make over the next several weeks.

THERAPIST QUALIFICATIONS AND CHARACTERISTICS

To incorporate dramatic play into play therapy sessions, therapists should have graduate training and a professional credential in a mental health–related field with additional training in play therapy and, ideally, in drama therapy. Fortunately, the two fields overlap greatly in theory and practice. Some of the main contributors to the professional literature in each field, such as Cattanach, Gallo-Lopez, and Harvey, have credentials in, have helped develop, and have presented at professional conferences in the areas of both play and drama therapy. In addition to graduate training, certain personal characteristics make some therapists better suited to the use of drama within play therapy sessions. These characteristics include an appreciation of and ability to use overt dramatic expression. Some experience with dramatic performance is helpful, as clients will often ask therapists to play a part in their enactments, and these performances require a commitment to the role. The therapist will also need to set up and direct scenes and improvisations for families. This often requires confidence in the using dramatic expression and formats. Interpersonal flexibility, spontaneity, a good sense of humor, and the ability to read social situations are perhaps the most important characteristics for the therapist using dramatic interventions because the dramatic enactments of children and their families can require multiple types of intervention, even within a single session.

CLIENT CHARACTERISTICS

Dramatic techniques can be flexibly used with children and adolescents of all ages, with a wide variety of presenting problems, and in many situations and settings, including mental health centers, schools, and hospitals. Harvey (2008a) and Jennings (2010) present ways of adapting this work with for use with very young children, and Schaefer and Gallo-Lopez (2009b) and Emunah (1985) present applications for use with adolescents. This chapter, however, mainly addresses using drama with children of primary and intermediate school age.

Because dramatic play occurs as part of normal development, there are few contraindications for using these approaches with most children. However, some caution needs to be taken with children who have difficulty with reality testing. In such cases, the therapist needs to make sure
the child knows what is imaginary dramatic play and what is everyday reality. If children are not able to make this distinction, dramatic play should not be attempted until the child is better anchored in reality.

Although the material in this chapter has focused on the inclusion of dramatic techniques in play therapy for individual children and their families, it has also been used in traditional therapy groups as well as therapeutic performing groups.

PLAYROOM SETUP

The focus of the action when using dramatic elements is on the use of character development, interactions among characters, and story development. The playroom and props should facilitate this type of imaginative play. As such, there is far less emphasis on toys and more on materials that facilitate participants’ development of characters and dramatic scenes or settings. Different therapists have suggested a variety of playroom set ups to accomplish this. Irwin (2014) suggests the room for younger children should contain some props that are more typical of a play therapy room: a sandbox, plastic buckets, spoons, art materials, dolls, and miniature life toys, such as trucks, planes, police cars, farm animals, soldiers, doctor kits, tanks, and miniature family kits. For older children, she suggests including a large variety of puppets along with a puppet stage, craft materials, and costume pieces.

Harvey (2003, 2005, 2011a) has suggested using far fewer toys so as to direct the projection to a specific interactive activity. Prop pieces should be of a more neutral nature to allow for greater projection. The setup should include a room with a large open space so children and adult family members can move their bodies in an expressive way, large pillows that can be used with activities such as making houses or to symbolize various “lands,” and life-sized stuffed animals that can be readily and easily included as characters in scene development. A large variety of colorful scarves and parachutes is useful because these items can (a) become props in setting up a scene (such as indicating lakes, rivers, or volcanic lava), (b) become costume pieces, or (c) be used in physical interactions such as tug of wars within the dramatic action. Art materials, including large paper, whiteboards, and a variety of music-making instruments can be used out draw out action plans, create music to accompany the dramas, or create scenery and props as they are required. Harvey also suggests the use of video cameras to record and review short scenes developed within the enactment portions of the session.

The use of such nonspecific materials (especially soft pillows and scarves) ensures the material can be changed to the keep up with the moment-to-moment improvisation of dramatic action. The large pillows, for example, can be used for a caregiver and child to run into one another and fall at one moment, only to be set up and used as a wall or made into a house for the large stuffed animals the next moment. The whiteboard is useful for keeping score of ongoing improvisational scenes with a competitive interaction or as a way to draw out the scenes that have happened or are about to happen as a way of extending the drama in another expressive media. Video reviews of short scenes can be particularly useful in planning and organizing new scenes with alternative endings to enrich theme and character development.

PREINTERVENTION ASSESSMENT

Assessments conducted prior to conducting dramatic play interventions are essentially the same as any other sort of child or family intake. Information should be collected on the presenting
Using Drama in Play Therapy

problems, the child's developmental history, family history, as well as any history of medical or mental illness, school performance, and peer socialization. Information concerning family separations, deaths of significant family members, family violence, or other history of psychological trauma experienced by the child or other family members should also be obtained. Standard measures, including problem inventories, specific instruments to measure depression and anxiety, and standardized measures of adaptive development, help to augment the intake. Conducting observations of caregiver–child interactions are also important. Summaries of these assessments can be used to determine whether referrals to other disciplines, such as psychiatry, special education, or other family services, should be considered. As with any form of treatment, ongoing dramatic play therapy should not be conducted in isolation when the presenting problems are multifaceted.

Information from the clinical intake can be integrated into initial dramatic play scenarios in family interventions to help caregivers understand the connections between the dramatic images and themes and both the presenting problem(s) and the ways in which they initially presented themselves and their children. This can be valuable in helping focus the dramatic scenes on family life issues as the intervention proceeds (Harvey, 2000a, 2003, 2006). Finally, the intake information can be useful in helping the therapist place a child or family's dramatic improvisation within a larger context of their lives.

RESEARCH

Very little formal research has been conducted on the use of dramatic elements in play therapy. While there are several clinical examples and case studies presented in the literature related to this topic, there are no randomized controlled studies in which dramatically oriented play therapy has been studied more systematically. Harvey (2008b) did report on the outcomes of using a family play therapy intervention that made extensive use of dramatic play in a clinical setting. In this action research design, no control groups were available and randomization was not used because all the families who presented within the study period required and were provided treatment. The outcome measures were selected from the instruments normally used in the clinic in which the research was performed and included diagnosis, clinical information from the intake, a problem inventory, and a measure of the therapeutic alliance. The children demonstrated significant improvements in all problem areas and the parents reported they developed a positive working alliance with the therapist. The parent–therapist alliance and improvements in the children's outcomes were positively correlated. The amount of improvement (effect size) was large and similar to the effect sizes reported in more controlled parent–child play. Children with more problematic diagnostic presentations required more sessions to achieve similar outcomes. These findings suggest dramatically oriented play with families shows promise as a method for helping reduce children's presenting problems in a variety of areas and across the range of diagnostic categories commonly seen in mental health settings.

Miller (2014) recently initiated a project in New Zealand in which she and a group of expressive art colleagues are using and developing measures to report on therapy outcomes in their clinical setting. These outcomes include the use of standard measures, observations related to the presenting problems, and importantly, observations based on the expressive techniques used. As part of this group effort, Barnaby (2014) reported on a study in which she used a group drama therapy approach to help a young, primary school–aged boy with ASD try to develop more socialization with his peers. In this case study, structured dramatic interactions that included group storytelling followed by dramatic enactment were used. The results of various observational measures related to social functioning (cooperation, communication, emotion regulation,
and imaginative play) were reported before and after a 12-session intervention in which this boy and four other classmates participated. These results revealed improvements in all areas and later generalization of those improvements to the school setting. The inclusion of measures of both social behavior and dramatic expression in this case approach provides a model for future study.

CONCLUSION

As soon as children and caregivers begin to communicate, their ability to spontaneously use dramatic play also begins to develop. Early dramatic episodes are usually related to the communication of strong emotions. When children use roles/character, interactive scenes, plots, and stories and create imaginative settings, they are able to expand their communication to include emotional expression related to their social contexts. This serves to facilitate both the development of the ability to regulate the inner experience of emotions as well the ability to form intimate relationships.

The central techniques of such dramatic play center on role-playing and extended scene and plot development. These dramatic elements can be incorporated into play interventions with children and their families to address emotional difficulties, especially with such problems in which there is a clear interactive component. The elements of imaginary role-playing and the development of interactive scenes among invented characters are useful in engaging children in their social worlds, perhaps for the first time. The resulting dramas can be used as springboards for addressing very difficult emotional experiences, such as those associated with underlying attachment issues and psychological trauma. Such scenes often develop heightened reality when the metaphors of the co-created dramatic world become personally relevant. When successful, dramatically oriented play improvisation leads to a heightened form of communication, heightened coping, better problem-solving and social skills, and, ultimately, to problem resolution.

REFERENCES


I just want you to know that you’re very special and the only reason I’m telling you is that I don’t know if anyone else ever has.

— The Perks of Being a Wallflower (Chbosky, 2012)

Play therapy is a powerful modality of working with children to assist them through the difficulties in their lives. The play therapist is in a unique position to provide an environment of both physical and emotional space within which to heal. Understanding children’s play language and helping them understand their own importance and power are part of this process.

Board games are one of many interventions used in play therapy, but they are often underutilized and undervalued. They are easily defined by the type of game play and the items included. There are game pieces, a board, a prescribed way the players move through the game, and ultimately some type of goal to reach. Although therapists can use traditional therapy games purchased through professional websites, this chapter focuses on the benefit of board games that can be purchased at local stores which families can play together for fun.

Traditional board game therapy utilizing games such as checkers, Uno, and others often has very little defined structure. The games are thought of as good icebreakers, but they are often not believed to have additional therapeutic value. The following information is designed to help therapists understand how these types of board games can be utilized in a structured, therapeutic way. Using board games in play therapy with a defined framework and direction will be referred to as board game play therapy (BGPT).

The use of games in play dates back to prehistoric times. Games have served the purpose of providing connection, fun, and education. Reid (2001, p. 3) posits that “early game playing appears to have had a direct correlation to adaptation and survival.” Why are humans drawn to structured games? How can this seemingly inherently attractive activity be utilized in a therapeutic way?
RESEARCH

Empirical research on the use of board games in play therapy is lacking; however, two important books have begun the conversation of their therapeutic value. In a time of emphasis on empirically supported treatments, research is of utmost importance. The concepts of both books described here inform future research.

In the book Game Play by Schaefer and Reid (2001), the authors identify 10 elements of gameplay that are therapeutic: therapeutic alliance, pleasure, diagnosis, communication, insight, sublimation, ego enhancement, reality testing, rational thinking, and socialization. Within the game play, they highlight the importance of the therapeutic process “repeatedly shift[ing] back and forth between the safety of the game to the more challenging arena of face-to-face discussion” (p. 21). With so many identifiable therapeutic elements to game play and an inherent interaction process within the play, the support for use in play therapy becomes even stronger.

In Jill Bellinson’s book Children’s Use of Board Games in Psychotherapy (2002), she hypothesizes the reason experts often do not see structured (board) games as useful is because the focus is on the content of the games, not the process and interaction within the game play. She posits there is a parallel between dramatic play and board game play, and therefore they can be used in similar ways. In her book, she focuses on the benefit of the use of board games and she is nondirective in her approach. Bellinson’s emphasis is on a therapist learning how to work with board games as opposed to a modality where a child is forced to “continue with the more regressed play of childhood or to push them prematurely into the verbal world of adolescents and adults” (Bellinson, 2002, p. 167).

Research on brain development in children also points to ways BGPT is beneficial. Siegel (2013) states the cortex and cortical region of the brain are in part responsible for awareness of self and others. The limbic area is involved in motivation, focusing our attention and how we remember. When the limbic area works with the brainstem, it can create reactive states of being angry or scared. In addition, the cerebellum has a role in balancing the interaction of our thoughts and feelings, and the corpus callosum links the left and right sides of the brain and coordinates their activities.

These essential functions of the brain allow us to engage in a myriad of activities in therapy, including playing board games. We are using these areas of the brain to interact, process, and function within the game. As the brain develops throughout childhood and adolescence, it becomes more specialized and connected; this is called integration. Seigel (2013, p. 77) also posited that the “mind develops at the interface of neurophysiological process and interpersonal relationships;” relationship experiences are clearly critical, too, for healthy development. Increased efficacy would likely bring about a level of satisfaction, importance, and role.

Isn’t this partially what we strive for in play therapy? With the addition of working through experiences, organizing experiences and thoughts, and exploring new coping strategies, we want to help move a child to a healthier, more satisfying existence. We strive to have self-awareness, motivation, attention, focus, memory, emotion regulation, both sides of the brain working together for maximum efficiency and results, and balanced thoughts and feelings. BGPT has its height of attractiveness in latency-aged children, and they are inherently drawn to games in this critical developmental phase. This stage is before the great growth of the frontal lobe in adolescence that “permits us to experience our human ability of knowing about knowing—of reflecting on how we think, how we feel, why we do what we do, and how we might do things differently” (Siegel, 2013, p. 92). If BGPT can be used to evaluate and improve brain
processing and interpersonal relationships, it can be a powerful tool in this delicate and essential process.

The use of BGPT is ripe for efficacy research. With defined factors to assess and good interrater reliability, the possibilities abound. Useful future research might evaluate: efficacy of therapist assessment in BGPT; efficacy of the implementation of assessed BGPT information in treatment plans for latency-aged children; or BGPT and traditional board game play in therapy: a statistical efficacy comparison.

THEORY

One can draw from various theoretical backgrounds to support the benefits of BGPT. The specific personal theory of the therapist isn’t important. The critical component is that the therapist has an identified personal theory and knows how to assess, formulate, plan, and implement interventions according to their identified theoretical model.

An identified personal theory allows therapists to have meaning and purpose in their playroom interactions. When therapists know the fundamentals about what they are doing, the results will be mutually powerful. The children experience a process that feels solid, structured, and safe, and they can sense that they are in the capable hands of someone who knows what he or she is doing, and this inspires the belief that help is possible. Both participants can feel more confident and hopeful.

Later in this chapter, you will find a discussion about the what, why, who, how and when aspects of BGPT. A therapist who can answer these questions about therapy in general will be able to make sound decisions in their personal theory. Other questions that should be answered are: What fosters change? What elicits change? What creates an environment to support change? What even needs changing? What will most successfully help this child move past the identified difficulties and on to healthy development? What are the goals of therapy, and how do you assist in meeting them?

Within BGPT, a therapist armed with an identified personal theory can understand how and why playing a game in a therapeutic setting is different. How is the child currently functioning, and what would the goal level of functioning be? How can the therapist best intervene to achieve these goals? A structured approach to BGPT allows the therapist to purposefully play the game and apply both what is learned and what is understood by the therapist to what will best help the child.

While utilizing BGPT, much of what is being interpreted is within the interactions between the child and the therapist. The focus remains in the interpersonal interaction, the extrapolation of those experiences, and what has been reported regarding this child in other settings. The interpretation and ultimately the intervention based on this gathered information will be formulated based on the therapist’s defined personal theory.

Per my personal theory, my office has open shelves and items from which the child can choose the day’s activities. If a child chooses a board game, I feel confident in my abilities to assess some or all of the listed categories within the game play. The games in my office are tried and true for me. I am so familiar with the games that I do not have to think about the game play process (rules, etc.) while I am playing, which leaves me to the task of therapeutic information gathering. It also allows, in some games, for minor intentional manipulations in play to attempt to elicit a response from the child. An example of this is in the game Mancala, in which two players move
stones around the board in an effort to fill their mancala (reservoir). The person with the most stones at the end wins. If I want to elicit a response in the area of frustration tolerance, I might purposely choose a play that would typically cause a person to become frustrated. If I wanted to assess for people pleasing, I might load up the child’s side so her turn would potentially result in a bad position for me and see what she does. Of course, I would also have to simultaneously assess whether the child realizes these manipulations are possible and whether she is purposely choosing or not choosing the turn I hope to elicit.

When formulating an understanding of a client, it can be useful to think in terms of red flags. If a topic or statement doesn’t feel right while interacting with someone, pay attention to it. A flag or two is not terribly worrisome. A collection of five or six becomes disturbing and can help the therapist decide what to pursue in terms of treatment. For example, if Johnny plays Sorry and is aggressive, purposely sending pieces back to home even when he has other options available, that is a red flag. The therapist can then pay attention to where else it shows up in his play. How does it fit in with his history, and how does this style manifests in his daily family and social life? How do these behaviors keep him from getting his needs met? It is important to know the games well before using them therapeutically. This allows the therapist to focus on noticing and evaluating the troubling aspects of the child’s functioning.

PROCEDURE/TECHNIQUE

In BGPT, the choice of the use of a board game can be either child or therapist driven. If the child chooses the board game, the therapist can utilize a structured assessment to learn more about the child and the reasons for choosing the specific game, as well as implement interventions tailored to specific needs. If the therapist chooses the board game, it would be to elicit something specific from the interaction.

Once the therapist has established a positive rapport and an understanding of the child’s history and the presenting issue(s), therapeutic intervention can occur. Within BGPT, the therapist can interject appropriate interventions into the interactions. For example, if a child has a low frustration tolerance, this may be the time to elicit frustration responses and then guide the child through the experience to elicit positive coping skills. The process a therapist uses with BGPT is very similar to ones used with other materials in play therapy.

As a psychologist, it is important to continually ask about the what, why, who, how, and when in regards to therapy. What are you doing? Why are you doing it? Who are you doing it with? How are you doing it? When do you do it? By answering these questions, a therapist will have a great therapeutic framework, regardless of the modality being used.

Board games have always felt natural to include in play. As a child, playing games was common among my family and friends. While in graduate school, there was a professor who discussed board games in play therapy and it went along with my preconceived notions. He discussed play as a child’s language and the use of multiple toys and games as therapy. However, upon graduating, a supervisor told us to have two games in our offices: The Talking, Feeling, Doing Game and the Ungame. These games are currently collecting dust and reside in storage. They didn’t feel natural or fun when played with children. Games do not have to be altered or probing to be therapeutic. Games can have therapeutic value as they are.

Maturing into my role as a psychologist and a Registered Play Therapist, I noticed a bias against board games. Exploring the what, why, who, how, and when aspects of board game play in therapy and also why it was not well accepted became a focus. There had to be a way to operationalize the therapeutic value of board game play.
What, Why, Who, How and When

What Is Board Game Play in Play Therapy?

Board games in general have some common benefits. Games that require two or more players automatically rely on interpersonal interaction for basic play. Often this results in eye contact, attending to verbal and nonverbal cues, camaraderie and laughter, chiding, banter—ultimately, fun. In addition, board games typically include a need for a level of organization, turn-taking, patience, rules, how to win and lose, and concepts of what is fair. Inherently, they also include some simple yet fundamental educational components such as reading, counting, and number, shape, and letter recognition.

In BGPT, the therapist has the opportunity to engage in all the areas listed and to assess a number of factors: level of mastery, frustration tolerance, coping skills, strategic abilities, rough IQ estimate, social interaction abilities, competitiveness, norm compliance level, level of rapport, and development (detailed later in the chapter). With rapport established and the goals of therapy outlined, the therapist can assess the factors and design an intervention.

Why Board Game Play in Play Therapy?

Reid (2001) states that board game play can “invoke behavior that is more goal-directed and carries a greater sense of seriousness” than other types of play (p. 2). Playing board games also fits well with Daniel Siegel’s explanation of important brain development and processes (Siegel, 1999, 2013). It is a natural progression to utilize BGPT with children. Schaefer and Reid (2001) state that “games can be used to enhance the therapeutic alliance, elicit fantasy expression, and provide important diagnostic information” (p. viii).

Play is frequently described as the child’s language, and board games fit this concept as well. If a child is drawn to any item in the therapy room, it is important to understand how it fits into his internal structure and process. Why did he choose that, and how does it either meet or reflect his needs? One can extrapolate information regarding which game a child chooses, what his behavior is like within the game, and to what each of those choices might be attributed. These aspects are not so different from other play therapy modalities, but are somehow discounted in BGPT. Utilize the language children speak via play and have a framework within which you can find the value.

Who Would One Use Board Game Play Within Therapy?

If a child is attracted to a board game in play therapy and the therapist utilizes a nondirective approach, it would make sense to explore what the attraction was about. If a 3-year-old wants to play Mancala, we will play Mancala. My job includes, in addition to all we are discussing in this chapter, assessing how she plays. For instance, is she advanced and wants to learn and play by the rules of the game? Or does she like the shiny stones, the way they feel in her hands, and the smooth board? Either way, or any other interpretation, it is valuable information to include in my understanding of this child.

Typically children who are latency aged are drawn to board games and BGPT. The latency period is frequently defined as spanning from the approximate age of five through the onset of puberty. During this stage, children are drawn to the structure, competitiveness, connection, fun, and excitement of a board game at a fundamental level. It is a time when they are developmentally ready for the tasks asked of them in these structured games. Some of the important aspects of playing games include communicating verbally and nonverbally, reciprocal respect, learning how to share, patience, taking turns, and having fun while connecting with others.
How Do You Use Board Game Play Therapeutically?

Bellinson (2002) likens the information and experiences gathered from game play to symbolic material uncovered through any other method of discovery: It can be seen that the structured games that are developmentally appropriate to latency-age children can reveal a child’s unconscious dynamics as well as dramatic play can for younger children or dream work can for adolescents and adults. It must be allowed to unfold in the same free-floating way that dramatic play or dream reports would flow, and we should search for the same underlying dynamics we would look for in these other symbolic expressions. Any method of game play can be seen and interpreted in this light. (p. 19)

Abilities and themes will show themselves over time; it is the therapist’s responsibility to track them and work to understand what those are and how they manifest in the child’s life. When looking at the overall picture of the presenting problem, the child’s known history, the environments in which the child’s difficulties manifest, and what is observed in play therapy, the result is a comprehensive and useful approach to help the child move through and past difficulties.

AREAS OF ASSESSMENT IN BGPT

The following is a list of key aspects to assess when using both play therapy and BGPT with children. At times a concept seems appropriate to add or delete, but for the most part, these key aspects organize the assessment process. They also serve as great launching tools to organize discussions with primary caregivers and collateral contacts. Some aspects of this assessment list are repetitive. The factors are not mutually exclusive, but separating them out can help with organization. Use it how it best fits your personal theory, framework, and approach.

Level of Mastery

Mastery is defined by Mirriam-Webster as “knowledge and skill that allows you to do, use, or understand something very well; complete control of something.” As therapists, we often have a goal of assessing what a child has mastered, what we would expect them to have mastered developmentally, and what we hope to help them master as part of our treatment with them.

A key aspect of development is gaining mastery. For example, mastery can be achieved regarding the use of an object, a thought process or concept, a physical activity, social skills, or a task. We have identified the latency period of development as a prime developmental stage for the use of BGPT. A sense of mastery is critical to one’s self-esteem and sets up a foundation for a successful adolescence.

In BGPT, the therapist can assess the child’s level of mastery in numerous areas. If the child shies away from an aspect of either the interaction or the task at hand, compare that with the information known about the child and see if there is a recurrent theme; if there isn’t, store this information away for possible future use.

Frustration Tolerance

Frustration tolerance is an issue that comes up frequently in play therapy. Often, children do not have a healthy level of frustration tolerance and act out when they don’t get what is desired. A therapeutic goal is often to increase children’s coping skills, to help them work through frustration, and to respond in a socially appropriate manner. Through
Board Games in Play Therapy

BGPT, a therapist can assess the level of frustration tolerance children have by watching how they react to the therapist's moves during the game and if the therapist wins the game. When the therapist reflects his or her reaction to the client's response(s), some valuable perspectives can be discussed that will help children understand the effect they have on others through their own behavior and responses.

Coping Skills

What are the child's coping skills? What skills have they gained to date when they need to handle a situation? What skills are they lacking? The interactions during the game will aid in assessing many of these questions. Patterns of behavior will emerge. Once the therapist identifies areas of competency and incompetency, the work can begin to help teach new skills and/or modify the existing ones.

Strategic Abilities

If working with children who are gifted, this category can be very helpful in understanding them. Strategic abilities translate into important life skills and help the therapist roughly—very roughly—estimate the child's intelligence. Even if one does not meet the criteria of the gifted population, understanding the child's strengths and weaknesses in this area can help with understanding the child and implementing intervention. If a child exhibits great difficulty in strategizing, how does that manifest in his or her world, both academically and within day-to-day life and relationships? If a child has strengths in this area, how might those be helpful or detrimental to getting one's needs met appropriately?

Rough IQ Estimate

As discussed with strategic abilities, an approximate estimate of cognitive functioning can be gained through BGPT. The usefulness of this has less to do with children's IQs and more with what can and should be expected from them. Both higher and lower abilities bring their own potential obstacles for processing, level of insight, and integrating the presented information and experiences into their lives. If a therapist has a rough idea of their abilities in these areas, the interventions and interactions can be tailored more specifically.

Social Interaction Abilities/Style

How children approach the game and interact within it is very useful information. These skills are essential to having positive interpersonal interactions. Many children do not have satisfying interactions, and it affects their worldviews, self-concept, self-esteem, and how they perceive they fit into society. A painful combination is when a child really desires these positive interactions but does not achieve them. BGPT is a powerful tool for assessing where these difficulties are demonstrated and how to intervene with skills and processing.

Competitiveness

A child's level of competitiveness can be both an asset and a hindrance. If a child's competitiveness helps propel him or her to achieve a goal or mastery, then it can be an asset if it is respectful to the other players. The difficulties lie in the competitiveness hindering the positive interaction between the players, commonly through disrespect or hurtful words and behaviors. It is valuable to explore other questions, such as: What is
the possible etiology of this competitiveness? How does it play into the child's worldview, worth, family role, and experience and/or behavioral reinforcement cycles?

Norm Compliance Level

How children fit into their culture and society is largely dependent upon complying with basic norms. Each culture and society can define these differently, but they typically include aspects of following rules and treating others well. BGPT incorporates the fundamentals of norm compliance. The board game inherently includes rules, which are either printed and included with the game or mutually agreed upon. If a player does not conform to these rules, then it is considered cheating. Cheating has been a topic of great discussion and debate in play therapy. Mutual respect is a key aspect of therapy. Cheating, when defined as one person not adhering to the agreed upon rules, inherently disrespects the other player. Therefore, I do not allow cheating in BGPT. I will include the child's desire, attempts, and possible propensity for cheating in my assessment, but I will not allow it to continue during the session. A discussion about both how the cheating felt to me as the other player of the game and a negotiation of rule changes (e.g., incorporating how they were attempting to cheat) so we are both following the same rules works very well with children.

How a person's level of norm compliance affects the child's life can vary greatly. At times, the result can be a type of child who thinks outside of the box and is creative and eye opening. At other times it can be that the child is disrespectful and hurtful to others in order to get his or her own needs met. There are many other possibilities as well, and assessing this level and how it effects interactions, self-concept, and place in the world is very valuable.

Level of Rapport

Seemingly very obvious, the level of rapport is still something important to assess and acknowledge when formulating the assessment, interventions, treatment, and discussions with primary caregivers and collaterals. If the level of rapport is lacking, then all the information assessed should be interpreted with that in mind.

Development

This category includes general development, attachment, emotional development, physical development, and reality testing. There can be considerable variability in a child's development within and among each of these areas. Is this child generally on target developmentally in each area? If not, how does that fit with the psychological information gathered so far?

How do any of these developmental aspects create a dynamic in which the child's needs aren't getting met? Are these needs healthy or realistic? What is the etiology of the needs, and are there more appropriate and/or satisfying ways to get them met? A metaphor for this concept could be a person driving too fast to work. If the fundamental need is to get to work on time, then that need could very well be greater than the need to avoid a possible speeding ticket. A more appropriate way to get that need met would be to leave earlier and safely arrive on time or with time to spare. There may be obstacles to that plan. Obstacles to getting one's needs met more appropriately would need to be discussed and negotiated or worked around. Highlighting the need, discussing it, and discovering appropriate ways to meet the need can be very powerful in behavior change.
When Do You Use BGPT?

Given my personal theory and working framework, board game play can be used therapeutically at any moment the child chooses the game. In addition, as mentioned previously, a therapist may pick out a game to gather specific information about a child. A therapist can benefit from using board games as an icebreaker, for assessment, in the active play therapy process, during intervention, and at the conclusion of the therapeutic process.

Therapist Qualifications, Training, and Characteristics

Therapists who are either trained extensively in play therapy, such as a Registered Play Therapist (RPT), or those who are supervised by a Registered Play Therapist-Supervisor (RPT-S), are appropriate to utilize BGPT. To conceptualize and appropriately use the technique, the therapist should have an identified personal theory, an understanding of the process of change, an ability to assess the child developmentally, and an ability to integrate this information to formulate an intervention.

Child Characteristics

BGPT can be beneficial for children of all ages and with any emotional and/or behavioral presentation. If the child is unable, for whatever reason, to utilize the game as it is intended, the game can be modified appropriately for his or her needs. Modifications in BGPT do not include altering the game to make it more therapeutic, such as with each roll the child answers a question or tells about something. In BGPT, the therapist is assessing and intervening based on the interactions within the game, not introducing additional factors. Directive therapists can utilize BGPT when seeking further information or when there is a need for a more structured play interaction.

Case Study 1: Joseph

Joseph is an 11-year-old who presented in my office with his grandparents. They were concerned about his level of anger, frustration, and lashing out behaviors at home. He lived with his grandparents and had ongoing contact with his father, but little contact with his mother. He was in a wheelchair due to muscular dystrophy symptoms. No one really understood what was going on with him neurologically, and he was deteriorating. This left him in a very frightened position.

Joseph really liked BGPT. He felt like he was a normal kid who could play things like other kids. He felt a sense of pride when he won or played a move well. Sitting at the table in his chair didn't single him out in any way; we were both sitting in chairs. He was able to feel a sense of mastery, normalcy, and connectedness. Treatment foci became stability; acknowledgment; expression of his medical, social, and familial realities; and improving his coping skills and frustration tolerance.

In the second phase of assessment, predominant patterns emerged: He either played in a very opportunistic way so he could feel superior, or he was very passive or let everything go, as if to say he wasn’t worthy, he wasn’t good, and what's the point? When noticing patterns with kids, it's important to envision what these patterns and behaviors must look like when they manifest with others. If the child's presenting problems include social issues, then I think about how these behaviors look when he is with peers and wonder how his peers would react. Most 11-year-olds wouldn't respond well to a peer who interacted with them
in such polarized ways or with opportunistic superiority. Social skills modeling through the game play and discussion were definitely warranted.

BGPT helped assess what was happening with Joseph in his interactions, but it also provided a window to how he was feeling: insecure, unstable, unimportant, unknown, even invisible and weak. When he was passive in his play, the air was almost painful to sit in. I would imagine what it would be like for him to feel that way and how hard it would be to move forward each day with such heaviness. When he was in his superior mode, I thought about what insecurities were underneath and how he needed to make himself so loud and big to be noticed and to feel successful.

There was so much in the play itself that could be helpful in these areas. At times I gave voice to reactions that were genuinely mine or that I felt peers would have if he behaved in certain ways. At times I stayed steady and true in our play, for instance, if he was feeling superior and we played Sorry together, he would attack my player and send it back to home as a primary goal. In these instances, because I felt he needed to bring it down a few notches, I stayed calm and steady, giving voice to my feeling sad or frustrated but not doing the same to him. It is similar to keeping a calm and steady voice when someone is louder and hoping the person will calm to match your affect or presentation. The more connected, safe, and stable he felt with me, the more he was able to do this. I understood his need to feel supported and safe was so great that the social downfall he experienced with his peers didn’t change his behavior. The more I could reinforce our supported, safe connection and model other ways of behaving in the play, the more he was able to meet me in that place and feel the natural reinforcement of it. He and his family reported school was going better, his anger had reduced, and his behavior at home had improved. There’s much more to do together in session, but BGPT has given us a great start.

Case Study 2: Mark

Mark was a junior in high school when we met. I was fulfilling my predoctoral training requirements when I traveled to his alternative school. This school was for kids who had been expelled from all the area public schools; in essence, this was where the troublemakers went to be educated. We met in a tiny, dirty trailer on campus. Meeting with me was mandatory for him if he wanted to comply with his school plan. It was also a way to avoid class once per week, which appeared to be his primary motivation to comply. He was 16 and had a difficult history of trauma and neglect. His family supported his lack of education and encouraged him to enter into a life of gangs.

Mark did not really want to discuss his family, his history, or his insights. He was too cool and tough to even be doing this therapy thing. We were slated to meet his entire junior year, and I proposed we make the best of it. We settled on playing games to pass the time. At the time, I wanted to fulfill my program’s requirements and not be assaulted or treated poorly while on campus. If I was able to help him, all the better, but I wasn’t sure how to accomplish that when he didn’t want anything to do with me.

After some trial and error, Mark decided MasterMind was his game of choice. We played MasterMind each session, without fail, for 8 months. At times I didn’t know what we were really doing. I didn’t know how our time was therapeutic. At the end of the 8 months, something amazing was revealed: Mark had improved his attendance, his grades, and his
attitude so drastically that he was being transferred back to the regular high school and was on track to graduate with his class. We high-fived and celebrated. He thanked me. I was left thinking, what in the world just happened?

What had happened? In hindsight, I could see that over those months many things occurred. A fundamental occurrence was that I showed up, each week, without fail. He was important. I showed up for him. Over the course of the months he also began to relax. I was not a threat. I relaxed as well. He was not a threat. In fact, after a few weeks of meeting, during the long walk across campus from where I picked him up to our lovely trailer, he would protect me from other students who had something to say to me or wanted to approach me. His investment, connection to me and the therapeutic process, and his self-worth all strengthened as we continued to meet. This generalized to other parts of his life. His grades and behavior improved, and his view of his own life possibilities blossomed.

But, we just played MasterMind week after week for 8 full months.

Obviously rapport was critical to this process. I would argue that through the game play, I was able to understand things about him, how he thought, how he viewed the world and himself in it, what his interpersonal relationship skills were, and what he wanted out of life. In fact, the repetitiveness allowed me to track improvements and changes better than if we had changed games. Through his play, I understood he had a higher intellectual ability than he was showing in his schoolwork. His ability to think through patterns, to strategize, and to extrapolate information based on limited information was far superior to most same-age people. His willingness to meet with me and interact let me know he had a desire to connect with others, and his protection of me indicated he wanted to connect in a meaningful way.

The placement of his pieces was thoughtful, and he put effort into increasing the challenge. He attended to details of my piece placement enough to anticipate patterns used. His frustration tolerance skills improved as his sense of safety within our interaction increased. His sense of mastery shone through when he became good at the game and could be playful with it as opposed to focusing on his image and my perception of him or his abilities. His ability, willingness, and desire to trust another person grew as the months went by.

He chose the game. He chose how often it was played. It was a medium, a pace, and an interaction he could tolerate to work through processes he needed to. It was my job to attend, be present, be open to him and what he needed to show me, and follow through with what I learned about him through the interactions. BGPT isn’t the only modality that could achieve these goals, but when a child chooses to use it, it’s a powerful intervention.

---

**Case Study 3: Michelle**

Michelle was an 8-year-old who was brought to my office by an exasperated mother. She reported that her daughter was out of control behaviorally, had tantrums, and in general demanded things be done her way. Mom was exhausted and wanted to regain a sense of appropriate hierarchy between herself and her daughter. The family was intact and the history given didn’t indicate any glaring psychosocial issues.

Michelle chooses to play the game Mancala. During the play, her level of competitiveness and outright aggression were prominent. She would purposely move her pieces in a way that sabotaged either one of us to land where she thought will be most advantageous to her. She saw my inability to get pieces into my home base as great success, even when it also
reduced her ability to get pieces into hers. She appeared to be on track intellectually and developmentally. Her strategic abilities were high, her frustration tolerance was low, and her social interaction style was predatory and opportunistic. She frequently coped with situations by elevating herself, if even in her own mind, to a level that made her feel superior.

What I began to understand about her is that her need to feel superior was so great she was willing to sacrifice others and even herself to achieve this feeling. Although she desired positive social interactions, she didn’t trust them. In turn, they didn’t prevail when she had to choose between feeling superior and interacting positively. My investigation and concern became focused on this issue of a lack of trust. It is a common theme in children we see, but for some it is a fundamental Achilles’ heel. With these red flags in mind, I began to verbally explore with her what the relationships in her life had been like.

While we played Mancala, we discussed her peers, her friends, her parents, and her family. What we uncovered was a long series of losses in her life. She had three prominent family members die in the last 5 years, and also many beloved pets. “Everyone leaves,” she stated. Over a span of six individual sessions, it became clear to us both that she didn’t trust the interactions or relationships she had with others. I’m not even sure how much she trusted me, but I think I threw her off by understanding and spearheading her Achilles’ heel. It seemed there was a level of respect and relief that I had seen this raw and protected portion of her. We continued to work on it in numerous ways, including multiple games of Mancala.

Initially the game was invaluable in my ability to assess and understand the issues with which she was struggling. Ultimately, it allowed me to monitor her progress because the play morphed into a much more interactive, less aggressive, less predatory interaction. She became more generous, and it was clear that her need to feel superior was no longer more important than her desire to have a positive interaction. Both Michelle and her mother reported this dynamic was being generalized to home and school.

**Indications/Contraindications**

BGPT can be used in the assessment or intervention phases of treatment, regardless of the presenting problem, as long as there is applicable information to be gathered. Whether a child indicates a desire to play a board game or the therapist presents one, the therapist can assess a structured inventory of items (as explained previously in the Areas of Assessment) during game play. Based on what is discovered during assessment, therapeutic interventions can be implemented within BGPT or other modalities of play therapy.

There are no known contraindications for BGPT. If a child is young or has cognitive or physical impairments, it is imperative that the therapist takes this into consideration. Depending on the therapist’s personal theory, games can be specifically chosen or modified for the child.

**Logistics**

**Playroom Setup, Toys, and Materials**

Playroom setup will depend primarily on the therapist’s approach. A nondirective approach will lend itself to open shelving with the games and other items in the playroom visible and accessible.
The therapist who uses a more directive approach would tend to have the items within a cabinet and items used in any given session would likely be at the clinician’s discretion. Board games chosen will depend on the therapist’s desired interactions, the type of game (strategic or chance based), and the level of comfort the therapist has with the game.

In play therapy, numerous board games are useful in assessing the factors suggested in this chapter. The board games children choose most often are Mancala, Othello, Monopoly Junior (the full version takes too long to play in a single session), Life, Uno, Sorry, Trouble, Chutes and Ladders, Guess Who, and the Littlest Pet Shop Game. Less popular but still often used are Clue and Clue Jr., Stratego (very popular with gifted young men), Connect 4, Candy Land, Battleship, chess, and checkers.

**Treatment Frequency and Duration**

The frequency and duration of the use of BGPT would be dictated either by the child’s choice or therapist’s introduction. Children appear to have a pattern of their own when using BGPT. Some children choose board games exclusively. Some incorporate them into the session among other modalities, such as sandtray, puppets, or doll play. Others prefer to either begin or end the session with a board game, possibly as a way of injecting structure or some separation from either the environment they are coming from or heading into. Whatever the frequency, a therapist with a personal theory and a structure to assess during the play can create a therapeutic interaction when using board games.

**Pretreatment Assessment and Treatment Planning**

Prior to beginning treatment, gathering information from caregivers is useful in determining the presenting concerns. The therapist then has information about some areas to observe within the play, as well as a potential treatment focus. Information gleaned from board game interactions is very useful in treatment planning and intervention because the information is structured and organized for the therapist’s use. The worksheet at the end of this chapter can be used as a guide to the therapist’s assessment within BGPT.

**Treatment Stages and Strategies**

BGPT can be used in any stage of treatment as determined by the child and/or the therapist. It can be useful in assessment, treatment planning, and intervention. Utilizing the therapist’s personal theory and a structured approach, such as the one described in this chapter, the therapist can integrate the use of board games in a highly therapeutic way.

During the assessment phases of treatment, games can help the therapist discover areas of inter- and intrapersonal concern. With knowledge of the presenting concerns in hand, the therapist can apply the structured BGPT approach to understand the therapeutic needs of the child. While in the treatment planning stage, the therapist can incorporate the assessed information and needs into the therapist’s personal theory. This creates a foundation for a structured treatment plan while utilizing an inherently attractive modality. Interventions can be implemented within the BGPT through verbal and nonverbal interactions during the game play.
CONCLUSION

With a well-thought-out approach, BGPT can be as useful as many other interventions in play therapy. Utilizing a defined framework for the assessment phase of BGPT elevates the interaction from play to play therapy. The therapist can be aware of and cue into particular concepts and document them accordingly. Once assessed and documented, the information can become a key element of the treatment plan and treatment implementation. Discussions with referral sources, collateral contacts, colleagues, and payment sources can be rich with content of the observations of the play rather than a statement of what was played. Instead of simply “therapist and child played Uno,” one could state, “During the session, the child chose to play Uno. The interaction yielded great information regarding her aggressive, predatory worldview, her potentially above-average intellectual functioning, her below-average frustration tolerance, and her well-developed strategic abilities. This effects her social interactions in x, y, z ways. This supports [or not] x, y, z reported behaviors/patterns. Continued treatment will include ….” In addition, the therapist can feel more confident that the interaction has value beyond rapport building, and the therapist will be able to utilize the modality without the anxiety of feeling the need to move on to other materials with perceived higher therapeutic values.

The assessment list can be adjusted to fit any theoretical framework by adding assessment elements as needed. The important aspects are that you know what you are doing and why you are doing it. When that is understood by you and organized in a meaningful way, conveying the importance, effectiveness, and usefulness of whatever modality you use will be much easier and substantial. Whether you are using miniatures, dolls, cars, puppets, Pokémon, songs, or games, it is crucial to speak children’s language and understand what it is they need to tell you in order to heal and get their needs met in appropriate ways.

BGPT WORKSHEET

Jessica Stone, Ph.D., RPT-S

Assessment Framework

Level of mastery: ________________________________
Frustration tolerance: ________________________________
Coping skills: ________________________________
Strategic abilities: ________________________________
Rough IQ estimate: ________________________________
Social interaction abilities/styles: ________________________________
Competitiveness: ________________________________
Norm compliance level: ________________________________
Level of rapport: ________________________________
Development: ________________________________
REFERENCES


PART 4

Applications for Special Populations
Play therapy has been the treatment of choice for children ages 3 to 12 since the beginning of its development. Over the past 20 years, the view of play therapy as a treatment modality has expanded to include adolescents (Schaefer, 2003), young adults (Kaduson, in press), and geriatric populations (Lindaman, 1994). Play remains an important part of many everyday experiences and is a less direct avenue to the internal lives of children and adults (Erikson, 1993). When play is presented, most people will join in, let go, and allow the play to heal. Play therapy allows older children and adults to regress to an earlier developmental level if they need to work through something that happened during an earlier stage of development. Play therapy can be used as a treatment for all ages, and the results are wonderful.

Play therapy is defined as the “systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development” (Association for Play Therapy, 1997). As is the goal with all therapy, a trained play therapist can establish a relationship with and help a client achieve optimal psychological growth and development.

Human development psychologists have recently embraced the life span perspective, which “maintains that important changes occur during every period of development” (Boyd, 2009, p. 4). This new point of view includes changes that occur in adulthood and places them on the same level of importance as those changes that take place in childhood (Boyd, 2011). Parallelizing the changes in developmental psychology, “insights into the healing power of play are being discovered” (Schaefer, 2003, p. 4), and play techniques are being used successfully with all age groups.
WHY PLAY THERAPY IS APPROPRIATE

Over the past six decades, play therapy has grown from a completely nondirective, Axlinian model (Axline, 1947) to more than 20 types of play therapy, including filial play therapy (Guerney, 2000; VanFleet, 1994), cognitive-behavioral play therapy (Knell, 1993), Jungian play therapy (Green, 2011), Adlerian play therapy (Kottman, 2011), Gestalt play therapy (Oaklander, 2011), release play therapy (Kaduson, 2011), Ecosystemic Play Therapy (O’Connor, 2011), and prescriptive play therapy (Kaduson & Schaefer, 1997). The prescriptive approach to play therapy encourages adapting the treatment to the child. The use of prescriptive treatments challenges the play therapist to examine the strengths and weaknesses of specific theoretical orientations for treating various disorders. This framework can be utilized with clients of any age. For example, if an adult had a trauma in early childhood, release play therapy would be indicated so the incident can be abreacted and slowly assimilated into the consciousness, allowing the person to heal. Whether the client is 2 or 82, play therapy can be an effective intervention. For the young, the research is clear because play is the language of the child. For adolescents and adults, play therapy is beneficial because it can help alleviate the emotional difficulties that have been spoken about over and over again in talk therapy, but without psychological relief.

Many trainings in play therapy use techniques for the participants to practice and experience in order to understand what that type of treatment might feel like for the child. When people question whether play can be used with adults, the proof is shown in the training. They just did it.

It is important that the play therapist is playful and silly when needed. Playfulness is not a universal trait, and there can be some difficulties if the therapist does not join as a playful participant when doing techniques with children, adolescents, young adults, and geriatric populations. A playfulness scale for adults (Schaefer, 1997) lists five factors that are included in being playful: The person is fun loving, has a sense of humor, enjoys silliness, is informal, and is whimsical. These characteristics enhance the ability of the play therapist to work with clients of all ages.

THEORIES BEST SUITED TO WORK WITH SPECIFIC AGE GROUPS

Despite the general acceptance that play therapy can be beneficial across the life span, there is very little information available to practitioners on its application with age groups that fall outside childhood. In this chapter, a prescriptive eclectic approach is used to facilitate the use of play therapy for different ages. The model of prescriptive play therapy takes into consideration: (a) the psychological issues that are commonly seen in specific disorders; (b) biopsychosocial variables that are unique to individuals; (c) immediate, short-term, and long-term needs of the client with specific presenting problems; (d) play therapy treatment planning that integrates and applies those therapeutic factors that relate to a client’s needs; and (e) skillful application of interventions that address play therapy goals and objectives (Kaduson, 1997). Within this prescriptive approach, psychological techniques and interventions are prescribed based on the characteristics and needs of individuals, and this approach uses the therapeutic factors of play in the conceptualization and treatment of children and adults with a variety of psychological disorders and adjustment difficulties (Kaduson & Schaefer, 1997). Research supports matching the theoretical intervention that works best for a particular psychological disorders. For example, psychodynamic treatment is effective for neurotic disorders among bright, verbal individuals, and cognitive-behavioral approaches are most effective for alleviating depression and anxiety (Beck, 1983).
A prescriptive approach to play therapy challenges the play therapist to weave together a variety of interventions in formulating a comprehensive treatment program tailor made for a particular client (Kaduson, in press). An approach of integrating techniques reflects what Norcross (1987) calls synthetic eclecticism because it stresses applying various theories into one interactive and coordinated modality of treatment.

Play is a natural and enduring behavior that has healing powers, and while it may have been socially dismissed as a child grows into adolescence through sayings such as “stop playing around,” play remains a very powerful need. Play enhances psychological strength by allowing creative problem solving and pleasure, and it keeps us mentally fit.

This chapter will illustrate how play therapy can be utilized in different stages of development throughout the life span. Piaget’s (1936) stages of cognitive development and stages of play, Eric Erikson’s stages of psychosocial development (1950/1993, 1968), and Abraham Maslow’s hierarchy of needs (Maslow, 1954) will provide the framework from which prescriptive play therapy meets the needs of the individual client.

Birth to 2 Years

Piaget’s (1936) sensorimotor stage is centered on the infant trying to make sense of her world through the use of schemas. Schemas are mental representations or ideas about what things are and how we deal with them. Piaget deduced the first schemas of an infant are about movement. He believed many of a baby’s behaviors are triggered by certain stimuli and are reflexive. A few weeks after birth, babies begin to understand some of the information they are receiving from their senses, and they learn to use some muscles and limbs for movement. These developments are known as action schemas. Babies are unable to consider anyone else’s needs, wants, or interests and are therefore considered to be egocentric.

During the sensorimotor stage, knowledge about objects and the ways they can be manipulated is acquired. Through the acquisition of information about self and the world, babies begin to understand how one thing can cause or affect another, and they begin to develop simple ideas about time and space. Babies have the ability to build up mental pictures of objects around them from the knowledge they have developed about what can be done with the object. What the objects are is irrelevant. More importance is placed on the baby being able to explore the object to see what can be done with it. At around the age of eight or nine months, infants are more interested in an object for the object’s own sake. Piaget (1936) discovered babies act as though the object has ceased to exist when it is removed from their sight. Around the age of 8 to 12 months, infants begin to look for hidden objects, a concept called object permanence.

Similarly, Erikson’s stage of trust versus mistrust focuses on the infant’s basic needs being met by the caregivers and this interaction leading to trust or mistrust. The infant depends on the parents, especially the mother, for sustenance and comfort. The child’s relative understanding of world and society come from the parents and their interaction with the child. If the parents expose the child to warmth, regularity, and dependable affection, the infant’s view of the world will be one of trust. Should the parents fail to provide a secure environment and to meet the child’s basic needs, a sense of mistrust will result. Development of mistrust can lead to feelings of frustration, suspicion, withdrawal, and a lack of confidence (Erickson, 1950/1993).

According to Erickson, the major developmental task in infancy is to learn whether other people, especially primary caregivers, regularly satisfy basic needs. If caregivers are consistent sources of food, comfort, and affection, an infant learns trust—that others are dependable and reliable. If they are neglectful, or perhaps even abusive, the infant instead learns mistrust—that the world is in an un dependable, unpredictable, and possibly a dangerous place. While negative, having some experience with mistrust allows the infant to gain an understanding of what constitutes dangerous situations later in life.
Maslow’s hierarchy of needs parallels this stage as well. During this first stage, physiological needs are the physical requirements for human survival. If they are not met, the body cannot function properly and will ultimately fail (Maslow, 1954).

**Functional Play (Birth to 18 Months)**

Almost all neurons are present at birth, but most are not connected in networks. The process of synapse formation is rapid during the first year of a child’s life, with brain activity becoming closer to that of an adult than that of a newborn by 12 months of age. Areas of greatest growth occur in the sensorimotor and visual cortex, then later in the frontal lobes. A baby learns about the world by sight, sound, touch, taste, and smell. That is why infant toys are usually brightly colored noisemakers. The baby then moves from the mobile and mirrored toys to grasping and holding toys that jingle or rattle and soft balls that can be dropped and retrieved, and the baby begins to learn dexterity and the concept of cause and effect. As the baby begins to sit up, crawl, stand, and then walk, the possibilities of this play quickly expand. The child experiments with nesting cups, activity boxes, stacking rings, and others. These toys help develop fine motor skills and reach relationship among objects. Practice play allows for the baby to learn about the world.

**Strategies and Interventions**

Play therapy can be used to help parents to understand the importance of play for children from birth. Being educated in the normal developmental play behaviors of infants has shown to be very helpful in the bonding of teenage parents and their newborns (Ammen, 2000; Munns, 2003). Using play therapy involving the parent has been proven to be very successful, as demonstrated by the effectiveness of Filial Therapy (Guerney, 2000; VanFleet, 1994), and Parent–Child Interaction Therapy (Eyberg, 2001). In both models, the parents are observed, trained, and supervised by professionals to increase positive therapeutic interactions between the parent and the child. While both of these approaches involve the use of parents as therapists, their theoretical orientations are different. Filial Therapy is a nondirective form of therapy, and Parent–Child Interaction Therapy is a behaviorally based therapy. In addition to attachment issues, there are more common developmental difficulties in children below the age of 3. Fears are most common and are within the normal response pattern for children in or below the preoperational stage of development. Play can enhance children’s mastery of their fears through play that begins with the game of peekaboo at age 1. When children playfully work through the fear of a parent’s leaving, they are also reducing their own anxiety through the game because it produces a sense of mastery and trust (Quackenbush, 2008).

It should be noted that in this age group, there is a tremendous amount of literature about reactive attachment disorder in adopted children. Play therapy can be a great catalyst for encouraging bonding with adoptive children. Filial Therapy (VanFleet, 1994) provides the avenue to do this by training parents to use various play therapy approaches at home with the children. Theraplay<sup>®</sup> also follows a similar path by modeling healthy interactions of early parent–child relationships that promote attachment (Jernberg, 1979). Lastly, Viola Brody’s developmental play therapy also uses play in a therapeutic way to regain trust through touch (Brody, 1993).

**Preoperational Stage and Preschool Children (3 to 7 Years)**

In the preoperational stage of development (Piaget, 1936), children’s thought processes are developing, although they are still considered to be far from logical thought. Children’s vocabularies...
expands and develops during this stage. The limitations of this stage of development include being egocentric, meaning children are only able to consider things from their own point of view, and they imagine everyone shares this view. Gradually, a certain amount of “decentering” occurs; this is when children stop believing they are the center of the world and are more able to image something or someone else could be the center of attention. Animism is also a characteristic of this stage. Preschoolers believe everything that exists has some kind of consciousness. They could punish a chair that fell over, as if the chair had the intent to fall. In this stage, a child assumes everyone and everything is like them, and they believe that because they can feel pain and emotions, so must everything else. Another aspect of this stage is symbolism. This is when something is allowed to stand for or symbolize something else. Moral realism is also an aspect of this stage; this is the belief that the child’s way of thinking about the difference between right and wrong is shared by everyone else. The child is only able to focus on one aspect of a situation at a time. It is beyond the child to consider that anything else could be possible.

Erickson (1993) focuses on this stage as autonomy versus shame and doubt through initiative versus guilt. As children gain control over eliminative functions and motor abilities, they begin to explore their surroundings. The caregivers still provide a strong base of security from which they can venture out to assert their will. The patience and encouragement given by the caregivers help foster autonomy in the child. Children at this age like to explore the world around them, and they are constantly learning about their environments.

At this age, children develop their first interests. For example, children who enjoy the outdoors may be interested in animals and plants. As they gain increased muscular coordination and mobility, toddlers become capable of satisfying some of their own needs. They begin to feed themselves, wash and dress themselves, and use the bathroom.

If caregivers encourage self-sufficient behavior, toddlers develop a sense of autonomy—a sense of being able to handle many problems on their own. But if caregivers demand too much too soon, refuse to let children perform tasks of which they are capable, or ridicule early attempts at self-sufficiency, children may instead develop shame and doubt about their abilities to handle problems.

Initiative adds to autonomy the quality of undertaking, planning, and attacking a task for the sake of just being active and on the move. Children are learning to master the world around them, learning basic skills and principles of physics. Things fall down, not up. Children learn how to zip and tie, count, and speak with ease. At this stage, children want to begin and complete their own actions for a purpose. Guilt is a confusing new emotion. They may feel guilty over things that logically should not cause guilt or when their initiatives do not produce desired results.

The development of courage and independence is what sets preschoolers, ages 3 to 6 years, apart from other age groups. Young children in this category face the challenge of initiative versus guilt. As described in Boyd and Bee (2014), the child during this stage faces the complexities of planning and developing a sense of judgment. Activities sought out by a child in this stage may include risk-taking behaviors, such as crossing a street alone or riding a bike without a helmet; both these examples involve self-limits.

Within instances requiring initiative, the child may also develop negative behaviors. These behaviors are a result of the child developing a sense of frustration for not being able to achieve a goal as planned, and the child may engage in behaviors that seem aggressive, ruthless, and overly assertive to parents. Aggressive behaviors, such as throwing objects, hitting, or yelling, are examples of observable behaviors during this stage.

Preschoolers are increasingly able to accomplish tasks on their own and can start new things. With this growing independence comes many choices about activities to be pursued. If parents and preschool teachers encourage and support children’s efforts while also helping them make
realistic and appropriate choices, children develop initiative and independence in planning and undertaking activities. If instead adults discourage the pursuit of independent activities or dismiss them as silly and bothersome, children develop guilt about their needs and desires.

Maslow (1954) focuses on this age stage as one of safety. With physical needs relatively satisfied, the individual's safety needs take precedence and dominate behavior. These needs include personal security, financial security, health and well-being, and a safety net against accidents/illness and their adverse impacts.

Constructive Play (18 Months to 3 Years)
During this time, the synapses continue to expand and reach about 1 quadrillion—twice the density of the adult brain. The structures sensitive to language and social-emotional response develop. Motor activity rapidly grows during this stage. The child manipulates the environment to create things. This type of play occurs when a child realizes that two things can be put together and something else is built. Constructive play allows the child to experiment with objects; find combinations that work and don't work; and learn basic knowledge about stacking, building, drawing, making music, and constructing. It also gives the child a sense of accomplishment and empowers toddlers with control over their environment.

Fantasy or Dramatic Play (3 to 6 Years)
This is the fastest growth period for the frontal lobe networks, and speed of processing, memory, and problem solving increases. The brain is at 90% of its adult weight by 6 years. The child learns to abstract, to try out new roles and possible situations, and to experiment with language and emotions with fantasy play. In addition, a child develops flexible thinking, learns to create beyond the here and now, stretches imagination, and uses new words and word combinations in a risk-free environment. Imagination and interaction during this time involve the substitution of an imaginary situation to satisfy the child's personal wishes and needs. The language and social skills practiced through dramatic play games come into play as preschoolers interact more. It is important to note that pretend or dramatic play has two levels of development. At first children will need functional real-looking items to fill the world of pretend, but as they develop through this stage, they begin to prefer objects such as Styrofoam chips or rocks to create the world in which they pretend.

Strategies and Interventions
The most research and clinical practice with play therapy has been done with the children in the preoperational stage of development (ages 3 through 7), due to the limitations of preschoolers’ cognition. There are many different play therapy approaches that help a preschooler with emotional turmoil, an adjustment issue, or posttraumatic stress disorder. For this population of children, child-centered, nondirective play therapy is very effective. Children must believe they are safe, and they can do what they want in the special playroom. The trusting relationship is the healing agent, and many preschoolers jump into a teacher or parent role, giving their ego over to the therapist, who would be “the child.” Children play out the issues at hand that are really disturbing them (not necessarily as presented by parents), and through the repetitive thematic play, they begin their own healing processes. When one reviews the stages of cognition and play, it is clear that children can communicate more effectively through play than through words.

Concrete Operational and School-Age Children (7 to 11 Years)
The concrete operations stage of development has specific characteristics, such as that the thought process of the child becomes more rational, mature, and adult-like. Although this
Play Therapy Across the Life Span: Infants, Children, Adolescents, and Adults  333

process most often continues well into the teenage years, Piaget (1936) divided it into two substages: concrete operations and formal operations.

In the concrete operational stage, children have the ability to develop logical thought about an object if they are able to manipulate the object. By comparison, in the formal operations stage, the thoughts are able to be manipulated and the presence of the object is not necessary for the thought to take place. While the belief in animism and egocentric thought tends to decline during the concrete operations stage, remnants of this way of thinking are often found in adults. Piaget (1936) argued that before the beginning of this concrete stage, a child’s ideas about different objects are formed and dominated by the appearance of the object. For example, there appears to be more blocks when they are spread out than when they are in a small pile. During the concrete operational stage, the child gradually develops the ability to conserve or learn that objects are not always the way they appear to be. This is seen when a child is able to take in many different aspects of an object simply by looking at it. The child begins to imagine different scenarios or hypothetical possibilities. Children are generally able to conserve ideas about objects with which they are most comfortable. After conservation has developed, they learn about reversibility, which means that even though things change, they will still be the same as they used to be. For example, a lineup of blocks looks larger, but it has the same blocks that are in what appears to be the smaller pile.

Erickson’s (1993) stage of industry versus inferiority (ages 5–12) focuses on children trying to bring a productive situation to completion, which gradually supersedes the whims and wishes of play. The fundamentals of technology are developed. To lose the hope of such “industrious” association may pull the child back to a more inferior sense of self. Children at this age are becoming more aware of themselves as individuals. They work hard at being responsible, being good, and doing things right. They are now more reasonable and better able to share and cooperate. Children grasp the concepts of space and time in more logical, practical ways. They gain a better understanding of cause and effect and of calendar time. At this stage, children are eager to learn and accomplish more complex skills: reading, writing, telling time. They also begin to form moral values and recognize cultural and individual differences.

Erikson (1950/1993) viewed the elementary years as critical for the development of self-consciousness. Ideally, elementary school provides many opportunities for children to achieve the recognition of teachers, parents, and peers by producing things: solving addition problems, writing sentences, and so on. If children are encouraged to make and do things and are then praised for their accomplishments, they begin to demonstrate industry by being diligent, persevering at tasks until completion, and putting work before pleasure. If children are instead ridiculed or punished for their efforts, or if they find they are incapable of meeting their teachers’ and parents’ expectations, they develop feelings of inferiority.

Maslow (1954) considers this stage to be about love and belonging. After physiological and safety needs are met, an individual needs interpersonal relationships and feelings of belongingness. This need is especially strong in childhood and can override the need for safety, as witnessed in children who cling to abusive parents. Deficiencies within this level of Maslow’s hierarchy—due to neglect, ostracism, and so forth—can impact the individual’s ability to form and maintain emotionally significant relationships in general. According to Maslow, humans need to feel a sense of belonging and acceptance among their social groups, regardless of whether these groups are large or small. Many people become susceptible to loneliness, social anxiety, and clinical depression in the absence of this love or belonging element. This need for belonging may overcome the physiological and security needs, depending on the strength of the peer pressure.

Games With Rules (6 to 11 Years)

During these years, the synaptic connections in motor and sensory areas are firmly established, and the process of eliminating synapses (pruning) in these areas begins. Because of the activity
in higher brain “control” centers, children increase in levels of attention and ability to inhibit impulses. Imaginative play still continues through pretend or crafts, but games with rules become predominant. This requires even more symbolism because not only does the child have to use the marker to represent a person or thing, but the entire board game itself is now another level of symbolism. Developmentally, a child progresses from an egocentric view of the world to an understanding of the importance of social contracts and rules. Part of this development occurs as children learn games that require everyone to adhere to the same set of rules. This is the stage that teaches a child a critically important concept: The game of life has rules (laws) that everyone must follow to function productively.

**Strategies and Interventions**

As children develop over time, play becomes more important for learning social and emotional roles, and yet play time is significantly decreased and children’s time is often spent in structured after-school activities. This leaves little time for them to preserve the play behaviors they still need. School-age children still want to play, but instead of free, pretend play, they may now be more interested in games with rules. This is a significant change, but it is also why we can do play therapy with any aged child. Using a board game is very helpful to increase the ego strength of the child, specifically taking turns, sharing cards or pieces, and learning how to win or lose graciously. Because competition starts so early in a child’s life, the competitive nature becomes of utmost importance. For this age group, a play therapist can use any game as a metaphor that will relate to the child’s life. For instance, *Sorry* is a game of strategy and luck, but the pieces can represent choices, and the play therapist can talk about the moves the therapist is contemplating. Taking into account that elementary school involves less play and much more academics, it would be helpful to engage a child in a silly way of responding to things by making mistakes. Desensitizing children from worrying about mistakes is one of the goals for anxious or learning disabled children because they are so afraid mistakes might mean they are not “good enough” or may make them feel “stupid.”

Children in this stage of development are capable of understanding metaphors, and once they are comfortable with it, play therapists can approach any issue the child has through many techniques.

**Formal Operations and Adolescents (11 to 18 Years)**

Finally, when a child reaches this stage of cognitive development, the structures of development become the abstract, logically organized system of adult intelligence. When faced with a problem, an adolescent can speculate about all possible solutions before trying them out in the real world. A key development in this stage is the capacity for abstraction. Adolescents begin to reason beyond a world of concrete reality to a world of possibilities and to operate logically on symbols and information that do not necessarily refer to objects and events in the real world. There are two major characteristics of the formal operational stage, one of which is hypothetic-deductive reasoning (Piaget, 1936). This is evident when adolescents are faced with a problem and they develop a general theory of all possible factors that might affect the outcome and deduce from it specific hypotheses about what might occur. Then they check to see which ones occur in the real world. The adolescent problem solving begins with possibility and proceeds to reality. The second important characteristic is propositional in nature. Adolescents can focus on verbal assertions and evaluate their logical validity without making reference to real-world circumstances.

Erickson (1993) identifies this stage as identity versus role confusion. Adolescents are now concerned with how they appear to others. In later stages of adolescence, they develop a sense
of sexual identity. As children make the transition from adolescence to adulthood, they ponder the roles they will play in the adult world. Initially, adolescents are apt to experience some role confusion—mixed ideas and feelings about the specific ways in which they will fit into society—and they may experiment with a variety of behaviors and activities. Eventually, Erikson proposed, most adolescents achieve a sense of identity regarding who they are and where their lives are headed.

Erikson (1968) is credited with coining the term identity crisis. Each stage that came before and each one that follows has its own crisis, but even more so now, for this marks the transition from childhood to adulthood. This turning point in human development seems to be the reconciliation between the person one has come to be and the person society expects one to become. This emerging sense of self will be established by forging past experiences with anticipations of the future.

What is unique about the stage of identity is that it is a synthesis of earlier stages and an anticipation of later ones. Youth is a bridge between childhood and adulthood. Youth is a time of radical change—the great body changes accompanying puberty, the ability of the mind to search one's own intentions and the intentions of others, and the suddenly sharpened awareness of the roles society has offered for later life (Bugental, 2000).

Adolescents “are confronted by the need to reestablish [boundaries] for themselves and to do this in the face of an often potentially hostile world” (Goble, 1970, p. 62). This is often challenging because commitments are being asked for before particular identity roles have formed. At this point, one is in a state of identity confusion, but society normally makes allowances for youth to find themselves, and this state is called the moratorium. The problem of adolescence is one of role confusion—a reluctance to commit that may haunt people into their mature years. Given the right conditions—and Erikson believes these are essentially having enough space and time, a psychosocial moratorium when a person can freely experiment and explore—what may emerge is a firm sense of identity, an emotional and deep awareness of who the individual is (Goble, 1970). As in other stages, biopsychosocial forces are at work. No matter how one has been raised, one's personal ideologies are now chosen for oneself. Often, this leads to conflict with adults over religious and political orientations. Another area where teenagers are deciding for themselves is their career choices, and often parents want to have a decisive say in that. If society is too insistent, teenagers will acquiesce to external wishes, effectively forcing them to foreclose on experimentation and, therefore, true self-discovery. According to Erikson (1968), when adolescents have balanced both perspectives of “What do I have?” and “What am I going to do with it?” they have established their identity.

Maslow’s (1954) hierarchy of needs identifies this stage as esteem, which incorporates confidence, achievement, respect for others, and respect by others. All humans have a need to feel respected; this includes the need to have self-esteem and self-respect. Esteem presents the typical human desire to be accepted and valued by others. People often engage in a profession or hobby to gain recognition. These activities give the person a sense of contribution or value. Low self-esteem or an inferiority complex may result from imbalances during this level in the hierarchy. People with low self-esteem often need respect from others; they may feel the need to seek fame or glory. However, fame or glory will not help people to build their self-esteem until they accept who they are internally. Psychological imbalances such as depression can hinder the person from obtaining a higher level of self-esteem or self-respect. Most people have a need for stable self-respect and self-esteem. Maslow noted two versions of esteem needs: a lower version and a higher version. The lower version of esteem is the need for respect from others. This may include a need for status, recognition, fame, prestige, and attention. The higher version manifests itself as the need for self-respect. For example, the person may have a need for strength, competence,
mastery, self-confidence, independence, and freedom. This higher version takes precedence over the lower version because it relies on an inner competence established through experience. Deprivation of these needs may lead to an inferiority complex, weakness, and helplessness. Maslow states that while he originally thought the needs of humans had strict guidelines, the “hierarchies are interrelated rather than sharply separated” (Maslow, 1970, p. 314).

**Strategies and Interventions**

Play therapy is now more widely used with adolescents. Play therapy has been used with adolescents in the schools to address emotional and social needs (Gallo-Lopez & Schaefer, 2005; Breen, 1998; Kottman, 1987). It is easier to express feelings when there are play strategies that are fun to do, such as the SplatE Eggs technique, expressive arts techniques, game play, or storytelling games (Kaduson & Schaefer, 1997; Reid, 1993; Stiles, 1990). It is not an either or situation, because there are adolescents who also like talk therapy. However, when an adolescent is guarded or feels threatened, talk therapy may not be as useful. In comparison, play therapy allows for the use of the therapeutic powers of play (Schaefer, 1993) and by doing fun techniques, anxiety decreases and guards are lowered. Whether treatment is in the schools or in the clinic, most play therapy techniques for adolescents help remove the resistance that many appear to have (Bow, 1997; Ward-Wimmer, 2003).

Additional cognitive-behavioral techniques are easily used with adolescents. One very powerful anger technique is called “the anger shield” (Glatthorn, 1997). Materials used in this technique are a piece of cardboard, one piece of paper, markers, pencils, a large rubber band, and a stapler. The client is invited to make representations of things that he hates, or to list 10 statements of things that make him angry, on a precut cardboard shield. When that is completed, the teen takes the blank sheet of paper and writes the numbers 1 through 10 vertically. Then he is asked to list feelings that cause anger (have a feeling words chart nearby for a frame of reference). The therapist will ask the adolescent to assign the number or numbers of the feelings that cause the anger next to each statement. This activity is an effective means of identifying affect and which feelings the client needs to work on to stop the anger from developing.

**Young and Older Adults (19 to 64 Years), Including Family**

Because Erikson’s (1993) stage of intimacy versus isolation is often characterized by marriage, many are tempted to cap off the fifth stage at 20 years of age. However, these age ranges are actually quite fluid, especially for the achievement of identity, since it may take many years to become grounded, to identify the object of one’s fidelity, and to feel that one has come of age. Erikson noted identity formation tends to be protracted in an industrial society, as it takes a long time to gain the skills needed for adulthood. A very approximate rule of thumb for our society would put the end somewhere in one’s 20s (Bugental, 2000).

For purposes of this chapter, Erikson’s next stage is also included, generativity versus stagnation. Generativity is the concern of guiding the next generation. Socially valued work and disciplines are expressions of this stage. A sense of productivity and accomplishment results when a person makes a contribution during this period, perhaps by raising a family or working toward helping society in general. On the other hand, a person who is self-centered and unable or unwilling to help society move forward develops a feeling of stagnation or dissatisfaction and lack of productivity. Tasks central to this stage in middle adulthood are expression of love through more than sexual contacts, maintaining a healthy life pattern, developing a sense of unity with mate, helping grown children to be responsible adults, accepting children’s friends, creating a comfortable home, and being proud of accomplishments.
Maslow (1954) defines this stage as a development of what a person’s full potential is and the realization of that potential. Maslow describes this level as the desire to accomplish everything one can, to become the most that one can be. Individuals may perceive or focus on this need very specifically. For example, one individual may have the strong desire to become an ideal parent. In another, the desire may be expressed athletically. Maslow believed that to understand this level of need, the person must not only achieve the previous needs, but master them.

Strategies and Interventions

Whether an adult is 19 or 55, the use of play therapy has proven to be very successful in many ways. When training play therapists, one can see how therapeutic many of the techniques are for allowing the exploration of the past through a timeline (Cook, 1997) or by just releasing the tension of the moment (Kaduson, 2011). Charles Schaefer (2003) has gathered many different approaches that are used with adults. It has been shown that when the therapist is able to use therapeutic humor, even with depressed adults, the clients are able to free themselves from the sadness and/or anxiety for that moment. All of the components of humor, whether seen as benign hostility which is not destructive or emphasized as kindly attributes, have powerful therapeutic effects (Sultanoff, 2003).

Many play therapists who have been trained in sandplay therapy use it quite successfully with adults (Ammann, 1991; Carey, 1999). Sandplay therapy is a recognized therapeutic modality for both children and adults that is based on the psychology of C.G. Jung and was developed by Dora Kalff. It has tremendous benefit for adults because it is useful for identifying and reconciling internal conflicts that manifest as anxiety and depression, as well as penetrating the depths of personality to experience the self directly. In addition, many trained sand play therapists use different types of play therapy, as well as puppetry, for the treatment of families through play therapy (Blatner, 1999; Carey, 1999; Guernsey, 1999; Harvey, 1999; Gil, 1994).

It should also be noted that group play therapy with adults illustrates the power of play and how it can produce cohesiveness among members who initially were withdrawn or defensive. Using games with adults in a play therapy group setting allows for the feelings of pleasure and joy, and it also requires more emotional control, intellect, and social skills. Group play therapy with adults can give the participants a closer connection with each other and feelings of pleasure through the play treatment.

Using release play therapy (Kaduson, 2011) with adults who have had traumatic experiences when they were younger has been shown to be an effective treatment method because it allows for abreactive play to work through the trauma.

Case Example

A case in point was with a 22-year-old, Nicole. At the age of 15, she was involved in a car accident. She was the only person in the back seat without a seatbelt on when the driver lost control of the car. It hit a fire hydrant, and the car rolled over three times. No one was injured except for Nicole, who had hit her head and was bleeding when she exited the car. Nicole was a rather compliant teen and did not have permission to go in anyone’s car unless parents were driving. In this case, the driver was 17 years old. Nicole’s first words after getting out of the car were, “Call my mother. Am I going to die?” Within minutes the paramedics arrived, and she was taken to the hospital. No one had spoken to her mother or father yet because their phone went to voicemail. She went into the ambulance by herself,
and the first words to the rescue worker were, “Am I going to die?” She seemed to manage all of the intrusive procedures by herself, and when the MRI was done, she was given a bed in a room. Her parents arrived at that time. The nurses and doctors told them how brave Nicole had been. Her injuries were not serious, and she was released from the hospital.

One week later, Nicole was having anxiety attacks at school, which generalized to other places, and she became agoraphobic within a month. She began cognitive-behavioral therapy, and she was able to manage her anxiety and return to school within 6 months. All symptoms were gone by the end of the school year. Seven years later, Nicole returned to treatment because of flashbacks to the car accident. Talk therapy was again used for the first two sessions, but there seemed to be underlying issues Nicole could not express. During the next session, she was asked to draw what happened prior to, during, and after the car accident. She was able to focus on the fact that the fire hydrant was the trigger for her because it was in all three drawings. She was still having difficulty managing her anxiety, despite being on psychotropic medication for the past year. Nicole was asked to show what happened the day of the accident, and that was done in the playroom. She spent several weeks showing the before, during, and after scenes from the car accident, always ending with the arrival of the paramedics. It wasn’t until the fifth week she played out and that she remembered she kept asking people to call her parents, and no one could find them. She played how they wrapped her neck for protection, put her on a stretcher, and she went into the ambulance alone. She asked the rescue worker directly, “Am I going to die?” and she remembered that he said, “Now way you are going to die.” This was the first time she remembered it, and then for the following 3 weeks, more and more of the traumatic experience evolved that had not been talked about before. It was all about being in the ambulance and hospital alone, with her head bleeding. The nurses had put her in one of the emergency rooms, and they ripped off her blouse to check where all the blood was coming from. She had forgotten all about that as well, and said she really felt like she was watching herself go through the entire exam and testing without being present. She had dissociated during the entire process, which was the key to her uncovering the underlying issues of her experience. It was not the car accident that was still affecting her, but the PTSD was from the fear of being alone at 15 and thinking she was going to die. She had never spoken about any of these experiences in 7 years, and within a few months of play therapy, she became aware and was able to work through the residual effects of that day.

Geriatric (65 and Older)

Erickson (1993) has characterized this stage as integrity versus despair. As we grow older, we tend to slow down our productivity and explore life as a retired person. It is during this time we contemplate our accomplishments and are able to develop integrity if we see ourselves as leading successful lives. If we see our lives as unproductive, or feel that we did not accomplish our life goals, we become dissatisfied with life and develop despair, often leading to depression and hopelessness.

The final developmental task is retrospection: People look back on their lives and accomplishments. They develop feelings of contentment and integrity if they believe they have led happy, productive lives. They may instead develop a sense of despair if they look back on lives of disappointments and unachieved goals. This stage can occur out of sequence when an individual feels she is near the end of her life, such as when receiving a terminal disease diagnosis.
Strategies and Interventions

Considering the varying degrees of cognitive functioning and limitations to communication the elderly so often experience, play therapy is a useful treatment modality for this population. Play therapy does not need language or words to communicate, and it can help elderly individuals who are resistant to talk therapy. There are many psychological and physiological changes that concern elderly people, and through different types of play therapy, whether it is nondirective or directive, clients can feel safe and enjoy the time as they manage their lives.

Group play therapy with game play has been shown to increase positive affect with nursing home residents (Ingersoll, 1978; Lindaman, 1994). Theraplay, which is an attachment and relationship enhancing treatment, has been used in individual and group play therapy treatment with adaptations for aging individuals (Sherman, 1981). In working with older adults, the Theraplay therapist must be alert to certain possible conditions that might be exhibited. This is quite different from working with children or adults of a younger age because the elderly may have trouble sitting, walking, remembering, hearing, seeing, and balancing. All of those needs must be incorporated into the play therapy. However, even with the limitations of this group, Theraplay can enhance self-esteem, increase trust in others, and reinstate the philosophy that there can be pleasure in day-to-day experiences (Jernberg, 1987).

Cognitive-behavioral techniques can also be used for this population. The level of worry is increased in many geriatric clients. “The Worry Can” (Jones, 1997) is particularly effective activity with individuals or in a group setting. This requires a can with a lid, construction paper and typing paper, markers, glue, and scissors. The therapist and client cut construction paper in a strip to cover the can. The client can draw scary things on one side of the construction paper strip and color them with the markers. If the client prefers, she can write down scary words instead. When each client is finished drawing or writing, have the clients glue the strip to their cans. The next step is to put the lid on the can and make a slot in the top of it using the scissors. The slot should be large enough to put small, folded pieces of paper inside the can.

Cut small strips of the typing paper. Each strip must be big enough to write a few words on it. On the strips of paper, have each client write down his or her worries, with one worry to a piece of paper. Each client should fold each worry and put it into the can he or she constructed. Clients take turns sharing one worry with their peers. Encourage the sharing of support and feedback.

CONCLUSION

Whether one is interested in treating children, adults, or families, play therapy is a viable alternative to talk therapy with people of all ages. Play will always be a natural and necessary ingredient for healthy development, whether one is a child or an adult. Play therapy is a dynamic, expanding field of psychotherapy, which crosses defenses, opens closed doors, and kicks out resistance to allow treatment and self-healing to occur. You can never be too young or old to play!

REFERENCES


Oppositional defiant disorder (ODD) and conduct disorder (CD) are among the leading referrals for youth in clinical settings in the United States (Frick, 1998; Loeber, Burke, Lahey, Winters, & Zera, 2000). According to Meltzer and colleagues (Meltzer, Gatward, Goodman, & Ford, 2000), prevalence rates of ODD and CD for children between the ages of 5 and 10 range from 0.6% to 4.8%. Other epidemiological studies estimate rates as high as 10% in American youth for both disorders (Coghill, 2013). These numbers are concerning when we consider how many of these children do not receive clinical services.

Early diagnosis of ODD and CD in youth has been linked to numerous poor future outcomes such as delinquency, academic difficulties, truancy, violence toward romantic partners, and substance abuse, when left untreated (Blair & Diamond, 2008; Capaldi & Clark, 1998; Kassel, 2010). In addition, behavior problems in childhood can lead to further difficulties in adolescence such as psychosocial problems, reduced educational and occupational opportunities, and an increased risk of comorbid psychological disorders (Lyons, Baerger, Quigley, Erlich, & Griffin, 2001; Nock, Kazdin, Hiripi, & Kessler, 2007).

Although many of these children continue to struggle with a wide array of problem behaviors throughout their lives, few empirically supported treatment programs exist that properly address these issues. In addition, involving the family network has proven to be a difficult task. Research indicates children with behavior problems and their families often face a complex array of issues that prevent these youth from being able to attend therapy sessions or make progress at a steady rate (Kern & State, 2008). One promising approach that produces reliable, long-lasting effects in a short time frame is parent–child interaction therapy (PCIT; Eyberg, Nelson, Duke, & Boggs, 2008). PCIT is an empirically supported program for children ages 2 through 7 with disruptive
behavior. PCIT treats children's behavior problems by guiding parents to utilize play therapy skills with their children (McNeil & Hembree-Kigin, 2010). A unique feature of PCIT is the required involvement of both children and their caregivers. Therapists coach parents and caregivers to directly provide the therapeutic intervention to their children in the context of play. PCIT focuses on the integration of individualized treatment with a manualized format. Each session is focused on a child and caregiver's specific needs. Skill acquisition is determined each session through a coded observation of the caregiver with the child taken at the beginning of a therapy session. If more than one caregiver wishes to be involved in treatment, each caregiver is coached and coded independently with the child. Therapy through play serves as a nonthreatening approach for families to change the way they interact with their children.

The primary purpose of this chapter is to provide empirical justification for PCIT’s effectiveness in reducing child problem behaviors and increasing positive parental skills through the method of play therapy. More specifically, the chapter begins by stating the theoretical foundations for the PCIT play therapy model and the success of this model with the specified population. Next, the model of service delivery is explicitly laid out for both traditional and nontraditional settings. The components and goals of PCIT are illustrated through the case example of a typical PCIT family, and are preceded by a list of fidelity components used to ensure the successful implementation of PCIT. Findings for effectiveness studies demonstrating the clinical success of PCIT are then summarized for various child populations. Last, implications and future directions of our work for families of children with behavior problems are discussed.

THEORETICAL FOUNDATIONS

PCIT was developed by Sheila Eyberg who established the theoretical basis of the model from the principles of Diana Baumrind's authoritative parenting style (McNeil & Hembree-Kigin, 2010). In this model, Baumrind emphasized the importance of warmth and nurturance as well as clear parental control developed by consistency, limit-setting, and predictable consequences for misbehavior (McNeil & Hembree-Kigin, 2010). The model additionally draws from attachment theory (Weisz & Kazdin, 2010) in its commitment to fostering a loving and responsive relationship between the parent and child.

Many of the dysfunctional parent–child interactions occurring in families referred for PCIT are consistent with Patterson's coercive cycle (McNeil & Hembree-Kigin, 2010). In this model, dysfunctional parent–child interactions have been perpetuated by a cycle of negative parent and child behaviors (i.e., yelling, arguing, whining, aggression) resulting in increasingly destructive interactions (McNeil & Hembree-Kigin, 2010; Weisz & Kazdin, 2010). Using the principles of social learning theory, PCIT teaches caregivers to model appropriate behavior while utilizing operant learning principles, such as social rewards and punishments to increase prosocial interactions and decrease antisocial behaviors (McNeil & Hembree-Kigin, 2010).

Although PCIT draws from each of these theoretical pillars throughout the course of treatment, the therapy's two-phase model, initially developed by Sheila Eyberg, attempts to strengthen the parent–child relationship by emphasizing warmth and parental responsiveness in the initial child-directed interaction (CDI) phase before teaching caregivers consistent discipline strategies in the second phase (McNeil & Hembree-Kigin, 2010). Treatment sessions during the CDI phase retrain parents to recognize positive child behaviors. Moreover, CDI focuses on teaching parents to use therapeutic play therapy skills to cultivate a trusting, positive relationship between the caregiver and child. Play therapy skills reformulate the dynamic of parent–child interactions. The caregiver is taught to follow the child’s lead during the play, as well as to imitate appropriate
Parent–Child Interaction Therapy With Children With Disruptive Behavior Disorders

behavior (McNeil & Hembree-Kigin, 2010). If the child behaves inappropriately during play for any length of time, attention is immediately withdrawn and returns only when the child again engages in appropriate behavior (McNeil & Hembree-Kigin, 2010). Through such interactions, the caregiver acts as a model for prosocial skills such as sharing, good manners, and turn-taking. Parents demonstrate the appropriate skills while additionally praising their occurrence in the child. Such play therapy skills teach caregivers to provide a stable, comforting, and consistent therapeutic base that is emphasized during both stages of treatment.

MODEL OF SERVICE DELIVERY

PCIT was created for delivery through a traditional outpatient therapy services model (McNeil & Hembree-Kigin, 2010). Therefore, treatment appointments customarily occur once per week and last for about one hour. PCIT is considered to be a short-term therapy, and the average course of treatment is 12 to 16 weeks. However, progress through PCIT is based on the acquisition of specific skills acquired in both phases of treatment. Consequently, treatment length is individualized based on the needs of each family.

Although PCIT is generally carried out through outpatient clinics, it requires a specific type of room and equipment (McNeil & Hembree-Kigin, 2010). The family plays in a childproofed playroom with little furniture and minimal decorations or other objects. In an adjacent observation room, the therapist observes and coaches the caregiver through a one-way mirror. A small, empty room attached to the playroom and observation room serves as a time-out backup room. This backup room is well lit and contains windows so both the caregiver and the therapist can observe the child. During therapy, the therapist coaches the caregiver from the observation room using a behind-the-ear receiver and microphone. While some community clinics may have difficulty adhering to standard PCIT room arrangements when beginning PCIT practice (Goldfine, Wagner, Branstetter, & McNeil, 2008), alternative methods can be utilized for quality PCIT delivery (McNeil & Hembree-Kigin, 2010). For example, video monitoring can allow for observation when one-way mirrors are not available, and walkie talkies can be used in place of the in-ear device. A half-door or Dutch door can also be used in backup rooms if there is a concern about seclusion.

PCIT also requires the use of specific toys that lend themselves well to parent skill acquisition (McNeil & Hembree-Kigin, 2010). Construction toys that encourage children to be creative and problem-solve should be used. Examples of preferred toys include blocks, Legos, Mr. Potato Head, dollhouses, toy cars, and crayons and paper. Toys promoting rough or aggressive play, or that have preset rules, should be avoided during PCIT (e.g., balls and bats, toy swords and guns, board games, messy items like paint). These toys often require the caregiver to instruct, correct, or discipline the child and, subsequently, they diminish the positive experience PCIT is attempting to foster (McNeil & Hembree-Kigin, 2010).

Previous research has determined PCIT is an effective treatment for childhood disruptive behavior, and it is being disseminated around the world (McNeil & Hembree-Kigin, 2010). To maintain the fidelity and integrity of the treatment, PCIT should only be delivered by trained PCIT therapists. Specific requirements have been set for PCIT therapists and trainers by the PCIT International Organization (http://www.pcit.org). Although this training is extensive, it is beneficial and necessary due to the intricate coding system and coaching involved with PCIT (McNeil & Hembree-Kigin, 2010).

While standard PCIT has conventionally been delivered in clinics, recent research has explored the implementation of PCIT in nontraditional settings. Therapists and researchers
have begun providing PCIT within clients' homes, with the intent to reduce barriers and improve accessibility to treatment (Bagner, Rodríguez, Blake, & Rosa-Olivares, 2013; Masse & McNeil, 2008). Initial evidence suggests in-home PCIT produces positive outcomes similar to those found with clinic-based PCIT (Galanter et al., 2012; Ware, McNeil, Masse, & Stevens, 2008). However, more research is needed to directly compare the effectiveness of PCIT within these two settings. Similarly, researchers are exploring how advances in technology may increase the implementation and dissemination of PCIT. Telemedicine and video technology have been used to consult with therapists currently in training to better approximate live supervision and to improve the quality of feedback (Funderburk, Ware, Altshuler, & Chaffin, 2008; Wilsie & Brestan-Knight, 2012). In the future, telemedicine may also be used to conduct PCIT directly with families in their homes or at other sites outside of the clinic (Comer et al., in press).

**COMPONENTS OF PCIT INTERVENTION**

To ensure the highest quality of service delivery, PCIT therapists follow a structured protocol for each therapy session, including predetermined tasks, questionnaires, and goals. The PCIT manual additionally provides homework, progress records, and coding sheets (Eyberg & Funderburk, 2011). For example, each PCIT session begins with therapists distributing the Eyberg Child Behavior Inventory (ECBI; Eyberg & Pincus, 1999) to caregivers, as well as collecting completed homework. This information is reviewed repeatedly as families progress through each phase of PCIT. Although the PCIT manual provides highly structured guidelines, therapists are not to advance in the therapy until goals for each session are met by the family. PCIT works to guide therapists' quality delivery of play therapy while also providing case conceptualizations and strategies for handling a variety of familial difficulties. In this section, a case study will be highlighted to illustrate a typical family and child referred to PCIT services. The case of Troy Williams will help give context to the rest of this chapter.

**Intake**

PCIT treatment cases follow a standard format, starting with an initial intake assessment. This intake generally consists of a semistructured interview by the therapist and the completion of parent-report behavior rating scales (McNeil & Hembree-Kigin, 2010).

**Case Example**

Troy Williams was a 5-year-old boy referred for psychological services at a family clinic for his increasingly problematic and disruptive behaviors. Troy was accompanied by his 30-year-old mother, Loraine Williams. Loraine was unmarried and had full legal custody of Troy. She had another son who was 2 years old. Although Loraine had been frustrated with Troy's behaviors, she decided to seek help only after his preschool teacher stated concerns about Troy advancing to kindergarten. He had been acting out in school by refusing to sit still throughout the day, trying to escape the classroom, and hitting his peers. Troy's teacher had removed him from the classroom on several occasions. Loraine was forced to leave work in order to pick him up and bring him home. Not only had this put a strain on her financially, but continuous absence from work was also causing problems in Loraine's relationship with her employer and coworkers. Lately, Troy had become increasingly violent in the classroom, making it unsafe for other children.
Loraine also reported increased misbehavior in the home. Troy refused to do what he was told and threw tantrums when he did not get his way. Tantrums occurred at least once per day and included screaming, crying, and throwing of household objects. Additionally, he had begun to hit his mother. Loraine was worried he was soon going to be too big for her to control. She stated she had used discipline, but time-outs and spanking do not seem to work with him. Loraine stated her younger son was now imitating some of Troy’s violent behaviors and hurtful language.

The intake prior to PCIT initiation includes a structured observation of parent–child interactions, coded using the Dyadic Parent–Child Interaction Coding System–IV (DPICS-IV; Eyberg, Nelson, Ginn, Bhuiyan, & Boggs, 2013). This allows the therapist to observe each caregiver independently playing with the child in child-directed play, parent-directed play, and a clean-up situation. The three interaction situations of the DPICS are as follows:

1. Child-led play: In this situation, the caregiver is instructed through an in-ear device by the therapist to let the child play with whatever he chooses, and for the caregiver to follow the child's lead. The dyad remains in this situation for 10 minutes. The first 5 minutes of this interaction serve as a warm-up period in which caregiver and child behaviors are not coded. Caregiver and child behaviors are coded in the second 5 minutes with the coding sheet.

During the DPICS situations, Troy and his mother played with colorful wooden blocks. During the child-led play, Loraine sat away from her son and did not speak much to him. When she did interact with Troy, she frequently asked him questions and gave him many indirect commands while he engaged in his play (e.g., “Why don’t you make a barn?”). Loraine often rolled her eyes or made comments directed toward the therapist rather than speaking to her son.

2. Parent-led play: After 10 minutes has elapsed, the therapist informs the parent it is now the parent’s turn to lead the play time. The parent should control the play and have the child adhere to the parent’s rules.

At the initiation of parent-led play, Loraine started to draw and tried to redirect Troy to play with her. At this time, Troy began to whine and voice his opposition to terminating his block building. She gave many direct commands. Loraine also engaged in negative talk, in which she told Troy he was a “bad boy” and she “didn’t want to play with him anyway.”

3. Clean-up situation: For the last 5 minutes, the therapist instructs the parents it is time to clean up. Parents are in charge of telling the child to clean up. They are not to help the child.

Once Troy was told he needed to clean up, he refused to help. He repeatedly said “no” and separated himself from his mother by walking to the other corner of the room. Loraine continued to say Troy’s name and tell him he needed to clean up. Loraine crossed her arms and threatened to not let him watch his favorite show later in the evening, but he continued to stay in the corner. Troy began to yell and throw his toys around the room. At this point, Loraine started putting some of the toys into the box. Troy attempted to escape from the playroom, but Loraine grabbed his arm and pushed the door shut. Loraine also stated “he is always like this” and she did not like it when he chose to “act like a brat.”
The initial assessment assists therapists in understanding the unique needs and special characteristics of each family, while also determining the current level of disruptive behavior and parenting skills. This time should also be used to decide if the family fits the mold for PCIT before moving on to further assessment and treatment.

Following the intake session, the therapist provides an overview of PCIT and highlights the rationale for the two phases of the program (McNeil & Hembree-Kigin, 2010). A developmentally appropriate explanation of the therapy is also given to the child involved in treatment. Treatment then continues through the child-directed interaction and parent-directed interaction phases.

**Treatment: Child-Directed Interaction**

The first stage of PCIT, child-directed interaction (CDI), focuses on building a strong relationship between a caregiver and child. Many families referred for PCIT display dysfunctional relationships, such as Loraine and her son. CDI focuses on building parental skills to create positive and richer interactions between a parent and child. During therapy, parents are instructed to use the skills they learn. Outside therapy, families are required to take part in “special play time” in which caregivers use their skills to play with their child for 5 minutes a day.

The skills taught to families to utilize during CDI are known as the PRIDE skills (praise, reflection, imitation, description, and enjoyment) found in Table 17.1.

Skills parents utilize to foster negative interactions with their children are to be avoided during CDI. These skills include questions, negative talk, and commands (Table 17.2).

Families can only advance to the next stage of PCIT after demonstrating mastery of PCIT’s PRIDE skills. Mastery in CDI is granted when parents use 10 labeled praises, 10 behavior descriptions, and 10 reflections in addition to using no more than three questions, commands, or negative talking during a 5-minute coding period (Eyberg et al., 2013). When a child misbehaves, the
Parent–Child Interaction Therapy With Children With Disruptive Behavior Disorders

A caregiver must also know how to appropriately ignore the undesired behavior and redirect the child to a more appropriate behavior.

After five CDI coaching sessions, Loraine achieved CDI mastery. Loraine's interaction with Troy had already improved remarkably; she was leaning over Troy as he played and following his lead. She gave him positive touches throughout play time and kept Troy engaged. Although he would sometimes attempt to throw toys, she would turn away from Troy and engage in play without him. As soon as he returned and engaged in appropriate behavior, Loraine gave him a big labeled praise. She reported looking forward to the special play time every day and believed Troy felt the same way. Loraine's reports of his negative behavior also decreased throughout CDI sessions.

Treatment: Parent-Directed Interaction

Parent-directed interaction (PDI) develops a base for parental consistency and ultimately targets parental control of child behaviors. Caregivers in PDI continue to utilize CDI skills but are required to use concise, clear, direct commands during the therapy sessions. PDI is meant to progress from small, simple commands in play to commands reflecting more real-world situations. All caregivers must learn to recite a specific script when a child does not adhere to a command. Strict guidelines dictate a time-out sequence used when a child fails to listen to his or her caregiver. Mastery for PDI is met once caregivers demonstrate that 75% of commands they give are direct, positively stated, single commands. They must also display 75% appropriate follow-through when a command is given, whether a child obeys or disobeys (i.e., labeled praise versus warning statement and time-out sequence). Last, caregivers must be able to accurately complete a time-out procedure independently.

The procedure families utilize during PDI can be found in Table 17.3. For the full procedure and wording, please refer to the PCIT manual (Eyberg & Funderburk, 2011) or McNeil and Hembree-Kigin (2010).

During the PDI phase, parents are coached to give commands and apply the appropriate follow-through in response to a child’s behavior. If a child complies during step 1 (see Table 17.3), the parent is coached to issue a labeled praise and return to CDI. If the child refuses to comply after 5 seconds, the parent proceeds with step 2.

If the child complies within a 5-second window of step 2, the parent will also deliver a labeled praise and return to CDI. If the child again refuses to comply, the parent proceeds to step 3.

Once the child has not complied in either step 1 or 2, the parent takes the child to the time-out chair (step 3). The child must remain in time-out for 3 minutes, plus 5 seconds of silence. If the child is able to stay in time-out for the duration of those 3 minutes, he is allowed to choose whether to comply to the original command. If a child chooses to comply, the parent is to issue another command. The second command is followed by a labeled praise and CDI upon completion.

If the child refuses to engage in the original command, step 3 is repeated and the child must stay in the time-out chair for 3 minutes, plus 5 seconds of silence. This process is repeated until the child is ready to comply (see details above).

Table 17.3 Brief PDI Procedure

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Step 2</th>
<th>Step 3</th>
<th>Step 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue a command</td>
<td>Provide a time-out warning.</td>
<td>Take the child to the time-out chair.</td>
<td>Take the child to a backup area.</td>
</tr>
</tbody>
</table>
If the child refuses to stay on the chair during time-out, the parent proceeds to step 4. The child will only complete step 4 after staying in the backup area for 1 minute, plus 5 seconds of silence. Upon completion, the child will return to step 3. Step 4 will be completed for every escape from the time-out chair.

If families feel there are still significant problems occurring in the household, they can choose to initiate house rules. House rules target problem behaviors that are aggressive, destructive, never acceptable under any circumstance (e.g., cursing), or “sneaky” behaviors that parents do not discover until after they have happened (e.g., hiding sibling’s toys or taking an item from the caregiver’s purse). Once this behavior is explained, if the child misbehaves, the child will be put into time-out. For example, Loraine decided to make a house rule where no hitting would be tolerated.

As families come closer to meeting graduation guidelines, therapists discuss managing child behavior problems in public places. Caregivers should prepare their child for the outing by stating expectations before the trip begins; punishments for misbehavior and rewards for positive behavior should be announced prior to the outing. Caregivers are encouraged to ignore poor behavior in public, such as whining or throwing tantrums to get a toy or a candy bar. They should also have a plan to implement a public time-out if needed. PCIT works to transition the coaching therapist out of the family’s life so the family can function independently.

Treatment: Graduation Session

Before families graduate from treatment, they have to demonstrate key skills in managing their child’s behavior. The child’s problem behaviors also have to be within normal limits as determined by the ECBI (Eyberg & Pincus, 1999). Families must state confidence in being able to control their child’s behavior before the graduation session can begin. In the treatment session prior to the graduation session, each parent is recorded and coded for a 5-minute CDI interaction followed by a 5-minute PDI situation. Each caregiver must demonstrate mastery of both CDI and PDI in order to graduate from PCIT. The graduation session is an exciting time for families. A shift in family dynamics should be evident and a positive family atmosphere should be more apparent.

FACILITATING SUCCESSFUL IMPLEMENTATION OF PCIT

Recognized as an empirically supported treatment for a variety of child conditions, PCIT has become widely known within the United States of America and around the world. Training in the model has become highly sought after (McNeil & Hembree-Kigin, 2010). Issues of maintaining treatment fidelity as the approach becomes more widely disseminated are often raised. In order to become trained as a certified PCIT therapist, one must possess a minimum of a master’s degree, have experience working with children and families, and be licensed to practice mental health (McNeil & Hembree-Kigin, 2010). Such individuals must also complete a 40-hour didactic PCIT training workshop conducted by a trainer. Following this workshop, mental health workers are supervised and receive consultation by a PCIT trainer for 1 year while conducting their first PCIT cases. Following the initiation of such cases (usually 2–6 months following the 40 hour training), PCIT therapists undergo an additional 16-hour, face-to-face, advanced training course with a PCIT trainer (McNeil & Hembree-Kigin, 2010). Next, therapists demonstrate mastery of the PCIT skills including administration of the ECBI, reliability of DPICS coding and coaching, a CDI teaching session, FRIDE skills, CDI coaching, a PDI teaching session, coaching a time-out sequence, as well as teaching house rules and public behavior. Therapists also complete two full PCIT cases and have the CDI teaching and coaching and PDI teaching and coaching sessions reviewed by a PCIT trainer during a live or video demonstration.
Each phase of PCIT training includes mastery criteria therapists must satisfy. CDI criteria requires the therapist, like parents, use 10 behavior descriptions, 10 reflections, and 10 labeled praises, and use fewer than three questions, commands, and negative statements in a 5-minute play period. PDI criteria requires the therapist issue at least four commands, 75% of which are effectively stated, and follow-through (labeled praise for compliance, warning or time-out procedure for noncompliance following the warning) must be demonstrated correctly (McNeil & Hembree-Kigin, 2010). Although intensive, the PCIT training model allows therapists to receive ongoing feedback on their performance, thereby decreasing the chance treatment fidelity will be compromised.

Once a clinician has fulfilled training requirements to become a PCIT clinician, the individual will have the opportunity to advance to become a PCIT trainer. PCIT trainers can either be in-agency trainers (level I), regional trainers (level II), or master trainers. Master trainers train both PCIT therapists and PCIT trainers at agencies outside of their own. The requirements to become a PCIT trainer are extensive and are detailed on the PCIT website (www.pcit.org).

In addition to training costs, there are several initial set-up costs for beginning a PCIT program. Agencies must purchase special equipment (in-ear hearing system, audio system, videotaping equipment) and have space designed and designated (one-way mirror, time-out room, toys) to conduct the therapy (McNeil & Hembree-Kigin, 2010). The treatment is worth the initial expense because the service is often well utilized by the community and may result in increased referrals (McNeil & Hembree-Kigin, 2010). In addition, the reduced problem behaviors for these high-risk families are priceless. It is recommended that at least two therapists from an agency be trained at a given time. This allows for ongoing professional support and communication to occur between therapists once cases begin, and helps to ensure the sustainability of the PCIT program when staff turnover occurs (McNeil & Hembree-Kigin, 2010).

**EMPIRICAL FOUNDATIONS**

Early outcome studies conducted on PCIT demonstrate the efficacy of this treatment in reducing child disruptive behavior problems (Eyberg & Robinson, 1982). Additional research provides evidence that the effects of PCIT generalize to child behavior problems in the school setting (McNeil, Eyberg, Eisenstadt, Newcomb, & Funderburk, 1991) and to untreated siblings (Brestan, Eyberg, Boggs, & Algina, 1997). Studies examining the maintenance effects of PCIT have found treatment gains maintain for up to six years following treatment completion (Boggs et al., 2004; Eyberg et al., 2001; Hood & Eyberg, 2003). More recent research provides support for the effectiveness of PCIT in community mental health centers. Pearl and colleagues (2012) examined the effectiveness of PCIT with high-risk families receiving services from community agencies and found the children in this sample experienced significant reductions in internalizing problems, externalizing problems, disruptive behavior problems, and trauma symptoms after taking part in PCIT. Although this study provides initial support for the effectiveness of PCIT in community health settings, more research is needed in the area.

Research studies have been conducted on the use of PCIT with families from diverse cultural backgrounds. These studies provide support for the use of PCIT with African American families (Fernandez, Butler, & Eyberg, 2011) as well as with Latino families, including Spanish-speaking Mexican American families (Borrego, Anhalt, Teroa, Vargas, & Urquiza, 2006; McCabe & Yeh, 2009; McCabe, Yeh, Lau, & Argote, 2012) and Puerto Rican families (Matos, Torres, Santiago, & Jurado, 2006; Matos, Bauermeister, & Bernal, 2009). The efficacy of PCIT has also been demonstrated with European families including those from the Netherlands (Abrahamse et al., 2012) and Norway (Bjorseth & Wormdal, 2005). In addition, research suggests that PCIT is efficacious
with Chinese families (Chen, 2010; Leung, Tsang, Heung, & Yiu, 2009; Leung, Tsang, Sin, & Choi, 2014), and Australian families (Phillips, Morgan, Cawthorne, & Barnett, 2008). Research supporting the use of PCIT with families from diverse cultural backgrounds and ethnic identities continues to grow as PCIT is disseminated to new populations. Although originally designed to treat children with disruptive behavior problems, PCIT has been used to successfully treat a wide range of behavioral and emotional problems associated with various disorders and medical conditions. These disorders and medical conditions include autism (Solomon, Ono, Timmer, & Goodlin-Jones, 2008), mental retardation (Bagner & Eyberg, 2007), major depressive disorder (Luby, 2009), separation anxiety disorder (Pincus, Santucci, Ehrenreich, & Eyberg, 2008), trauma (Pearl et al., 2012), chronic illness (Bagner, Fernandez, & Eyberg, 2004), traumatic brain injury (Cohen, Heaton, Ginn, & Eyberg, 2012), and preterm birth (Bagner, Sheinkopf, Vohr, & Lester, 2010). Thus, there is overwhelming evidence PCIT can be tailored and adapted to reduce behavioral and emotional problems in children with diverse presenting problems.

PCIT has also been used with maltreatment populations to reduce child behavior problems and child abuse recidivism. Timmer, Urquiza, Zebell, and McGrath (2005) reported reduced child behavior problems, parental stress, and child abuse risk after a sample of maltreating parents completed PCIT with their children. Chaffin and colleagues (2004) found families who completed PCIT had a 30% lower re-report of physical abuse rate than families who received the standard community-based parenting group. PCIT has also been used with children who reside in foster care with no differences in the effectiveness of PCIT found between foster parent–child dyads and biological nonmaltreating parent–child dyads (Timmer, Urquiza, & Zebell, 2006). Taken together, these studies highlight the significant effect PCIT can have on children who have experienced maltreatment.

There is considerable research to support the use of PCIT with families from diverse backgrounds who present with a range of behavioral and emotional problems; however, more research is still needed to improve our understanding of this intervention. One area for further research is family and therapist factors that influence attrition rates and treatment outcomes. For example, despite its overwhelming success in treating children with a variety of psychological and behavioral disorders, attrition in PCIT remains high (McNeil & Hembree-Kigin, 2010; Werba, Eyberg, Boggs & Algina, 2006). Factors such as being placed on a wait-list, parenting stress, and critical/sarcasticparent statements during parent–child interactions have been found to be related to higher attrition rates (Harwood & Eyberg, 2004). In an attempt to circumvent high attrition rates, therapist variables related to treatment success have been examined. By examining three integral therapy process variables, researchers have been able to predict completion versus drop-out rates after only 30 minutes of therapist–client interaction (Harwood & Eyberg, 2004). During the assessment interview and initial coaching sessions, more therapist facilitative statements, fewer supportive statements, and a lower rate of questioning were related to higher completion rates (Harwood & Eyberg, 2004). Such findings indicate PCIT treatment success may be significantly related to therapist–client interaction variables.

A better understanding of the most effective ways to train therapists and to disseminate PCIT is also needed to ensure therapists are providing services of the highest quality. Finally, further research is necessary to examine the effectiveness of PCIT in community mental health centers, as most research to date has been conducted in a university setting. There are countless additional areas for future research that would enhance our understanding of PCIT, the populations with which it is effective, and the ways it can be provided to families.
CONCLUSION

To strengthen families of children diagnosed with ODD and CD and prevent poor future outcomes for these children, effective treatments must be implemented in community mental health clinics. Some available treatments focus on providing the child with individual therapy. Others use manualized treatment without individualizing sessions for specific child needs. Although the reduction of child behavior problems remains a priority for therapists and treatment-seeking families, both may not recognize the full potential that including parents in therapy can have in shaping the family dynamic. In addition, a treatment focused on an individual family’s strengths and challenges may improve the overall efficacy of the treatment for both the child and the caregivers (McNeil & Hembree-Kigin, 2010).

PCIT is an empirically supported parent training program focused on reducing child problem behaviors through play therapy. PCIT has been shown to be effective for families with children with severe problem behaviors, and more recent research on PCIT is showing positive outcomes for diverse groups of parents and children. As highlighted earlier, PCIT has been shown to be effective with children possessing a range of behavioral and emotional problems and from families of varied cultural and ethnic backgrounds. The characteristic features of PCIT, specifically its foundation in play therapy techniques, has allowed for positive relationship building and firm limit-setting in families regardless of challenges or diversities. PCIT addresses key components that foster structure and positivity needed for each child to thrive in the home, school, and the community.

REFERENCES


Parent–Child Interaction Therapy With Children With Disruptive Behavior Disorders  


CHAPTER 18

DIR®/Floortime™: A Developmental/Relational Play Therapy Approach Toward the Treatment of Children With Developmental Delays, Including Autism Spectrum Disorder (ASD) and Sensory Processing Challenges

ESTHER B. HESS

Play is a complex phenomenon in which most children naturally engage; they move through the various stages of play development and are able to add complexity, imagination, and creativity to their thought processes and action. From a developmental perspective, play evolves throughout childhood, beginning as sensorimotor engagement with the physical world and culminating in the capacity to symbolically and internally represent the world. Play frees children from physical, temporal, and spatial constraints, providing them with limitless, as-if possibilities. Coupled with the capacity to take another's perspective (theory of mind) and to project human attributes onto inanimate objects, typical children’s play promotes engagement, reciprocity, and creative thinking with caregivers and other children.
DEFINING THE POPULATION

For many children with autism spectrum disorder (ASD) and sensory processing challenges, the various stages of play are difficult to achieve. Difficulty with motor planning, expressive and receptive communication, imitation, and fine and gross motor movements are just some of the many obstacles children with ASD encounter during play (Mastrangelo, 2009).

WHY PLAY THERAPY IS APPROPRIATE

To fully appreciate the play of children on the autism spectrum, it is important to consider the various developmental functions play serves. First, from a cognitive perspective, the manipulation, organization, and later use of objects to represent people, places, and things in the real and imaginary worlds helps children develop a working model for understanding and problem solving. Second, from a social perspective, playing with objects and ideas, first alone and then with others, helps children connect. Third, from an emotional perspective, play allows children to explore and express both positive and negative feelings. And last, from a language and literacy perspective, play provides opportunities to develop narrative and storytelling skills, which contribute to autobiographical awareness (Habermas & Bluck, 2000), and, in turn, contribute to the development of social connections. It is a misconception that children with autism spectrum disorders do not play in any real sense, are not capable of pretending, and neither engage in social play nor enjoy playing in any measurable way (Boucher & Wolery, 2003). Current research points optimistically to the potential for children with developmental delays to learn how to play. For example, Kasari's (2010) research on mutual engagement in children suggests significant improvements in joint engagement, joint attention, and diversity of functional play acts when intervention was focused on the development of play routines in which the adult could follow the children's interests and then expand upon their play activities. If meaningful play is possible with children impacted by developmental delays, the question then becomes, what kind of play-based intervention helps to bring out the best in children with special needs so as to create the potential for reciprocal relationships?

THEORIES BEST SUITED TO WORK WITH THIS POPULATION

There are several theoretical approaches to working with developmental delays; this chapter will focus exclusively on a developmental/relational perspective, DIR/Floortime. This developmental approach is founded on work first pioneered by major developmental theorists such as Piaget, Vygotsky, Erikson, and Kohlberg. This specific approach considers behavior and learning in the greater context of a developmental or changing process. In 1997, evidence first showed the promise of the DIR/Floortime approach when Dr. Greenspan and his partner, Dr. Wieder, reviewed 200 charts of children who were initially diagnosed with autistic spectrum disorder. The goal of the review was to reveal patterns in presenting symptoms, underlying processing difficulties, early development, and response to intervention in order to generate hypotheses for future studies. The chart review suggested that a number of children with autistic spectrum diagnoses were, with appropriate intervention, capable of empathy, affective reciprocity, creative thinking, and healthy peer relationships (Greenspan & Wieder, 1987). The results of the 200 case series led Greenspan and Wieder to publish in 2,000 the full description of the DIR/Floortime model (ICDL, 2000).

Developmental play therapy programs like DIR/Floortime, in contrast to behavioral approaches measure specific targeted behaviors, target underlying capacities, with progress evident in a complex array of changes in interactive behavioral patterns (Cullinane, 2011).
A Developmental/Relational Play Therapy Approach Toward the Treatment of Children

Developmental models emphasize individual processing differences and the need to tailor intervention to the unique biological profile of children as well as the characteristics of the relationship between parent and child. Because both the factors being measured are complex and because of the wide range of individual neurological processes in the population, research on the effectiveness of a developmental framework has progressed by examining the subcomponents of the overall approach. The subcomponents can be summarized by looking at the three major aspects of the DIR/Floortime approach:

D: for developmental framework
I: for the individual, underlying, neurological, processing differences of a child
R: for relationship and subsequent affective interactions

D: The Developmental Framework

Developmental approaches seek to measure changes in an individual's:

- Capacity for shared attention
- Ability to form warm intimate and trusting relationships
- The ability to initiate (rather than respond) using intentional actions and social engagement and spontaneous communication
- The ability to participate in reciprocal (two-way, mutual) interactions while in a range of different emotional states
- Capacity for problem solving through a process of coregulation, reading, responding, and adapting to the feelings of others
- Capacity for creativity
- Thinking logically about motivations and perspective of others
- Developing an internal personal set of values

I: Individual, Underlying, Neurological Processing Differences

In 1979, occupational therapist Jean Ayres pioneered discoveries about the way in which children's sensory processing capacities could impact the way children learned and integrated themselves into their worlds (Ayres, 1979). This revolutionary idea provided a new way of understanding the importance of movement and regulatory behaviors in children and began to offer explanations for some of the more worrisome behaviors affecting children with developmental concerns like autism spectrum disorders. Over the past 40 years, a large body of research has further illuminated the impact of biologically based differences in regard to both sensorimotor processing and its impact on emotional regulation. In addition, this work showed these biological differences could be influenced and changed by specific therapeutic interventions.

Developmental models emphasize individual differences and the need to tailor intervention to the unique biological profile of the child and to the unique characteristics of the parent–child interaction. In 2001, the National Research Council of the National Academy of Sciences supported the first part of this statement when it published a report titled “Educating Children With Autism.” In the report, the council called for the tailoring of treatment approaches to fit the unique biological profile of the individual child (Committee on Educational Intervention for Children with Autism, 2001). Lillas and Turnbull (2009) added support to the second part of the statement as they described how all behavior is influenced by the sensory systems in the brain. They suggested an infant's sensory capacities are genetically prepared to respond to human interaction and are in direct relationship to the caregiver's touch, facial, vocal, and movement expressions. Child–caregiver interactions and sensory activities create nerve cell networks and
neural pathways in the development of the child’s brain. The exchange that takes place during child–caregiver play interactions are an ongoing loop of sensorimotor transformations.

R: Relationship and Affect

Developmental therapy models have evolved from many years of discovery in the field of infant mental health. Beginning in the 1950s, there was a new understanding of the importance of caregiver–child interaction (Bowlby, 1951). Building on these concepts, Dr. Greenspan and his partner, Dr. Wieder, began their work studying the interaction of mothers–infant dyads at high risk for attachment problems (National Center for Clinical Infant Programs, 1987). Subsequently, there have been numerous research studies confirming the importance of caregiver–child interaction and the value of intervention programs that focus on supporting the caregiver–child relationship, particularly in the areas of joint attention and emotional attunement (Mahoney & Peralies, 2004). In 2006, Gernsbacher published a paper showing how intervention between a caregiver and child could change the way in which caregivers interact, in turn increasing reciprocity, and found these changes correlated to positive changes in the child’s social engagement and language. In 2008, Connie Kasari and colleagues at the University of California-Los Angeles (Kasari, Paparella, Freeman, & Jahromi, 2008) used a randomized controlled trial to look at joint attention and symbolic play in 58 children with autism spectrum disorders. Results indicated expressive language gains were greater for treatment groups where a developmental model was utilized as compared with a control group who received an intervention based exclusively on behavioral principles. Evidence continues to support caregiver-mediated intervention as effective for the treatment of children impacted by autism spectrum disorder. A review of the literature, which included only randomized controlled trials, found evidence for positive change in patterns of caregiver–child interaction and caregiver synchrony and was suggestive of improvement in child language comprehension and reduction of the severity of children’s autism spectrum disorder characteristics (The Cochrane Collaboration, 2013). In addition, a large review of over 1,000 articles found evidence for “caregiver-implemented intervention.” Studies are documenting the importance of the key relationships in a child’s life as a focus of intervention (Wong et al., 2013).

Floortime is the heart of the DIR/Floortime model, and it is the play therapy component of a comprehensive program for infants, children, and adolescents (and their families) who have a variety of developmental challenges, including autism spectrum disorder and sensory processing challenges. DIR/Floortime model focuses on improving children’s functional emotional developmental levels and addressing the underlying, individual, neurological differences in processing capacities. In so doing, it creates those learning relationships children need to move ahead in their development. In turn, these relationships are tailored to the child’s individual neurological differences, providing the opportunity for the child to move forward developmentally, mastering each and every functional emotional developmental capacity of which she is capable (Greenspan, 2010). As mentioned, the focus of this chapter will be on the Floortime component that helps caregivers create a lifestyle with the potential for a reciprocal relationship with their children. Included will be both case examples and tips for overcoming problematic behaviors geared to help play therapists and caregivers both get started with their Floortime regimen, as well as what to do when either the caregiver, the play therapist, or the child you is feeling “stuck” in the play. In addition, throughout this chapter there will be an expansion on the implication of working from a developmental perspective with a special needs population. Finally, this chapter will include a
A Developmental/Relational Play Therapy Approach Toward the Treatment of Children

summary of current evidence-based research supporting this developmental/relational-based play intervention for children impacted by developmental delays, including autism spectrum disorder and sensory processing challenges.

THE FLOORTIME MODEL

Floortime is a particular technique in which the play partner, usually the caregiver, is encouraged to get down on the floor and work with his or her child to master each of the child’s developmental capacities. To represent this model fairly, you will need to think about Floortime in two ways (ICDL, 2000):

1. As a specific technique in which caregivers get down on the floor to play with their child for 20 or more minutes at a time.
2. As a general philosophy guiding all of the caregiver’s interactions with the child. All of the interactions have to incorporate the features and goals of Floortime, including understanding the child’s emotional, social, and intellectual differences in motor, sensory, and language functioning; as well as the existing caregiver, child, and family functioning and interaction patterns.

The definition of Floortime is split into two areas of emphasis. One is following children’s leads; the other is joining them in their world and then pulling them into a shared world to help them master each of their functional, emotional, developmental capacities (Greenspan & Weider, 1999). These emphases sometimes work together very easily, and at other times may appear to be at opposite ends of a continuum. Awareness of both of these polarities, tendencies, or dimensions of Floortime is critical because one element encourages the initial engagement of a child into the potential for a reciprocal relationship, and the other element encourages expansion and development of the initial “seed” of an idea into the potential for higher-level learning and thought.

Following the Child’s Lead

The most widely known aspect of Floortime is following the child’s lead, which means harnessing the child’s natural interests. However, what exactly does that mean? By following children’s interests, or their lead, we are taking the first steps in making what I have coined a great date with a child, in other words, creating a validating emotional experience. What are the elements of a great date? For most of us, it includes being in the company of someone who is attentive, available, and fun. And when we are with a person who incorporates all of these emotionally affirming elements, we obviously want the date to go on forever. Conversely, if we were on a bad date with someone who does not make us feel good about our experiences or ourselves, most of us would attempt to escape the encounter as soon as possible. Following a child’s lead, means taking the seed of his or her idea and making it the basis of the experience you are about to share with the child. It actually encourages the child to allow you into his or her emotional life. By attending to the child’s interests and having an understanding of his or her natural desires, caregivers get a picture of what is enjoyable for the child. A child who feels understood and affirmed is a child who stays regulated and engaged longer and is able to learn within the experience and ultimately moves forward developmentally (Hess, 2009).
Case Example

James, a developmentally delayed 6-year-old, appears unable to leave his home without holding onto a stick. This seems a bit inappropriate and like something a parent might want to discourage. However, something about this object has meaning for this child. The play therapist needs to help the parent think of the stick simply as a prop that facilitates interaction. James’s father is guided by the therapist to start asking himself what about this stick is so meaningful to his son. It is minimizing to simply attribute what we assume to be aberrant behavior to the child’s developmental delay. Not only is this shortsighted, but it does little to help us understand the underlying causes fueling the odd behavior. The key to understanding any child is to follow his or her lead as an entry point into the child’s world, thus creating the potential for an emotional connection. This builds a relationship that allows us to pull the child into a shared validating experience. James’s dad is coached to match his son’s behaviors and picks up his own stick, all the while attempting to mimic his son’s gestures. Then Dad is guided by the play therapist to expand the initial gesture into something socially appropriate and mutual. He begins by taking the two sticks and gently pretending to fence with them. The gesture is tolerated well. Encouraged, Dad now ups the ante and helps his developmentally delayed son to enter the world of symbolism by pretending he and his son are now knights in shining armor defending their castle.

Here the two principles of Floortime are at work. We are accepting the child and his beloved object, knowing there is something intrinsically valuable in the relationship the child has with the object. (I will speak later in the chapter regarding how individual, underlying, neurological processing differences are often guiding a child’s choice of play and/or flight.) We are also encouraging a child to leave his preferred world of isolation in favor of an experience in which his original idea of holding onto a stick has magically transformed into a shared play experience.

Joining the Child’s World

Following the child’s lead is only one half of this dynamic we call Floortime. The other half involves joining children in their world and pulling them into a shared emotional experience in order to help them master each of their functional emotional and developmental capacities. These are the building blocks of emotional, social, language, and intellectual development. When we talk about functional emotional capacities, we are talking about the fundamentals of relating, communicating, and thinking (Greenspan, 2010).

We start by joining children in their world as the avenues to then pull them into a shared world with us so we can teach them and help them learn how to focus and attend. The next step is to learn how to relate to another person with real warmth, how to be purposeful and take initiative, and how to have a back-and-forth set of communications through nonverbal gestures, and eventually through words. We want to teach them how to problem solve and sequence and get them involved in a continuing interaction with the environment and the people in their environments. We want to teach children to use ideas creatively. Creativity lends itself to accessing ideas logically and then progressing developmentally until children are not only using ideas logically but also actually showing high degrees of reflective thinking. In turn, high degrees of reflective thinking can lead to an ability to be empathic and understanding the world around them, so children can evaluate their own thoughts and feelings. Once the interaction is reciprocal and there is a nice back-and-forth rhythm, including attention, engagement, and purposeful
communications, then we need to work to ensure the communication continues to expand. The hardest thing for children with developmental concerns like ASD is to engage in back-and-forth communication that moves forward into a continuous flow of intentional verbal and nonverbal gestures. To achieve this goal, the play therapist is encouraged to create numerous obstacles so children must interact with the play therapist on a continuous basis to get what they want.

Not every child is capable of achieving the highest level of reflective thinking, but almost all children are capable of moving forward, mastering their own functional emotional and developmental capacities with regard to optimum social, emotional, intellectual, linguistic, and academic growth (Greenspan, 2001). One of the concerns expressed by play therapists is whether DIR/Floortime is applicable to children who have moderate to severe forms of developmental delays. The direct answer is yes, even with children who are severely impacted with developmental delays, with the right kind of support, you can move the child forward and upward.

Case Example

Although Janey is 5 years old, her current developmental age is about 6 months. She has no functional language and does not appear to have the interest or the ability to play with toys. In addition to the diagnosis of severe developmental delay, she also has a diagnosis of moderate to severe intellectual delay. She enters the playroom mostly aimless, unable to stay engaged with anything or any person for any length of time. Characteristic of children with ASD, the child flaps her arms in a self-stimulatory gesture in a continuous horizontal pattern.

The difficulty play therapists often face with severely impacted children is in determining how to follow a child’s lead when the child appears to not be able to offer any lead to follow. This is the art of Floortime. You cannot do Floortime, the play therapy portion of this intervention, unless you understand the underlying reasons potentially responsible for the child’s delay. Here is where having an understanding of DIR (the child’s developmental capacity; the underlying, individual, neurological, processing difference; and how to use the child’s relationship in the world to woo the child into a shared experience) creates a map for future intervention. By understanding a child’s DIR, the therapist knows how and where to enter the child’s world in such a way as to create a validating experience (i.e., the great date). To move children forward developmentally to become a more complex thinkers, despite overt intellectual delays, we need to make sure they possess the basic capacity to be regulated and stay engaged (Hess, 2012).

Because Janey is only offering her hand movements as the lead, this is where the play therapist must start the interaction. Playfully, the therapist rests her own hands within the child’s self-stimulatory hand and arm movements. The play therapist is not entering the play encounter thinking she is with a 5-year-old child; rather, the therapist joins Janey at her own developmental capacity. In the play therapist’s mind, she is now playing with a child who is 6 months old, and therefore she must adjust her intervention and her level of expectation to match while she uses her relationship to support the child in addressing her underlying processing challenges. As the play therapist slows the child’s flapping gestures, she creates a regular opening and closing rhythm to what was a moment before a chaotic gesture. As the therapist slows and regulates to the beat of the activity, she also uses her voice and her facial gestures to create a high affective encounter. She begins to sing a classic child’s song, “Pat a cake, pat a cake, baker’s man. Bake me a cake as fast as you can.” Suddenly, Janey, who up until this time appeared not to be able to
focus and attend, looks with curiosity into the face of the play therapist. She appears intrigued and curious. The play therapist has just taught this child her first fundamental game, pat a cake. The developmental age of this child, and consequently her ability to be a more complex thinker, has improved within one play session from 6 months to 9 months of age.

Progressing from Following a Child’s Lead to Mastery

How do we use following the child’s lead to actually mobilize and help the child master these critical developmental milestones? To help children master the first stage of shared attention, when they are, for example, wandering away from our interaction with them, play a game in which the play partner is placed in front of the child, essentially blocking the child’s exit from the interaction. This playful blocking gesture necessitates the child creating some kind of engagement with the therapist, even if it is a gesture of annoyance. This will form the foundation of the first act of shared attention. The play therapist is encouraged to continue to up the ante by creating more playful obstructions (like asking for a ticket or a token from the child before the therapist moves out of the way). These types of maneuvers create multiple opportunities for shared attention, as well as sustained engagement, because the child is otherwise involved with the therapist. Interestingly, this is also the beginning of purposeful action because the child is trying to move the obstruction (in this case the play therapist) out of the way. As the child continues to attempt to maneuver the obstacle out of the way, the therapist plays dumb, forcing the child to problem solve. These strategies are called playfully obstructive strategies, and they are for the most aimless of children or avoidant children (Greenspan, 2010).

Case Example

A 5-year-old boy named Ian, impacted with a moderate degree of autism spectrum disorder, enters the playroom and appears to absentmindedly pick up a piece of chalk, before dropping it randomly on the floor. Previously, his mother has expressed concern her son is not showing any age-appropriate interest in drawing, coloring, or cutting, and she fears the child is progressively falling further and further behind his classmates. The play therapist, keeping in mind the parent’s concern, decides to take the play activity out of the playroom and into an outdoor play area. She follows Ian’s lead by attempting to incorporate his fleeting interest in the chalk and expanding it into a sustained play encounter by doing some chalk drawing on the sidewalk. Once outside, she places Ian in her lap, both to prevent flight and also to help him become more regulated and engaged by providing proprioceptive input (deep pressure) around which he can organize and reduce the anxiety that is potentially fueling his resistance to the play activity. She hands him a piece of chalk while gently guiding his hand in its use. Ian completely rejects the activity and withdraws his hand from any attempt to handle the chalk.

What is going on in the mind of the play therapist? The question arises as to how far to push this child in terms of his capacity to tolerate further playful obstruction. One of the basic principles of Floortime is never take no for an answer. In other words, try not to back away from the resistance the child is going to present when you try to initially move a child forward developmentally. The first step, in this case, is to clarifying Ian’s actual capacities to see if he has the physical ability to hold a piece of chalk in his hand. Utilizing occupational therapy strategies, the therapist explores whether Ian has an adequate pincher grasp (the ability to pinch together
the thumb and the forefinger) by seeing if he is capable of handing the play therapist’s therapy dog a dog biscuit. The thinking is that Ian’s resistance to drawing can be overcome by his greater love for the play therapist’s dog. He is readily able to feed the dog with the appropriate grasp. This encourages the play therapist to further expand the interaction by having Ian draw the letters of the dog’s name in chalk and then having him use his pincher grasp to dot the letters of the dog’s name with a muffin (left over from a previous social skills baking activity) while instructing the dog to “eat up her name” on command. This time around, the request to draw with the chalk is met with absolutely no resistance, as Ian delights in the use of this “living puppet” to playfully overcome his resistance to the task and ultimately move him forward developmentally.

The goal of playfully obstructive strategies is to follow the child’s lead on the one hand, but then create opportunities and challenges that help the child master each of his functional emotional developmental goals, on the other. This is the dialectic, the two polarities of Floortime: Joining the children in their rhythms while creating systematic challenges that create opportunities to master new developmental milestones.

As play therapists, we are always trying to broaden the children’s capacities within their current levels of development. In other words, if children show the capacity to be a little bit purposeful, the next step is to encourage them to be very purposeful. If they can open and close a series of back-and-forth encounters (circles of communication), then we want to playfully enlarge this capacity until they are able to sustain a series of 50 or 60 of these reciprocal interactions (Greenspan, 2010).

In order to engage in these Floortime interactions in which we are following the children’s lead while continually challenging them to master each functional emotional and developmental milestone, we must be aware of their individual, underlying neurological processing differences. The play therapist must be aware of the child’s particular and unique developmental challenge, be it sensory, social, or motoric, and use this as a starting point for intervention. If, for example, a child is underreactive to touch and sound, this necessitates the play partner (caregiver or the therapist) to be very energetic as he pulls the child into the shared world. Conversely, if another child is oversensitive to touch and sound, for example, covering his or her ears to avoid sudden noises, and becomes easily agitated, the therapist may have to be extra soothing while still being compelling. Many children present with a mixed profile, a combination of different levels of reactivity under different circumstances, where they can be both under- and overreactive to environmental stimuli. In this situation, the rhythm of the play therapist needs to match both the internal and external beat of the child by being both soothing and compelling; for example, the therapist can use a soft yet energetic whisper as he approaches the child (Greenspan, 2001).

The play therapist must also be aware of children’s auditory processing capacities and language abilities, because the more pleasurable their play encounters are, the more likely they will be in investing in future emotional experiences. Auditory processing has less to do with hearing and more to do with the way the brain processes auditory messages. I often ask play therapists to imagine being on a bad cell phone line, where the message is not necessarily being dropped, but rather incessantly interrupted (Hess, 2009). Likewise, children with a form of auditory confusion may symptomatically resemble children who are tuned out of the world because the auditory message is too confusing to follow. Too often, the play partner does not take into account this area of processing distortion and speaks too rapidly or at a level far too complex for the child’s developmental level. This is where keeping DIR in mind is critical. Rather than demand that a child meets the play partner with regard to auditory regulation, it is up to the play partner to realistically assess where the child is developmentally and to take into consideration the individual, underlying, neurological difference (in this case auditory processing concerns), and then use his or her relationship to help support the child’s differences. For example, the practitioner may
woo the child with simple energetic phrases, such as “Open door?” rather than either a monotone request or command.

With regard to visual spatial processing, some children may have good visual memory, but may not be good visual problem solvers. Therefore, the play therapist may need to use a great many visual cues while building visual memory skills to help children join a shared world experience. Additionally, many children have both motor problems and sequencing difficulties. To address these issues, we need to start with simple actions and then go on to more complex action patterns. By tuning in to children's underlying, individual, neurological processing differences, we can challenge them to master more complex levels of development (Greenspan & Weider, 1999).

**Case Example**

A 4-year-old named Joseph, who is impacted by high-functioning autism spectrum disorder, is in a total inclusion class in which the teacher-to-student ratio is 1:16 and in which there was no teacher’s aide. Our first indication that he may have had underlying, neurological processing differences is, despite it being November and his mother having sent him to school in long pants and long sleeves, Joseph has stripped down to tennis shorts and a T-shirt and stuffed his original outfit into his cubby. He wore this uniform each day in class. While not necessarily indicating some kind of pathology per se, we had a red flag regarding Joseph's ability to tolerate different textures against his body, and we needed to be thoughtful as to how his potential for tactile defensiveness could affect his ability to learn.

Joseph is now in class and looks somewhat interested in joining his peers on the floor during morning circle time. However, although he has been in school for over 2 months, he appears lost and does not know exactly where he is supposed to sit. There are no definitive markings to indicate his spot on the carpet. Consequently, Joseph spends much of his initial time in the class trying to figure out exactly where he belongs. The teacher appears to ignore Joseph’s dilemma and begins the lesson. While the teacher is reminding the students about last evening’s homework assignment, in which the children were supposed to bring something from home that started with the letters H, M, or B, the overhead PA system goes off, announcing the lunch specials for the day. The conflicting auditory messages of the PA system and the teacher’s instruction appear to totally confuse Joseph. However, he does have certain coping skills. He is looking around earnestly trying to copy the actions and gestures of his peers. He even raises his hands as he sees his classmates do, to ask the teacher if he can go to his cubby. Joseph’s hand-raising gesture and question come about a beat and a half after his classmates have asked their questions. This is called a processing delay, and although not a critical issue at this point in his academic career, it is a potential harbinger of future learning challenges. When finally given permission to join his classmates, Joseph proceeds to the bank of cubbies. Again, he appears quite lost. Not only is he confused about what the teacher wants from him, but he also appears to have no idea which of the unmarked cubbies is his. He returns to the carpet appearing disoriented.

One of the many ways play therapists can use DIR/Floortime is by first identifying a child's strengths. Joseph is clearly a visual learner. He is trying very hard to copy his peers, and overall he is quite compliant. Why do we want to focus on a child’s strengths before moving ahead to treatment? Remember the idea of a great date: Any validating emotional experience you have with a child reinforces his desire to stay engaged with and learn from the play therapist, and ultimately
move forward developmentally. By focusing initially on a child's strength, the play therapist is creating the entrance into both treatment and a reinforcing relationship. Once children feel validated, then they are more likely to allow a play therapist the opportunity to challenge them without causing them to flee the experience (Hess, 2009).

In the case of Joseph, many strategies can be incorporated to support his individual, underlying, neurological differences. As a visual learner, he could benefit from having the teacher strategically place visual cues around the classroom, including a textured and colored spot on the carpet to support his challenges regarding motor planning, particularly when he is stressed and overwhelmed. Likewise, his cubby could have his picture at the opening to help him locate where to place his assignments. The teacher could also be more cognizant of Joseph's auditory processing challenges. Instead of exclusively giving him oral instruction, she could supplement the lesson with various visual maps and schedules around the classroom to give additional direction and ensure at least one type of message (either oral or visual) is processed. Also, although Joseph does not really understand how to use his peers for support, he does indeed appear curious about his classmates and seems to want to try to imitate their gestures and movements. “Soft souls” are the children we find in every classroom. These are the ones who understand children with developmental concerns. These are the ones who are neither intimidated by autistic self-stimulatory gestures nor put off by some of the more esoteric movements of children with special needs. In contrast to kind adults, who might be more inclined to feel sorry or excuse the behavior of an atypically developing child, a typical peer generally demands that the child on the spectrum fully participate in social activities. Teachers need to point out these “soft souls” in their child's peer group to the caregivers of children impacted by autism spectrum disorder so typical peer play dates can be arranged as part of the therapeutic treatment process (Hess, 2009).

A Caveat About the Caregiver

We also need to pay attention to ourselves as caregivers, as families, as family members, and finally as play therapists. What are our natural strengths and weaknesses? What do we do easily? Are we high-energy individuals who are great with underreactive children who need lots of energizing and wooing, but who have a hard time with children who need to be soothed? Or are we great soothers, the type who are good with hypersensitive children who need calm and a lot of soothing, but who have a hard time energizing for the child who is underreactive? In regard to our own personal foibles, do we take the child's avoidance of our overtures as a personal rejection and therefore shut down? Or do we take children's avoidance as a challenge and try too hard and become too intrusive as we demand children involve themselves in the relationship with us? By paying attention to our own individual personalities, our family patterns, our therapeutic skills and strategies, we are ultimately going to make better clinical decisions that make the best use of our abilities and help us create the learning interactions that help children succeed (Greenspan, 2010).

The Escape Artist

Play therapists are constantly asking how they can create and sustain an interaction. Following the child's lead sound great, but often the child doesn't stand still for a moment to follow any kind of a lead, seemingly running away from any sustained interaction. At best, games together often consist of the play therapist trying to catch the child before he runs out of the office and gets himself into trouble. When a young child is on the move, there are often a lot of underlying escape efforts going on. He may not want to be hemmed in or forced to attend and focus on you or the caregiver, let alone engage. The key point is to harness the child's initiative and both receptive and expressive processes and not feel pressured to come up with a particular product at
the end of each encounter. The first step is to observe what the child is doing and then find the right rhythm—the moment that allows joining the child in doing what he is already involved in. Thinking about the child’s ‘I’ the individual neurological differences can help a play therapist understand what could be making sustained engagement so difficult. If the child is sensory reactive, then perhaps there is too much stimulation (including verbal discussion) and the child is feeling overwhelmed and overloaded (De Faria, 2010). Children react to what initially feels good or bad to their body and then their behaviors follow (Hess, 2012). Perhaps in a previous experience with other therapies the child has been forced into an interaction and, as a result, the child has ultimately become an expert in escaping what feels bad to his or her body. The message is, don’t take resistance as a rejection. As previously mentioned, part of the DIR/Floortime message is not taking no for an answer. The art of being a Floortimer is to use even an attempt to escape engagement as an opportunity for reciprocal interaction.

**Playful Obstruction**

To understand the concept of playful obstruction, it is simply not enough to get into children’s faces and block their movements in an attempt to force interaction. Rather, the idea is to gently and playfully use yourself and your body as something children have to deal with as they navigate in what may appear initially to be purposeless wandering. Here is where it is crucial to get on the floor adjacent to the child. As he or she moves away, move in front of the child, capturing attention and gaze, even if it only for a moment. The expectation is that the child will move away again. As play therapists, it is important to teach caregivers to move with the child, playfully dodging and blocking his or her escape. The next step is to take a gesture in which the child is merely tolerating your presence and then turn the encounter into imitative gestures that can be taken to the next level by challenging the child to move forward developmentally. Above all else, remember that DIR/Floortime is an affect-driven treatment model. This means the need to engage in overexaggerated gestures and big smiles to catch the child’s attention. Remember, this is not a power struggle. The goal is to induce that gleam in the child’s eye that lets you know he or she is feeling emotionally affirmed (Greenspan, 2010). That is the beginning of the great date with the child.

**Case Example**

Sally is a 3-year-old brought to the clinic by her aunt and uncle who are her legal guardians. She continually wants to go out of the door. Rather than simply acquiescing to the request, the play therapist makes the objective much more complex by turning it into a four-step process. As Sally indicates her need to go outside, the aunt resists, saying, “Go get Daddy if you want me to open the door, it’s too heavy.” Sally must now find her uncle, who additionally offers his own playful obstruction to the process to prolong the social interaction. The uncle says something like, “Can you show me where to turn the knob?” The child shows her uncle the knob, and the uncle then adds, “Help me pull on the door” and begins to make sounds of exertion. Sally begins to mimic the sounds of exertion as she supports the process of getting herself outside. The adult play partner has just added the beginnings of language, making the whole process all the more complex. Play therapists should vary their own movements and gestures as a response to the child’s process (Greenspan, 2010).
DIR/Floortime requires play therapists, and the caregiver they are training, to appreciate the polarity between following the child’s lead and entering his world. Only then can children be pulled into a shared world by finding their pleasures and joys while continually challenging them to master each of the functional developmental capacities. That means paying attention to the child’s underlying neurological differences in the way he or she processes sound and sights and movements and modulates sensations. It also means paying attention to the family patterns and to your own reactions as a play therapist. This encourages both self-awareness and improved techniques as one enters a child’s world and tailors interactions to the child’s specific nervous system.

**TECHNIQUES/STRATEGIES SPECIFIC TO AUTISM SPECTRUM DISORDER**

**Getting Started With Floortime**

**Start Where the Child Is**

The premise of Floortime, as mentioned, is to follow the lead of the child. This means we are not concerning ourselves with the child’s age-appropriate or inappropriate behaviors; rather, we need to fine tune the caregivers’ ability to see what their child is interested in, however innocuous it seems, and then join in and, if possible, expand that initial seed of an idea. Begin by simply watching; you will learn a lot. Use your eyes and your instincts. Where is the child going? What does the child like to do? What captures his interest? What comes hard for him?

**Case Example**

Bobby, age 3, is sitting on his father’s lap and beginning to perseverate by stroking his father’s face with a glazed look in his eye. Dad is guided by the play therapist to start sucking on Bobby’s fingers to try to create even more intimacy and closeness, but in an interactive way. Dad opens his mouth and, as his son strokes his face, he gets one of the little fingers in his mouth for a game of sucking on fingers. Surprised, Bobby pulls his hand away, *but* with a big smile. He then puts his fingers back in his father’s mouth, starting a flirtatious, interactive game. Later, Bobby is sucking on his own thumb and Dad, picking up on the same theme, says, “Oh let me suck on that thumb!” This time, instead of a glazed look, Bobby *intentionally* inserts his finger in Dad’s mouth and lets his father suck on his thumb for a moment; then he pulls it back with a big smile on his face. Encouraged, the father continues to create a lovely back-and-forth scenario and playfully adds more demands by asserting, “Give it to me! Yes? Or no?” Now Bobby is fully engaged and responds, “No, no!” but this time with a big flirtatious smile, putting his thumb up to his father’s face as though he wants to play the game again. Dad is instructed by the play therapist to offer his son his own thumb, and as the session progresses, the child begins taking more initiative, flirting more, seeking his father out, and using simple words and phrases, becoming decidedly less perseverative and self-stimulatory.
Become a Play Partner (Not a Movie Director)

Invite yourself in to meet the child at his or her level of specific developmental ability. Put your agenda aside and attempt to woo the child into the opportunity for a reciprocal relationship. Play therapists need to educate caregivers that when regression starts occurring, there's an understandable and common tendency for caregivers to get frustrated because their child is not doing what they want them to do. Then the tendency is to either get more intrusive and controlling, or to give up and become angry. When this happens, it is critical to understand the caregiving patterns and begin reversing these by going back to the basics, where there is shared pleasure and then once again challenging the child to take the initiative.

Case Example

Stuart's mother was trying to get him to play with some colored blocks. She was concerned because her 4-year-old son was not able identify colors, and she was determined to get him “up to speed.” Consequently, she was being intrusive, holding his hands, and putting the blocks in her son's hands. Stuart was becoming more resistant and began to kick the blocks, creating chaos in the playroom. Mom was coached by the play therapist to use Stuart's idea of kicking blocks and incorporate her desire to get him to learn his colors, but this time changing the game into something fun and flirtatious. A goal area was created at one end of the playroom, and then Mom was instructed to kick the blocks into the goal but while using language to identify the color of the toy: “Red block scores! Blue block scores!” Intrigued, Stuart stopped his tantrum and started watching Mom play this new game of block soccer. Eventually, Mom began to ask her son for help: “I need the green block now.” Stuart brought his mom the correct block. Mom continued to expand on the play by suggesting it was now time for Stuart to kick a colored block into the goal. With a big giggle and a smile on his face, he began kicking blocks toward the goal and saying, with some cueing from his mother, “Red block scores!” As a result, there was some lovely interaction that also incorporated Mom's now-thoughtful agenda.

Pacing Is Everything

Try not to move too fast or try too hard with your client, as this will result in tension and is sure to lead to resistance. Try to slow down your eagerness and first go with what the child can tolerate. The play themes will expand with time and experience. The key is to pace pursuit or wooing, to the sensitivities of the child. If he or she is a slow mover (hyporeactive to environmental stimulation), then you want to move more aggressively in pursuit. However, if you have a child who is more acutely aware of his or her environment (hyperreactive to stimulation), then you'll need to be slower and a bit more cautious with your approach. For example, Casey is a 4-year-old who is extremely hyperreactive to environmental stimulation. He is what I lovingly refer to as a “rocket ship guy”: a child who becomes overly agitated in a matter of moments (Hess, 2012). How do you connect with a child like Casey? Here the play therapist used a simple game of chase as a wonderful Floortime opportunity. When she moved in close to Casey, he scooted away. She moved after him, being careful not to move too fast or too spirited, so she didn't overwhelm him, taking into consideration both the ‘I'-individual neurological differences and the ‘R'-relationship
of the child to the world of the DIR model. She also used her voice to be enticing: “I’m going to get you.” Since Casey could tolerate being touched, the therapist captured him in a big sweeping hug. If he had not been able to tolerate such a big gesture, then she could have simply given him a gentle squeeze or a high five. Then she released him and allowed him to take the lead by asking, “Now what?”

Give the child enough time to signal to you that he or she wants more interaction, in whatever way he or she can manage. Children's signals can be verbal, but more likely they will be something more subtle in the realm of a gesture or nuance. As play therapists, it is important to tune in and really focus on understanding that a sideways glance or a half-smile indicates interest, even as the child appears to be darting away from you (De Faria, 2010).

How to Deal With Problematic Behaviors

**The Train Engineer**

The repetitive behaviors often seen in ASD can be compared with behaviors frequently associated with obsessive compulsive disorder. It is, for example, quite common for a child to play with toy trains by lining them up in a straight line. The play, however, appears to never move beyond lining up the engines. Clearly this is not the typical way most children play with their toy trains, and worried caregivers have a hard time resisting the urge to break the repetitive pattern. In Floortime, play schemas, however innocuous they may seem to be, are honored as the seed of the idea for future play. The task of the play therapist to take the very small (albeit repetitive) idea and enlarge the concept into the potential for social reciprocal play.

**Which Hand?**

**Case Example**

Peter is one of those children who repetitively lines up his train cars. His therapist positions himself in front of Peter, with the trains between the two of them. He then joins Peter in lining up the trains by adding cars. Peter initially resists the therapist and even picks up one of the train cars the therapist had placed and replaces it with one of his own choices. However, as Peter begins to realize the play therapist is not going to intrude and redirect the play, he is able to get more comfortable with the therapist’s participation and he even begins to look for the therapist’s next overture.

Now the play therapist can get a little mischievous. Making sure Peter is watching, the play therapist playfully takes some of the child's collection of trains and places them behind his back. The play therapist makes sure the child is visually tracking his actions. Visual tracking is the precursor for both verbal and social communication. While the play therapist is hiding Peter's trains, he remembers to be very expansive in his affect, acting as if he has this amazing secret Peter is about to discover. He uses his body to gently block the child, who begins to grab for the train. As soon as Peter is paying attention, the play therapist takes a couple of the hidden trains in each of his hands. He presents Peter with two clenched fists. For an instant, the play therapist opens his hands, so the trains are revealed. He then quickly closes his hand, so the game can continue.

Peter now tries to pry the play therapists hands open; that’s okay. The play therapist encourages the child to retrieve the trains. The objective is not to have meltdowns; rather, it is to create
an emotionally validating relationship. The play therapist smiles encouragingly and repeats the gestures. This time when Peter goes for the therapist's fingers, the play is made a bit more complex. The play therapist asks the child, “Which hand?” Even if Peter only remotely brushes the hand that contains the toy, that gesture warrants the release of a train. After a few rounds of successful back and forth, the play therapist continues to make the play even more complex. This time, he presents Peter with both hands, but makes the hands empty. Now Peter has to figure out the next step, and the play therapist is helping him navigate the difficult world of sequencing. Understand that no matter how time consuming these initial back-and-forth gestures seem, they are all part of a bigger strategy to help the child not be isolated in his play. The beauty of this approach is that once extended reciprocal play is achieved, then language develops, as the child uses various forms of communication to signal his interest in the interaction (touching the hand, pointing to the correct hand, etc.). The goal is social referencing where the child is now looking at the play therapist to figure out what is going on. As mentioned, social referencing is the precursor to verbal communication and is one of the building blocks for all future communication skills (Hess, 2012). In Floortime, emotional expression is used to entice a child's interest and attention and to make an effective connection with a child that leads to the possibility of wooing the child into an interaction and the possibility of even further, more-complex connections. This means using facial muscles in a turned up smile to suggest happiness, or turning one's mouth into a frown or even a scowl that represents being serious. The voice can be used as an interactive tool as well; a lilting voice suggests silly moments, and speaking in whispers can suggest thoughtfulness and concentration. Think of affect as both the carrot and the glue holding interactions together. The art is balancing affect with the sensitivities of the child in front of you (De Faria, 2010). For example, a highly emotional and sensitive child may back off if the play therapist comes on too strong. In contrast, a child who is “low tone” or presents rather flat in her affective abilities needs a lot of cheerleading from the play therapist or she will not take notice of the overtures.

**Keeping Track**

How does a play therapist initiate the next steps to expand play with the child so the activity is more developmentally appropriate? A two-word answer to this problem is spontaneous creativity (Hess, 2012). What this means is that once you have established a back-and-forth rhythm with the child, now you need to think outside the box and help your client create a story around the trains. “Where are the trains going?” You can expand your initial game of guessing which hand holds the trains to which hand now holds the train tracks. Collect them as he chooses correctly, and then be the child's assistant as the child begins to start putting the tracks together. As you build on the idea of train tracks, consider adding elements of developmentally appropriate pretend play: toy houses, animals, and people along the track. As you join in his play, you are beginning to break up the familiar, limited activity pattern and make the play into something larger and grander than the original idea.

**The Spin Master**

A lot of children impacted by ASD like nothing better than to lie on their sides and perseveratively spin the wheels of a toy car. Again, you need to overcome your initial tendency to wish the child was doing something more purposeful. Instead, join them at their developmental level, get down on the floor together and watch the wheels spin. Once the child is tolerating your presence, interfere just a bit, perhaps with a feather you poke into the spokes of the car wheels. See if you can develop a rhythm with the appropriate supportive affect for the interaction: As the child spins the wheels, you playfully insert the feather, wheels spin, in goes the feather, and so on. After a short time, see if you are achieving a back-and-forth pattern of engagement. Congratulations,
you have just completed one circle of communication (Greenspan, 2010). Once you’ve achieved basic reciprocity, the next step is to enlarge the play, perhaps weaving a colored ribbon into the spokes of the wheels to make a rainbow racer.

**The Toss Champ**

Let’s say your client seems to like nothing better than to simply pick up toys and throw them in the air. How do you turn that idea into something playful and meaningful? Again, we return to the original premise of DIR/Floortime: following the lead of the child. It is helpful to approach the child not where he or she is chronologically but developmentally. Start off by trying to figure out what appeal throwing objects has for the child. Often the behavior comes out of the child’s individual neurological needs, his or her “I”. A sensory-craving child is looking for a reaction to give his or her fragile nervous system a clearer idea where he or she is in space and time. This helps reduce the general state of anxiety that often accompanies ASD (Hess, 2009).

Initially, try imitating the child’s gestures, so there is the experience of being emotionally validated. Once the two of you are connected, then slowly up the ante by creating a game of target practice. Take a basket, and begin to challenge the child to see who can get the most points by throwing the toys directly into the basket.

**Case Example**

Marcus is an 8-year-old who loves to throw balls around aimlessly. Father, son, and play therapist were in the garage playroom of the family home when Marcus discovered several balls in the corner. He immediately began to throw them around the room. Utilizing the clinical instruction he had been given, Dad quickly emptied a small trash can and made it the target for he and his son to aim at. This game expanded into several opportunities for turn-taking (circles of communication). Marcus began to tire of the structure the game and again started to toss the balls around the garage haphazardly. The garage door (which operated vertically) happened to be open. One of Marcus’s balls landed on top of the open garage door. Quickly, Dad was again instructed by the play therapist to take the empty child’s wading pool located just outside the garage and use it as the next basket to catch the balls. As luck would have it, after throwing a couple more balls on top of the open garage door, one of the balls dropped right into the new basket. Delighted, Marcus immediately began to tell his dad they had created a new game! Dad and son worked on coming up with a name for this new game (moving the child into the higher developmental level of complex thought). That evening, they spent the better part of play time teaching the new game they had created to the rest of the family.

**What to Do When a Child Starts Regressing**

**Case Example**

Alisa is a 3-year-old with limited verbal language and a diagnosis of moderate to severe autism spectrum disorder. After several Floortime sessions, she was beginning to use her words more, becoming a problem-solving communicator. However, when she returned to preschool following a month-long winter break, she became much more perseverative,
self-stimulatory, passive, and avoidant at home, although she was very compliant at school. The school program was a very controlled, discrete trial program where she complied, but she was unable to generalize the skills she was learning to her greater social, emotional world. In fact, outside the school, there was marked regression.

Her mother had great difficulty trying to get her daughter to interact with her at home. Alisa seemed resistant, angry, annoyed, passive, and self-stimulatory. This resulted in her mother getting frustrated and becoming more intrusive and more controlling. Mom was beginning to give up trying to interact with her daughter, leading to even further regression.

After observing the mother–child interaction patterns and doing a quick developmental profile of the child’s functional and developmental levels, individual neurological differences, and relational/interactive patterns, the play therapist determined that the combination of Alisa’s difficulty returning to school and her mother’s fear that Alisa’s regression was indicative of a permanent setback was a lethal combination. With some additional coaching, where Mom was reminded to follow her daughter’s lead, Alisa started to demonstrate renewed initiative in becoming interactive. With this change, her affect began to blossom again and a smile came to her face. She began flirting and looking at her mom and began interacting in a problem-solving way, using simple words and phrases. As a general rule, relationships providing more warmth and support tend to create more initiative-taking in the child, usually reversing the regressive pattern more quickly.

In the face of momentary regression, it is important for caregivers to remember to do several things. First, they need to remind themselves that their child still has a broad range of capacities when interacted with in a very flexible manner. Second, the caregiver needs to remember to explore all possible reasons for the regression, starting with physical causes, such as change in diet and nutrition, health/illness issues, medication and the like. Third, the caregiver should explore broad family and environmental changes. These changes can include differences in the child’s ecology, for example, a new classroom, painting being done in the house, or exposure to anything that could create an allergic or toxic reaction. Last, it is very important to look at what is happening in the family, such as changes in work status, health/illness, visits from in-laws, or the basic routines at home, as well as the sibling and marital patterns. Any of these changes or issues could be contributing to a child’s dysregulation (De Faria, 2010).

After the situation has been diagnosed, it is very important to create interactive learning opportunities to reverse the trend. Usually, this involves going back to the basics and working up the developmental ladder during interactive opportunities. With the child in our example, it meant focusing on Alisa’s basic desires and needs and having Mom validate her daughter emotionally, so they could get back to having a great date together. DIR/Floortime is the euphemism for the potential lifestyle with the child in which wonderful, natural, interactive moments can happen and do happen all day long. Our job as play therapists is to encourage caregivers to be aware of their child’s sensitivities and then match those sensitivities into rhythms that expand into creative and playful back-and-forth interactions.

**EVIDENCE BASE FOR THE DIR/FLOORTIME APPROACH**

Specifically, evidence-based practice refers to the practice of periodically assessing clients to determine whether the treatment being implemented is effective and whether the client is making progress. This practice promotes and integrates the best available scientifically rigorous research,
clinical expertise, and the play therapist’s characteristics to ensure the quality of clinical judgments and delivery of the most cost-effective care (Weisz & Gray, 2007).

In order to measure treatment effectiveness, one must first determine the factors to be measured. Obviously this will be determined by the focus, targets, or goals of the treatment. Behavioral interventions use behavioral change as an outcome measure. Cognitive therapies use changes in thought processes to assess outcome. As previously mentioned in this chapter, developmental play therapy programs like DIR/Floortime target underlying capacities, or core deficits, as the focus of intervention. In addition, developmental models emphasize individual processing differences and the need to tailor interventions to the unique biological profile of the child as well as to the characteristics of the relationship between the caregiver and the child. The complexity of the treatment method and the treatment goals necessitates therapists measure progress across a complex array of changes in interactive behavior patterns (Cullinane, 2011).

**D: The Developmental Framework**

The DIR/Floortime Model has provided a developmental framework that has been studied and found to be accurate in understanding behavior. In 2005, Greenspan and Wieder published a 10- to 15-year follow up study of 16 children diagnosed with autism spectrum disorder that were part of their first 200 case series. The authors described that 10 to 15 years after receiving DIR/Floortime as a treatment method, these children had become significantly more empathetic, creative, and reflective adolescents with healthy peer relationships and solid academic skills (Greenspan & Wieder, 2005). Previous approaches using behavioral principles relied on outside motivators on the premise that children with autism did not have their own motivation to participate in social interaction or learning.

Two additional studies have demonstrated the effectiveness of DIR/Floortime. In 2007, Solomon, Necheles, Ferch, and Bruckman published an evaluation of the Play Project Home Consultation (PPHC). The program trains the caregivers of children with ASD in ways to use the DIR/Floortime model at home. The results show a significant increase in the child subscale of the Functional Emotional Assessment Scale (FEAS; Greenspan and DeGangi, 2001) after 8 to 12 months (Solomon et al., 2007). In June 2011, Pajareya and Nopmaneejumruslers published a pilot program of DIR/Floortime with preschool children with ASD. Results showed developmental improvements in FEAS, CARS (Children’s Autism Rating Scale), and the functional emotional questionnaires developed by the researchers, confirming the results of the Solomon study.

**I: Individual Underlying Neurological Processing Differences**

Because of the wide range of individual differences in autism spectrum disorders, the use of a single-subject research design allows for finely tuned research. Dionne and Martini (2011) created a single-subject study design to evaluate the effectiveness of Floortime play with a 3-year-old boy with ASD. The study had an observation and intervention phase and used circles of communication as the measure of change. Results showed a significant improvement using Floortime play strategies, and the journal kept by the mother over the course of the study showed insights on the changes observed. Additionally, Pajareya and Nopmaneejumruslers (2011) conducted a pilot control study in which randomized client selection showed the effectiveness of sensory integration treatment for children with ASD. Results showed significant improvement in individuals’ underlying neurological processing capacity, particularly in the areas of sensory processing and functional motor skills.
R: Relationship and Affect

Keeping playful interactions 'alive' and fun actually requires a lot of attention to the play partner's nonverbal communication and the ability to make rapid adjustments in response to these cues, while also regulating emotional intensity to stay in the "right frequency" for sustaining this pleasurable connection. Shifts in this frequency, much like changes in prosody in humans, can bring play to a halt instantly, along with a shift into the freeze mode of mobilized defense. In short, free play is actually a very creative process requiring a lot of people-reading and emotion regulation skills—a lot of emotional intelligence. When playfulness is suppressed in a caregiver–child relationship, both caregiver and child are robbed of one of the most powerful processes for strengthening their connection (Hughes & Baylin, 2012).

DISCUSSION: INTEGRATION AND APPLICATION OF DIR

The considerable, ongoing research into ASD, the various intervention components most suited to addressing it, and DIR all show great promise. ASD is now recognized as a disorder in which children have difficulty integrating various distinct brain functions. Research is currently focused on understanding deficits in neuronal communication as a basis for the wide array of behavioral manifestations of the disorder (Cullinane, 2011). Efforts continue to deepen our understanding of the complexities of autism spectrum disorders. The alarming increase in the diagnosis of ASD worldwide (Kogan et al., 2009), as well as the lack of specific information about etiology of the disorder, demands that play therapists and, most importantly, caregivers increase their knowledge and understanding of how a child's development is impacted by the individual, underlying neurological processing differences and the interaction of the relationships the child has in the world (Greenspan & Wieder, 2005).

In September 2009, Zero to Three focused an issue on the importance of play, specifically the role of spontaneous, child-led, social play experiences that support social, emotional, and cognitive growth (Hirschland, 2009). The Bridge Project 2009 is a joint effort of the Bridge Collaborative, a group comprised of therapists from the University of California–San Diego, Rady Children's Hospital, the San Diego Regional Center, the Harbor Regional Center (Torrance, Long Beach), Kaiser Permanente, and caregivers. They were awarded a $250,000 NIH R01 grant for a pilot study, with a clear path toward a $2,500,000 grant to implement evidence-based screening and an intervention in Southern California. In addition, Dr. Richard Solomon is doing a randomized control trial of the Play Project. The Play Project is a home-based version of DIR/Floortime, in which caregivers are the primary interventionists with the child. The caregiver–child dyad is supervised monthly by a play therapist trained in this model. The National Institute of Mental Health has granted $1.85 million to execute the next phase of this study. The Play Project has partnered with Easter Seals and Michigan State University to conduct this three-year study (Cullinane, 2011).

In 2010, Wallace and Rogers published a review of controlled studies that identified the four most important factors for effective intervention for infants with ASD: (1) caregiver involvement in intervention, including ongoing caregiver coaching focusing on both on caregiver responsivity and sensitivity to child cues and on teaching families to provide infant interventions; (2) individualization to each infant's developmental profile; (3) focusing on a broad rather than a narrow range of learning targets; and (4) temporal factors, such as beginning as early as the risk is detected and providing greater intensity and duration of the intervention.

Developmental intervention has advanced to incorporate the use of affect to enhance integration of sensory-regulatory, communication, and motor systems. As a result, neuroimaging research
is beginning to provide a deeper understanding as to how emotional experiences are actually impacting developing brain growth. Siegel (2001) show how attuned relationships in infancy change brain structure in ways that later impact social and emotional development. To further investigate the efficacy of DIR/Floortime, researchers Casenhiser, Stieben, and Shanker (2011), through the Milton and Ethel Harris Research Initiative at the York University in Canada, conducted a randomized controlled trial study. The specific aims of the preliminary study were to assess (a) the efficacy of the 12 months of intensive DIR/Floortime treatment; (b) the magnitude of the gains made by children receiving 24 months of DIR/Floortime treatment; and (c) the neurophysiological changes that occur as a result of intensive treatment for ASD. Recently, Casenhiser, Stieben, and Shanker (2013) updated the findings of their preliminary investigation, showing behavioral and neurophysiological outcomes of an intensive DIR/Floortime intervention using both event-related potential (ERP) and electroencephalography (EEG) measurements. They have found significant improvements in attention, joint attention, enjoyment, involvement, social interaction, and language after 2 hours a week of DIR based therapy over a 1-year period. Results of other imaging studies are in publication. Discussion is also continuing on ways to apply the basic principles of DIR/Floortime to work on an adult developmentally delayed population (Samson, 2013).

As the research continues, it is imperative that developmental approaches such as DIR/Floortime remain viable play therapy interventions for therapists and caregivers to use with children who have developmental delays. DIR/Floortime requires the appreciation of the polarity between following children’s leads and entering their worlds. Only then can children be pulled into a shared world, finding their pleasures and joys while they are continually challenged to master each of the functional developmental capacities. This means paying attention to the children’s underlying individual neurological differences with regard to the ways they processes sound and sights and movements and how they modulate sensations. It also means paying attention to the family patterns and to your own reactions as a play therapist. Each time we fine tune our interactions based on children’s needs, we are creating the potential for that great date: a mutually emotionally validating play experience for all.

REFERENCES


A Developmental/Relational Play Therapy Approach Toward the Treatment of Children


CHAPTER 19

Play Therapy With Children With Attachment Problems
SARAH C. PATTON AND HELEN E. BENEDICT

Attachment-focused play therapy is a collection of interventions ideally suited for treating young children who suffer attachment problems during the fragile neurodevelopmental window of their early years. Formation of an attachment bond is a critical developmental task (Bowlby, 1988). Reciprocal, coregulating transactions between a child and his or her attachment figures literally direct neurodevelopment (Schore, 2010) and shape implicit blueprints for self, others, and the world (Schore, 2011). The attachment bond is an irreplaceable vehicle for emotional, cognitive, behavioral, and social development (Kobak, Cassidy, Lyons-Ruth, & Ziv, 2006). Problematic attachment relationships may have vast, enduring consequences. Attachment theory (Bowlby, 1988), regulation theory (Schore, 2011), and interpersonal neurobiological research (Siegel, 2012) provide guiding frameworks for conceptualization and treatment of this population. This rich literature allows clinicians to more deeply understand attachment-focused therapeutic mechanisms as right hemisphere–dominant, intersubjective, psychobiologically attuned transactions (Schore, 2011) that address neurobiological dysfunction and implicitly stored negative working models underlying insecure attachment patterns and a host of interrelated symptoms (D’Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012).

DEFINING THE POPULATION

Attachment problems may arise in the midst of numerous, often interacting factors, including insecure working models of the caregiver (Berlin, Zeanah, & Lieberman, 2008), constitutional features of the child (e.g., difficult temperament), insensitive parenting behaviors, and caregiver abuse/neglect of the child. Among risk factors for attachment problems, childhood interpersonal trauma deserves highlighting due to its pernicious ubiquity. The national estimate of unique victims of child maltreatment in 2012 was 686,000, with the greatest percentage (78.3%) suffering neglect. Leading researchers believe childhood trauma to be the gravest public health
crisis of our time (Anda et al., 2006; van der Kolk, 2005). Compelling neuropsychobiological research (Perry, 2006) articulates the devastating structural and functional neuroanatomical deviations associated with early relational trauma (Anda et al., 2006). Empirical and epidemiological evidence suggests that early relational trauma creates a runaway train of enduring neurobiological dysfunction (Anda et al., 2006) underlying emotional, behavioral, cognitive, relational, and medical problems across the life span. Even worse, this dysfunction self-perpetuates via intergenerational transmission of attachment trauma (Schore, 2011; van Ijzendoorn, 1995). Therefore, refining attachment-focused therapies is imperative to reducing the suffering of our and future generations.

To describe the population of insecurely attached children, it is important to understand (a) how secure attachment bonds form; (b) how early attachment problems sabotage neurodevelopment, specifically in the right hemisphere; and (c) how dysfunctional attachments become internalized in a child’s implicit memory.

According to Schore’s regulation theory (2010), a secure attachment bond forms during infancy through a co-created “specifically fitted interaction” requiring a sensitive caregiver’s “regulation of the infant’s internal states of arousal, the energetic dimension of the child’s affective state” (p. 20). This coregulation occurs through a primary level of intermental communication (Trevarthen & Aitken, 2001) characterized by predictable, synchronized, emotionally significant patterns of visual–facial, tactile–gestural, and auditory–prosodic communication (Schore, 2009a). The protoconversations (Bateson, 1971) between mother and child are bidirectional, complex (Lavelli & Fogel, 2013), and mutually contingent (Trevarthen & Aitken, 2001). Mothers instinctively reach for an intimate, coregulating connection with their infant via the physiological language of motherese: “the dynamic narrative envelope of a mother’s utterances, their pitch contours, and other dynamic qualities” (Trevarthen & Aitken, 2001, p. 8). Newborns attend preferentially to facial configurations and exhibit an optimal distance of visual focus suggestive of innate relational seeking (Sigelman & Rider, 2005). In an optimal attachment scenario, the psychobiologically attuned caregiver “appraises the nonverbal expressions of her infant’s internal arousal and affective states, regulates them, and communicates them back to the infant” (Schore, 2010, p. 20) through synchronized communication.

Affectively synchronous attachment transactions “co-create positive arousal and interactive repair of negative arousal” (Schore, 2010, p. 21) that facilitate self-regulatory capacities, favorably affecting the developing hypothalamic-pituitary-adrenal (HPA) axis and prompting “homeostatic alterations of neuropeptides (oxytocin), neuromodulators (catecholamines), and neurosteroids (cortisol)” (Schore, 2010, p. 21), which are essential to neurodevelopment and social bonds (Schore, 1994, 2001; Wismer-Fries et al., 2005). Co-regulating dyadic transactions are particularly vital during the child’s first year, while the right hemisphere and limbic system are undergoing a growth spurt (Schore, 1994, 2011). Infants are born with undifferentiated neural systems that require environmental and internal prompts (neurotransmitters, neurohormones) to organize to their full capacity (Perry, 2001). Attachment transactions literally wire neural connections between the child’s bodily based, subcortical affective states with conscious emotional states in the right hemisphere. They also shape development of the orbitofrontal cortex, as well as its connection to the limbic system. This region is understood to be the “locus of Bowlby’s attachment system” and is the brain’s “most complex affect and stress regulatory system” (Schore, 2010, p. 23), which undergirds empathy, affect regulation, and development of a coherent self (Schore, 2010).

As children grow, they need ongoing, open channels of communication with attachment figures that are physically accessible and emotionally responsive (Bowlby, 1973; Kobak & Madsen, 2008) to maintain secure attachment bonds. Bowlby offered the term caregiver availability to capture both a caregiver’s accessibility and responsiveness as the attachment system’s goal
Play Therapy With Children With Attachment Problems

(Bowlby, 1973; Kobak & Madsen, 2008). Bowlby defined caregiver responsiveness as the caregiver’s willingness to provide comfort and protection when a child is afraid. Bowlby also emphasized the importance of caregivers engaging consistently with their children in mutually enjoyable, interactive moments with one another (i.e., play). These exuberant moments of shared, playful joy are essential for healthy attachment and affect regulatory capabilities (Trevarthen, Aitken, Vandekerckhove, Delafield-Butt, & Nagy, 2006).

Numerous factors may disrupt affectively synchronous attachment transactions and hinder the caregiver from being emotionally responsive, physically accessible, and openly communicative with his or her child. Examples include caregiver illness, stressful life events (e.g., divorce), caregiver psychopathology or substance use, and child maltreatment. Attachment research suggests that genetic variation may play a role in children's differential susceptibility to negative caregiving influences (Berlin et al., 2008; van Ijzendoorn & Bakermans-Kranenburg, 2006). Of importance, the quality of children's attachment relationships and their internal working models dramatically shape how they appraise subsequent stressful life events and attachment disruptions (Kobak & Madsen, 2008).

Attachment stress can precipitate prolonged hyperarousal, which shifts a child's physiological set point upward, intensifies alarm system activation, and sensitizes the stress-response system. Increased adrenergic activity ramps up the child's physiology (increased heart rate, blood pressure, anxiety, respiration, sweating) (van der Kolk, 2006). As the child develops, this physiological state inhibits brain regions mediating verbal communication, memory, and sensory integration (van der Kolk, 1994). The child's cortical regions are poorly equipped to restrain the dominant, overwhelming forces of lower brain areas (Gaskill & Perry, 2012; Lehrer, 2009; van der Kolk, 2006), increasing a child's vulnerability to emotional volatility and relational problems and obstructing exploration and learning. In cases of severe attachment trauma, some vulnerable children transition from a sympathetic dominant (hyperarousal) response into a parasympathetic-dominant response (dissociation). This represents a psychologically and biologically protective shift, as prolonged episodes of hyperarousal generate hypermetabolic, neurotoxic effects (Schore, 2001, 2010). If habitual, this metabolic shutdown (Schore, 2009a) removes adequate resources to sustain right hemisphere growth and functioning. This may, in turn, profoundly disrupt the child’s sense of self, creating voids of consciousness, and possibly leading to chronic psychological disorders in adulthood (e.g., borderline personality disorder) in which implicit affect regulation is impaired (Schore, 2010).

The aberrant physiological, neurobiological, and neuroanatomical characteristics of many children with attachment problems make it very challenging for them to navigate life stressors and benefit from relationships. These children manifest dysregulation in emotion and behavior including emotional lability/constriction, oppositional behavior, hyperactivity, and tantrums. They also suffer disturbances in consciousness and attention, such as dissociative symptoms, inattention, and difficulty concentrating. Distorted attributions and interpersonal struggles are common. These children are slow to trust and quick to infer malevolent intentions in the behavior of others. They are often overly clingy or overly independent and have problems reading social cues and interacting appropriately with peers (D’Andrea et al., 2012). The clinical literature (Zeanah & Borris, 2000) aptly describes these multifarious, interrelated symptoms, however, our psychiatric nosology does not yet adequately depict them.

In children as young as 1 year of age, developmental researchers have identified four relatively stable attachment patterns: secure, resistant, avoidant, and disorganized (Ainsworth, Blehar, Waters, & Wall, 1978; Main & Solomon, 1990). The latter three of these patterns reflect nonoptimal activation and coordination of a child’s fear, attachment, and exploratory systems. The most maladaptive of these, disorganized, “type D” attachment (Main and Solomon, 1986), is
diagnosed in children who lack a coherent attachment strategy. Disorganized attachment occurs as a result of extremely pathological caregiving relationships in which the attachment figure provokes tremendous fear in the child and fails to soothe the child. This presents an irresolvable, paradoxical scenario for the child, who is instinctively drawn to the attachment figure for protection while concurrently impelled to flee from the frightening attachment figure. The child, therefore, is bereft of a workable coping strategy (Schore, 2001).

Zeanah and Boris (2000) proposed three attachment categories for clinical use, including disorders of nonattachment, secure-base distortions, and disrupted attachment. Children with disorders of nonattachment do not demonstrate preference for a specific attachment figure and manifest disturbances in exploration, self-regulation, and the ability to show affection or to seek comfort. The secure-base distortion category contains four subtypes, all featuring a deficiency in the attachment figure’s capacity to provide a secure base for the child’s exploration and a safe haven to which the child returns in times of duress (Cooper, Hoffman, Powell, & Marvin, 2005). These subtypes are:

1. The self-endangerment subtype is characterized by reckless, dangerous exploration, self and/or adult-directed aggression, and failure to utilize the attachment figure as a safe haven.
2. The clinging-inhibited subtype includes children who are clingy, uneasy when separating from the attachment figure, and reluctant to explore.
3. The hypercompliance subtype includes emotionally constricted, hypervigilant children who are neither clingy nor explorative.
4. The role reversal subtype includes children who are visibly preoccupied with their attachment figure’s well-being and enact either controlling or overly solicitous behavior (Teti, 1999).

Last, the disrupted attachment category includes children whose initial attachment relationships are severed for reasons such as hospitalization of the child or caregiver, death of the caregiver, or removal of the child by child protective services. These children vastly differ in their adaptation to disrupted attachment, depending on the quality of their initial and new attachment relationships (Zeanah & Boris, 2000).

SPECIAL CONSIDERATIONS

The timing, duration, and nature of attachment disruptions are of the upmost significance in determining symptom severity and the extent of neurodevelopmental impairment. According to Perry’s (2006) neurodevelopmental principles, brain development is “experience dependent” and unfolds in a time-sensitive, sequential, and hierarchical manner, with less complex regions (brainstem, diencephalon) organizing before higher regions (limbic system, cortex), and higher areas contingent upon lower areas for optimal functioning. Early attachment problems can cause catastrophic fallout by distorting the structure and functioning of low brain regions (brainstem, diencephalon). Interpersonal trauma may result in a stored, subcortical pairing of certain sensory cues (smell, facial expression, tone of voice) with the autonomic fear response in memory (Perry, 2006). External and internal sensory input first enters the lower, nonconscious, primitive areas of the brain (brainstem, diencephalon). As new input arrives, it is matched against stored templates, and can potentially activate a nonconscious, bodily based alarm response if a match is made.
Of importance, this often occurs without conscious awareness, as the alarm system is activated before the neural activity reaches limbic and cortical regions (Perry, 2008). Therefore, children with attachment problems may be triggered repeatedly by seemingly harmless interpersonal and environmental elements.

THEORETICAL FOUNDATIONS

The ancestral home of attachment-focused play therapies lies in the formulations of British object relations theorists John Bowlby (1988), Donald Winnicott (1965, 1971a, 1971b), and Mary Ainsworth (1963). Object relations theories share several vital assumptions. First, close relationships serve as the principal motivational incentive of human development (Glickhauf-Hughes & Wells, 1997). Second, attachment figures and infants together create cognitive-affective “internal working models,” essentially relational templates (Bowlby, 1988) reflecting emotions and beliefs regarding others, self, and self in relation to others. These templates guide children’s characteristic approach to perceiving and engaging with the world, others, and themselves. Internal working models interact reciprocally with a child’s ongoing relational experiences, shaping the child’s transactions, while being modified by them in return (Bowlby, 1988; Siegel, 2012).

Attachment theory and several classical psychodynamic constructs have been substantiated and/or refined by contemporary interpersonal neurobiological research (see Schore, 2009b, for full discussion). The notion that a child’s “mental representations of self and others become enduring psychic structures” (Glickhauf-Hughes & Wells, 1997, p. 18) surfaces in Schore’s (2009a) research regarding implicit working models of the right hemisphere. John Bowlby (1958) predicted the “rapprochement” (Schore, 2010) of biology and psychology. Bowlby inextricably intertwined psychological and biological processes in his model, which he refined collaboratively with his research associate, Mary Ainsworth (1963). The attachment figure provides a secure base from which to explore (Ainsworth, 1963) and a safe haven to which a child returns in times of distress. Contemporary research confirms dynamic interrelationships amongst a child’s exploratory, fear, and attachment systems (Cassidy, 2008). The child’s attachment system maintains safe proximity to the attachment figure through caregiver-eliciting behaviors such as crying and crawling close to the caregiver. When a child’s attachment figure is perceived as readily accessible and safe, the child’s attachment system hushes, enabling the child to engage in exploratory system behaviors such as examining new toys, building things, and crawling away (i.e., secure base). Both the attachment and fear systems activate during times of extreme stress, and when this occurs it inhibits the exploratory system.

Five psychodynamic constructs developed by British object relations theorist Winnicott (1971a) inform attachment-focused play therapy: the false self, good enough mothering, holding environment, attunement, and transitional object. The false self is a phenomenon whereby children become estranged from their authentic self via excessive compliance with attachment figures. Good enough mothering is the term for the caregiver’s provision of a caregiving atmosphere that affords the child acceptance and fulfillment of needs, without impingement (Abram, 1996). A holding environment refers to a therapeutic relationship that recreates the caregiving environment. Last, caregivers provide attunement when they accurately read a child’s needs and sensitively and consistently meet them. Fairburn’s (1952) notion of obstinate attachment is also relevant to the treatment of children with attachment problems. Obstinate attachment occurs when a child becomes paradoxically attached to a neglectful or abusive caregiver.
WHY PLAY THERAPY IS APPROPRIATE

Play therapy engages the right hemisphere and helps organize lower regions of the brain through sensory communications such as eye contact, movement, sound, and touch (Booth & Jernberg, 2010). Therefore, play is an ideal modality for children with attachment problems. Developmental researchers demonstrated that play is an essential element of healthy caregiver–child attachment relationships and is vital to a child's language, cognitive, and relational development (Cicchetti & Valentino, 2006). Children with attachment problems have often missed out on inculcable playful moments with caregivers; therefore, they need these moments to be recreated again and again in psychotherapy and with caregivers at home to progress developmentally. Thematic play can be an invaluable therapeutic tool, allowing the child's implicit object relations to take residence in the representational toys, figures, and materials of play. When occurring in a deeply safe therapy relationship, thematic play provides the child externalization and projection opportunities (Gil, 2003) to aid trauma recovery. Potentially distressing experiences and affects are safely externalized and contained. This externalization creates sufficient psychological distance for the child to process memories, beliefs, and emotions without becoming unnecessarily dysregulated (O'Connor, 2006).

THERAPEUTIC STRATEGIES

A wonderfully diverse collection of individual, dyadic, and family play therapeutic strategies exist to help children with attachment problems. Examples of explicitly attachment-focused play therapy models include Theraplay®, dyadic developmental psychotherapy, and object relations and attachment-based play therapy (Patton & Benedict, 2014). Clinicians may use these models as stand-alone interventions, or they may integrate elements from multiple approaches to adapt treatment to unique needs of children and caregivers (O'Connor, 2006; Weir, 2007). Clinicians may also modify existing play therapy approaches (Barfield, Dobson, Gaskill, & Perry, 2012) to address attachment problems.

Children with attachment problems and their caregivers need the initial portion of therapy to focus heavily on establishing a safe to the bone (Hughes & Baylin, 2012) relationship. This relationship will serve as the primary vehicle of intervention. The therapist must exude warmth, acceptance, curiosity, empathy, and playfulness (Hughes, 2009) through body language cues, as well as the tempo, tone, rhythm, prosody, amplitude, and timbre of speech, all of which are central to psychotherapy processes (Hutterer & Liss, 2006). The healing power occurs through right hemisphere–dominant nonverbal transactions with attachment figures, given that the child's relational trauma history is implicitly stored there (Schore, 2009a).

Providing attunement and relational constancy are vital to creating a secure-base relationship with a child in individual play therapy approaches. Dyadic and family models involve a clinician creating a secure base relationship with a child and caregiver, and then helping the caregiver provide attuned, intersubjective communication with his or her child via modeling, role-plays, and/or structured play activities (Booth & Jernberg, 2010; Hughes, 2009). Attunement involves creating an intersubjective state in which the attachment figure and child sense the other's emotions through shared experiences (Trevathan et al., 2006). A therapist conveys/models attunement via child-responsive and/or caregiver-responsive interventions, as well as timely reflections regarding

---

1Theraplay is a registered service mark of The Theraplay Institute, Evanston, IL.
the child's emotional and behavioral expressions. Attunement also involves the therapist matching the vitality or intensity of the child's or caregiver's affect (Stern, 1985). This matching gives the child an experience of feeling “felt” and deeply understood. In addition, the play therapy room, procedures, safety rules, room layout, and availability of play toys and materials should remain as consistent as possible. Establishing a predictable place and time for therapy also helps the child and caregivers experience the therapist's constancy. Children with attachment problems can become alarmed in the face of even minor surprises or changes to routine. Therefore, the therapist should anticipate this by preparing the child in advance for changes in therapy time, location, and play materials.

Attachment trauma can sabotage a child's ability to implicitly regulate strong emotions, prompting behavioral problems and undermining the child's coherent sense of self. The attachment-focused play therapist addresses this procedurally by acting as a coregulator, essentially lending the child the therapist's regulatory capacities during times of high arousal. To provide coregulation, the therapist must first provide attunement, matching the child's “vitality affect” (Stern, 1985) to “capture” the child at his or her current state before either arousing a constricted child or calming an overly aroused child. Coregulation also involves the therapist reflecting the child's emotions and explaining how the therapist detected them (e.g., child's loud voice, wide eyes). On a neurobiological level, the therapist is fostering connectivity between subcortical and cortical regions of the right hemisphere (Schore, 2009a). Coregulation also involves engaging the child in self-soothing and modifying the child's response to safety threats.

Children with attachment problems and their caregivers need to experience both physical and psychological safety in treatment. The therapist must consistently and creatively maintain physical safety limits while maximizing the child's freedom. This can be inordinately challenging in the face of the child's recklessness, poor coordination, and impulsivity. Children with the self-endangerment behaviors frequently catch therapists off guard with self- or other-directed aggression. The therapist must maintain warmth and full acceptance of the child's behaviors and emotions, no matter how problematic, while avoiding becoming permissive.

The therapist's right hemisphere–dominant creativity (Schore, 2011) and clinical intuition are essential to therapeutic effectiveness (Schore & Schore, 2008) with insecurely attached children. The therapists’ capacities to tolerate and modulate their own affect and to deeply empathize with and enjoy the child are essential to establishing psychological safety. Children with attachment problems often elicit strong emotional reactions in therapists through impulsive, aggressive, and provocative behaviors, as well as withdrawn or distancing presentations. According to Schore (2009a), heightened affective moments precipitate the most stressful countertransference responses, including the clinician's implicit coping strategies rooted in his or her own attachment history. Unresolved emotions will be unconsciously conveyed through non-verbal indicators, underming the child's perceived psychological safety and weakening the secure base relationship. The therapist must avoid being overly directive by relinquishing control over many therapy elements. For example, the therapist may fulfill the child's requests to know how much time is left by providing a child-friendly clock to alert the child when the session ends.

Another procedural modification for treating children with attachment problems is planning and sequencing play therapy to correspond with the brain areas requiring repair. Perry's (2006) neurodevelopmental principles clearly establish the importance of remediating lower areas (brainstem, diencephalon) of brain dysfunction as a necessary precursor to targeting relational and cognitive disturbances. Therefore, even a well-planned, relationally focused intervention may backfire if the child has not achieved foundational self-regulation capabilities. According
to Perry's neurosequential model of therapeutics (NMT; Perry, 2006), achieving brainstem regulation requires patterned, repetitive sensory input to foster neural development and organization. Interventions that facilitate this input include rocking, singing, sequencing, therapeutic touch, infant games, movement activities, and calming activities, all of which are characteristic of Theraplay (Booth & Jernberg, 2010). These brainstem regulating activities may also be added to approaches such as filial play therapy (Barfield, Dobson, Gaskill, & Perry, 2012) to meet the needs of children with attachment difficulties.

A child with poorly organized self-regulation capabilities requires therapeutic repetitions surpassing those provided in weekly psychotherapy (Perry, 2006). Therefore, to foster meaningful change in children with substantial low brain dysfunction, play therapy must be seen as one element in a comprehensive treatment program involving the child’s entire system of care (e.g., parents, teachers). In such cases, play therapy should be accompanied by other brainstem-remediating activities such as occupational therapy or music/movement classes. Attachment-focused play activities, such as those utilized in Theraplay, translate well to school, home, and daycare environments. A therapist may work with a child’s teachers, grandparents, and siblings to ensure that playful, healing interactions transpire throughout the week.

Thematic play can be an invaluable therapeutic tool for addressing attachment problems. Play therapy researchers (Benedict, 1997, 2004; Benedict & Hastings, 2002; Benedict, Hastings, Ato, Carson, & Nash, 1998) have determined that children play out a plethora of identifiable themes. These themes can be common across children, but also involve unique characters and scenarios containing idiosyncratic meaning for the child. Examples include family themes (e.g., separation, reunion, nurturance), safety themes (e.g., danger, rescue), and themes of aggression (e.g., good guy–bad guy, death play, aggressor–victim). Play therapy researchers have also determined that children’s thematic play features recurrent affects and interpersonal patterns (Benedict, 2004; Benedict et al., 1998). These elements can reveal the child’s implicit working models, implicit affects, and habitual relational patterns.

Within thematic play therapy, the therapist discerns the relevance of play themes, affects, and relational patterns to the child’s attachment history and developmental experiences. The therapist is psychobiologically attuned to the child as he plays, and responds with novelty and creativity, both of which are right hemisphere resources (Arnold, 2007; Schore, 2011). Entering the child’s metaphors, the therapist makes creative invitations (Gil, 1991) to indirectly, gently modify maladaptive object relations. Overt interpretation of children’s play themes is unnecessary and potentially counterproductive because it may overwhelm the child and shift from play into a left-hemisphere mediated intervention (Schore, 2009a). Research indicates implicit object relations are more effectively altered through experiential, unconscious therapy processes. Schore (2011) explains, “just as the left brain communicates its states to other left brains via conscious linguistic behaviors so the right nonverbally communicates its unconscious states to other right brains that are tuned to receive these communications.” Within the child’s metaphorical world, the therapist utilizes play characters to convey empathy, voice a new perspective, or enact solutions (e.g., dispatching police to rescue the girl trapped in quicksand) to modify the child’s implicit models. In addition, the therapist’s play character can portray intolerable, unintegrated elements of a child’s trauma, embodying a disowned “not me” (Bromberg, 2006) emotion or experience. The therapist can express emotions and beliefs to which the child does not have conscious access so these can be integrated into the child’s narrative. Thematic play becomes what Schore (2011) describes as “the self-exploration process of psychotherapy, especially of unconscious affects that can be potentially integrated into a more complex implicit sense of self” (p. 94).
Eliana, a Caucasian, 3.5-year-old, was a tornado of curly brown hair and flailing arms and legs as her mother carried her over one shoulder into a psychology clinic. Eliana’s disheartened parents, both professionals in their early 30s, bemoaned Eliana’s frequent tantrums, bedtime refusals, defiance, and rough play. Eliana struggled massively with daycare classroom transitions, melting down with each activity change and emphatically refusing to lie down during naptime. Her teacher often put her in the time-out chair, where she began kicking, spitting, and hitting. Eliana was hypervigilant and had trouble playing and concentrating. On the bright side, Eliana had formed a few friends; however, her volatility made her social connections tenuous. The daycare administrator was preparing to dismiss Eliana from the daycare program. Her parents were panic-stricken.

Eliana’s therapist, Cynthia, noted that Eliana’s mother appeared anxiety-ridden and hyperactive, while Eliana’s father seemed detached and emotionally subdued. Eliana had entered daycare at 2 months. At age 2, she witnessed her father collapse on the front lawn. Wide-eyed, she watched as the EMTs rushed to the scene to revive and whisk him away. His medical diagnosis was unknown for 6 months. He suffered painful headaches and avoided Eliana after being discharged from the hospital. Eliana’s mother became the primary breadwinner and caretaker. She felt enormous pressure as she rushed between household and professional tasks.

Utilizing a neuropsychobiological conceptual framework, Cynthia surmised that Eliana did not experience sufficient coregulating attachment transactions to optimally organize the right hemisphere and establish positive implicit working models. Eliana’s parents clearly loved her; however, they were not emotionally attuned due to work-related and medically related stress and difficulty modulating their own affect. When Eliana cried, her mother’s anxious, hyperactive response increased rather than decreased Eliana’s arousal. Eliana’s father emotionally withdrew during times of distress. His subdued nonverbal expressions fell far beneath Eliana’s affect vitality, leaving her alone in her dysregulation. Eliana spent prolonged periods in hyperarousal. This sensitized her stress response system, impaired her affect regulation capacities, and hindered higher-level brain development/functioning (attention/concentration, imaginative play). Eliana formed implicit “procedural” expectations that attachment figures cannot provide a safe haven during times of emotional distress. Eliana also internalized a negative self-view, as her distress precipitated negative emotions or withdrawal from caregivers.

With these underlying vulnerabilities, Eliana witnessed her father’s traumatic physical collapse. This shattered her implicit trust in attachment figures to be invulnerable and constant. Eliana became vigilant concerning her parents’ whereabouts and was unable to utilize them as a secure base. Eliana’s negative internal working models were further confirmed when her father avoided her and her mother became overwhelmed. Neither caregiver engaged Eliana in playful, joyful moments of intersubjectivity to induce and regulate positive affect states. Eliana failed to internalize a positive implicit working model of self, as she did not experience her parents enjoying her as their daughter. Parent–child interactions became task-focused, and Eliana was reprimanded for emotional upsets. She became very controlling of and oppositional toward caregivers and remained unable to self-soothe or manage stress.
Eliana’s treatment spanned 45 individual weekly, attachment-focused, play sessions. Her parents attended sessions separately with another therapist to learn brain-based attachment principles (Hughes, 2009; Hughes & Baylin, 2012; Siegel & Hartzell, 2004), to gain insight into their own thoughts and feelings toward Eliana, and to learn ways to coregulate Eliana’s affect. The treatment plan also included supplemental music classes for Eliana. These provided repetitive, rhythmic sensory input to help organize and regulate lower areas of her brain. Eliana’s parents and teachers learned infant games to play with her at home and daycare, and they rocked her daily while singing.

Eliana’s therapist first established a secure base relationship. This process took many weeks, as Eliana was anxious, highly controlling, and unpredictably aggressive. Eliana had great difficulty playing. She primarily dumped out toys and became easily frustrated by things “not working.” Eliana handled toys roughly. Once she hurled the “bop bag” across the room at Cynthia. Matching her vocal volume, tone, and pace to Eliana’s elevated arousal, Cynthia knelt down and said, “We don’t hurt in the playroom, so it’s not okay to throw the bop bag at me. I can hear by your loud voice that you get so mad and scared sometimes, and that’s hard for you. Let me show you how to hit the bop bag safely when you do have those mad feelings.”

Cynthia provided attunement, coregulation, and welcomed safe, bodily expressions of emotions. In addition, Cynthia monitored her own physiological and emotional responses, giving attention to and making sense of her own emotional and cognitive responses while drawing connections to elements from her own attachment history. Eliana tested nearly every limit imaginable by demanding to play in both playrooms, running to grab candy from the treat jar midsession, and locking Cynthia out of the room. Cynthia maintained safety while yielding as much control as possible to Eliana. For example, she allowed Eliana to “interrupt” her parents’ sessions as often as needed to check-in, and she followed Eliana’s lead in play activities. As the secure base relationship formed, Eliana began struggling with ending the play sessions and would refuse to stop playing or insist on taking toys home. Cynthia provided attunement and labeled Eliana’s thoughts and feelings through reflection. She also suggested Eliana carry a piece of artwork to the waiting room at the end to ease transitions home. Cynthia assured Eliana the same toys would be there next week, and she created a special box of Eliana’s artwork to keep safely in the cabinet between sessions.

Eliana’s thematic play initially depicted aggressive themes, anger, and controlling relational patterns via teacher–student play. Eliana revealed her internal working models by casting herself as the punitive, disappointed teacher who reprimanded Cynthia, “the student,” for all manner of bad behavior. Cynthia was banished to the closet for failing at naps, dismissed to the carpet for “sitting too close” to teacher, and told to “be alone” because she was “bad.” As the student, Cynthia embodied Eliana’s fear and helplessness. This indirectly communicated empathy and helped Eliana reintegrate disowned aspects of her emotional life. Cynthia conveyed how hard it was to settle down and elicited nurturance (e.g. “Can you please bring me an extra blanket and stuffed animals to help me calm down?”). Eliana initially refused this invitation, insisting upon harsh punishments for “bad” students. However, over time, Eliana began offering extra blankets to the students and surrounding them with puppets during naptime. Eliana once initiated a play scenario in which dinosaurs attacked the students. Cynthia suggested a rescue operation using puppets, which Eliana accepted. Eliana began initiating nurturing activities, though she first utilized role-reversal as she asked to “brush” and “cut” Cynthia’s hair. Eliana gradually began switching roles but clearly found this unsettling. She briefly tolerated receiving nurturance before retaking control as the nurturer. Over time, Eliana requested nurturance directly. She would ask for
blankets on particularly stressful days and allowed Cynthia to rub her back and sing to her when she needed a nap.

After several months, mother–baby thematic play began surfacing in Eliana’s play. Play scenarios depicted abandonment experiences and a poor emotional connection at the expense of maintaining a hurried pace and arriving places on time. Within the metaphor as “the baby,” Cynthia embodied Eliana’s implicit sadness and loneliness and verbalized her implicit fears by interpreting the metaphor within the play to modulate its impact (e.g., “Mommy, sometimes I worry you won’t come back when you leave me”). Cynthia also suggested ways the mother could nurture and emotionally attune to her baby. Cynthia used the same techniques within the therapy relationship when abandonment fears surfaced. For example, Eliana’s father once brought her to session by himself when Eliana’s mother was out of town. Eliana was clearly more hypervigilant and dysregulated. She plastered herself to the window to watch her father in his vehicle outside. Cynthia resonated emotionally with Eliana’s distress while highlighting Eliana’s nonverbal manifestations of fear and verbalizing her worries. Cynthia invited Eliana to bring a transitional object from her father to ease her separation distress. Over time, Cynthia began including Eliana’s father in play sessions, and facilitating attuned, intersubjective, playful transactions between Eliana and her father.

Eliana showed marked improvement in several areas during the final phase of therapy. She was able to make smoother transitions between therapy tasks. Her play contained fewer hostile and controlling play themes. She was able to elicit and accept nurturance from her therapist in session and her parents at home. And, she showed increased ability to manage stress and tolerate transitions. Play therapy ended with a celebratory graduation and goodbye session. Eliana chose the games to be played, made a special painting with Cynthia, and took a Polaroid photo with Cynthia to remember their work together.

EMPIRICAL EVIDENCE

A vast empirical literature supports the neurobiological and neurodevelopmental frameworks that inform attachment-focused approaches (Perry, 2006; Schore, 2011). Substantiating the right hemisphere’s role in attachment, researchers who conducted a near-infrared spectroscopy study of infant–mother attachment at 12 months asserted, “our results are in agreement with that of Schore (2001) who addressed the importance of the right hemisphere in the attachment system” (Minagawa-Kawai et al., 2009, p. 289). In addition, preliminary findings indicate that incorporating Perry’s neurosequential model of therapeutics into filial play therapy is linked to gains in social–emotional development and improved behavior for preschool children with complex neuropsychiatric problems (Barfield, Dobson, Gaskill, & Perry, 2012). Interpersonal neurobiology research resonates with attachment theory and many classical psychodynamic constructs (Schore, 2009b), including attunement and intersubjectivity.

Research also supports the effectiveness of specific attachment-focused models discussed in this chapter, such as Theraplay and dyadic developmental psychotherapy. Children receiving dyadic developmental psychotherapy demonstrate greater improvement than children in the control group receiving “usual care” (e.g., individual, family, group therapy) both at the conclusion of treatment and at a multiyear follow-up (Becker-Weidman & Hughes, 2008). Findings from a pilot study (Weir, Lee, Canosa, Rodrigues, McWilliams, Parker, 2013) in which adoptive families participated in whole family Theraplay (WFT), an integrative treatment comprised of
Theraplay components and family systems strategies, indicate statistically significant benefits in family communication, children’s overall behavioral functioning, and adults’ interpersonal relationships. Researchers also found that shy and socially withdrawn children who participated in Theraplay improved significantly on assertiveness, self-confidence, and trust, while social withdrawal decreased. Improvements were maintained over a 2-year period with no instances of relapse (Wettig, Coleman, & Geider, 2011).

CONCLUSION

Children with attachment-related difficulties have many unique needs and require play therapy interventions geared to meeting those needs as efficiently and effectively as possible. Play therapists can draw on object relations theory, neurobiological attachment research (Schore, 2009a), and the principles of neurodevelopment (Perry, 2006) to provide children with attachment focused play interventions. Through individual, dyadic, and/or family approaches, the attachment-based play therapist endeavors to ameliorate insecure attachment patterns and a host of interrelated symptoms accompanying childhood adversity (D’Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012) by addressing underlying neurobiological dysfunction in a sequence and manner consistent consonant with neurodevelopmental principles (Perry, 2006). The child’s implicit internal working models manifest in the secure base therapeutic relationship and also take residence in the here-and-now of his or her thematic play. The therapist engages the child in attuned, intersubjective interactions and issues gentle invitations within the child’s play metaphors to modify maladaptive relational schemas. The integration of these approaches maintains the historical psychodynamic elements supported by current interpersonal neurobiological literature while integrating neurodevelopmental principles and a neurobiological model of attachment.

REFERENCES


Wismer-Fries AB, Ziegler TE, Kurian JR, Jacoris S, & Pollak SD. Early experience in humans is associated with changes in neuropeptides critical for regulating social behavior. *Proceeding of the National Academy of Sciences USA, 102*, 17237–17240.

The literature on interventions for children with disabilities falls into two broad categories: “I can” and “I am.” The “I can” approach focuses on maximizing children’s pragmatic and practical abilities. The “I am” approach focuses on improving children’s sense of self and emotional functioning. The “I can” interventions are the purview of physical therapists, special education teachers, diagnosticians, and occupational therapists, to name but a few of the specialists who work to help the children with disabilities. Their interventions focus on maximizing children’s physical, academic, and cognitive development, as well as developing accommodation and remediation strategies. The “I am” interventions are the purview of mental health practitioners, including play therapists. Their interventions focus on children’s senses of self, as well as their emotional growth and development. When these two approaches are well integrated, they can contribute significantly to the overall growth and development of children with disabilities. Further, the various specialists contribute to the welfare of children with disabilities by working with the children’s caregivers, providing knowledge, support, and training to help the children capitalize on their strengths and to provide remediation or accommodation as needed.

Because it is geared toward play therapists, this chapter focuses on the “I am” approach to helping children with disabilities. Some discussion of special accommodations in the playroom, the provision of caregiver support, and specific techniques will be presented. Because of the sheer number of different identified disabilities, the chapter will take a general, as opposed to a disability-specific, approach to the topic of working with this population.

DEFINING THE POPULATION

There are many ways of defining and classifying the diagnoses of children with disabilities. One way is to use the federal government’s definition and the terms used in IDEA (Individuals With Disabilities Education Act, 20 U.S.C. § 1400) (2004).
§ 300.8 Child with a disability.

General. (1) Child with a disability means a child evaluated in accordance with §§300.304 through 300.311 as having intellectual disability, a hearing impairment (including deafness), a speech or language impairment, a visual impairment (including blindness), a serious emotional disturbance (referred to in this part as “emotional disturbance”), an orthopedic impairment, autism, traumatic brain injury, and other health impairment, a specific learning disability, deaf-blindness, or multiple disabilities, and who, by reason thereof, needs special education and related services.

Because the IDEA(2004) definition is designed for use in educational settings, it focuses on those cognitive and physical disabilities most likely to interfere with children’s academic achievement. The definition also includes the general category of “emotional disturbance” and several specific mental health disorders and diagnoses. Because play therapists are already familiar with the issues involved in treating children with emotional difficulties, this chapter will focus on the special challenges play therapists face when working with children who have various sensory and physical disabilities.

According to the International Classification of Functioning, Disability, and Health for Children and Youth (ICF-CY) (Petersson, Simeonsson, Enskar, & Huus, 2013), a chronic disability is defined as one that is present throughout the life of the individual and cannot be changed. These chronic disabilities may create daily challenges for the child and the child’s family. In turn, these chronic disabilities may interfere with the child’s physical, social, and emotional development. It is also important to consider the actual quality of the child’s life, as well as how the child may perceive his or her own “physical health, level of independence, psychological state, social relations and personal beliefs” (Petersson et al., 2013, p. 2).

Common Childhood Disabilities

Children may have a single disability or may be challenged by multiple disabilities. Even when children have a single disability, it may manifest in multiple areas of their functioning. Specific disabilities may compound the developmental, social, and emotional challenges faced by all children (Tarver-Behring & Spagna, 2004). The most common types of disabilities involve impairments in the areas of fine or gross motor functioning, vision, hearing, communication, and learning.

“Motor disabilities” describes a range of motor impairments that includes both congenital and acquired conditions involving the neurologic and musculoskeletal systems. Some of these conditions include cerebral palsy, traumatic brain injury, myelomeningocele, spinal cord injury, neuromuscular disease, juvenile rheumatoid arthritis, arthrogryposis, and limb deficiencies. Children with these conditions may experience muscle weakness, abnormal muscle tone, decreased joint range of motion, and problems with balance and coordination. The degree of impairment may range from very mild and barely noticeable to so severe the child requires assistance with functions as basic as breathing. Regardless of the cause or severity of the motor disability, it may limit the child’s ability to participate in age-appropriate activities in the home, school, and community (Michaud, 2004).
Visual disabilities may also result from a wide variety of congenital and acquired conditions, and the level of impairment may range from relatively mild to complete blindness. Children with visual impairments have difficulties navigating the physical environment and its potential hazards, recognizing objects and their size, and learning the subtleties of nonverbal communication. Even a diagnosis of blindness does not necessarily mean the child cannot see at all. The child may be able to detect light, shapes, colors, and even some objects sufficient to allow for facial recognition or to allow the child to read large-print books. Common visual impairments, such as blindness, near-sightedness, and far-sightedness, are familiar to most play therapists. However, some of the less familiar visual impairments are strabismus (eyes look in different directions), congenital cataracts (cloudy lens), retinopathy related to prematurity (light sensitivity because the retinas were inadequately developed at birth), retinitis pigmentosa (an inherited disease that destroys the retina), coloboma (part of the eye structure is missing), optic nerve hypoplasia (underdeveloped optic nerve resulting in difficulties in depth perception, light sensitivity, and acuity), and cortical visual impairment (result of damage to the vision center of brain). Unless the visual impairment is detected early, the child may be delayed in achieving basic developmental tasks. Children with any degree of visual impairment may have to accomplish tasks in a different way or using different materials or tools. They may learn best when whatever vision they do possess is augmented with additional sensory input, such as touch, sound, smell, taste, and movement. This type of sensory learning should be incorporated into the play therapist’s choice of playroom items and therapeutic experiences (National Dissemination Center for Children with Disabilities, 2012).

According to the American Speech-Language-Hearing Association (ASHA, 1993b), children with hearing loss are affected in four major ways. Hearing loss can cause (1) a delay in children’s receptive and expressive communication, (2) reduced academic achievement, (3) social isolation and poor self-concept because of communication difficulties, and (4) limitations on leisure and career choices. Children with partial hearing often have difficulty with vocabulary development, especially when it comes to words that have the same sound but different meanings (homophones), such as blue/blew and cruise/crews. Because these children cannot always hear the word endings, they may misuse verb tense, pluralization, subject–verb agreement, and possessives. When speaking, they may leave sounds out of words, speak too loudly or softly, have high voice pitches, and have odd cadences to their speech. Children with hearing loss may find it easier to use more concrete words to describe objects and events than to use the more abstract words required to describe emotions. They may also have difficulty listening to and using long or complex sentences. Academically, math and reading may present special problems for the child with hearing loss. The child’s level of achievement is dependent on the quantity, quality, and timing of support services the child receives. Socially, children with severe to profound hearing loss report that they often feel isolated, friendless, and unhappy in school and similar environments. Interestingly, children with mild or moderate hearing losses report having problems in social situations more frequently than their peers with more severe hearing loss (ASHA, 1993b).

Children with communication disorders have difficulties receiving, sending, processing, and comprehending verbal and nonverbal cues as well as graphic concepts or symbols. As was made apparent in the discussion of hearing loss, communication disorders are common in children with hearing difficulties. However, they also present in children with adequate hearing and may manifest as problems with language processing (central auditory processing disorder), language use (form, content, or function), and/or speech difficulties (articulation, fluency, or voice disorders). The presence of communication disorders may make it very difficult for the child to benefit from any sort of language-based intervention in play therapy. It is often best in such situations to augment any cognitive-verbal work with experiential activities.
Finally, the international definition of learning disabilities requires the child to manifest specific cognitive processing and/or academic achievement difficulties in spite of normal or even superior intellectual capabilities (Buttner & Hasselhorn, 2011). A learning disability may be diagnosed when a child is unable to achieve academically at the level expected for his or her intellectual functioning. Specific learning disabilities include developmental disorders of scholastic skills, such as reading disorders or developmental dyslexia; spelling disorders; arithmetic skills disorders, or dyscalculia; inability to write legibly, or dysgraphia, and written expression disorder. Children with learning disabilities may have emotional problems and poor self-concept, and they may lack confidence due to poor performance in school. Any type of disability may have far-reaching effects on the child and the child’s family (Clarizio, 1997; Tzang, Chang, & Liu, 2009).

The presence of multiple disabilities represents a special challenge to the child, the family, and the therapist. Children with multiple disabilities have been found to have three to seven times more emotional and behavioral problems than unimpaired children (Alimovic, 2013) Further, the greater the number of disabilities, the greater the likelihood the child will have emotional and behavioral problems (Alimovic, 2013). Alimovic (2013) used the Child Behavior Checklist (Achenbach, 1991) to compare three groups of children ages 4 to 11: (1) a group with both intellectual disability and visual impairment, (2) a group with either intellectual or cognitive impairment, and (3) a group of unimpaired children. Parents reported more behavior problems among all of the impaired children when compared to their unimpaired peers; however, the highest incidence was among the group with both cognitive and visual impairments, the second-highest was among those with cognitive disabilities alone, and the third-highest was among those with visual disabilities alone. These behavioral problems included attention, social, and aggression problems. Einfeld, Tonge, and Turner (1999) and Tonge and Einfeld (2000, 2003) found that behavioral problems have a tendency to increase over time without intervention. In the group of children with intellectual disabilities, about 65% of the children who had exhibited extreme levels of problem behavior continued to have persistent difficulties. Dosen (2005) found that children with disabilities have all of the commonly diagnosed psychopathological problems seen in those without diagnosed disabilities, but at a much higher level.

Cultural differences need to be taken into consideration in the identification of specific disabilities. Cultural differences resulting from differences in language, socioeconomic privilege, and behavioral expectations have led to the overidentification some disabilities in various cultural groups (Tarver-Behring & Spagna, 2004). Thinking in one language and speaking another can mimic several communication disorders. What may appear to be a communication disability can simply be a child trying to remember what the word is in the less familiar language. Socioeconomic privilege comes into play when assessments are based on the “typical” experiences of children within the predominant culture. Children in poverty may not have these typical experiences, which limit their ability to respond to culture-bound test items. This often shows up as significantly reduced vocabulary scores among children from disadvantaged backgrounds. “Teachers sometimes mistakenly misinterpret a difference as a disability or problem” (Smith, 2007, p. 82).

According to Smith (2007), different cultures, professional disciplines, and even individuals do not always agree about the definitions of disabilities or their causes. Disability models usually come out of three basic perspectives: deficit, cultural, and sociological. The deficit perspective looks at human abilities along a continuum from low to high. This perspective is most common among psychologists, educators, and medical professionals in the United States of America.
This model typically relies on the concept of skills and functions being normally distributed, meaning the majority of the population falls somewhere in the middle, with progressively fewer individuals performing as one moves further toward the higher or lower ends of the spectrum for the particular skill or function being measured. In the USA this concept underlies the medical model of disability, which in turn drives the legal definition of disability (Smith, 2007).

In the cultural perspective, the concept of disability is not universal or uniform across cultures. Behavior that might be described as a problematic or as “different” in one culture may not be so in another. Even the degree of how different an individual is from the average behavior within a culture may not be considered uniformly by different cultures. The dominant culture in the USA tends to believe in a cause-and-effect relationship between a biologic or traumatic cause and the resulting disability. Other cultures may believe disabilities to be caused by bad luck, sins of the parent, evil spirits, taboo foods mother consumed while pregnant, or the will of a god or spirit. What is considered a disability by the dominant culture in the USA may be considered a gift, a sign of good luck, a sign of wisdom, or otherwise positively attributed in other cultures. These divergent views may mean that when dealing with parents from another culture, a family’s perceived need for support may be different from what many play therapists expect. The culturally astute play therapist will understand that the way the family wishes to address the child’s needs and the intervention services they require will vary depending on their cultural background (Smith, 2007).

The social perspective construes differences in skills as socially constructed. In this model, it is not the disability itself that defines the nature of the difficulty, but rather the way society describes and reacts to the issue. That is, society limits the individual, not a condition or impairment. The idea is that if the social barriers were removed, then individuals who are different from the average could be equal and independent in society. The more radical view of this perspective views societies as stratified in such a way that distinctions such as disability, race, and ethnicity support economic and political imperatives. In order to maintain class structure, some individuals have to be determined to be inferior to restrict opportunities (Smith, 2007).

In summary, disabilities include limitations in any area of functioning, including the physical, cognitive, motor, or sensory domains. These might include cognitive challenges, traumatic brain injury, motor or orthopedic impairment, visual impairment and blindness, hearing impairment or deafness, or speech or language difficulties. Comorbidity is the existence of more than one disability or diagnosis, and when it occurs, it increases the chances the child will have emotional and behavioral problems. Chronic disabilities are those that persist throughout a child’s life, even with intervention. Finally, because many disabilities appear to impact all aspects of the child’s life, they may require specific accommodations throughout the life span.

The Social–Emotional Issues Often Faced by Children With Disabilities

Children with disabilities share the common social–emotional developmental problems of their peers without disabilities. However, children with disabilities may have a more difficult time with normal developmental, social, and emotional challenges and have a more difficult time learning the necessary skills. These children face particular challenges that may be a result of the unique experiences of their disabilities and the perceptions of children with disabilities about their limitations and strengths. Through an understanding of what children with disabilities may encounter, the play therapist is more apt at developing play interventions that may capitalize on children with disabilities’ strengths.
Poor Social Skills

Because disabilities may limit the kinds of peer interactions children have, they often lack social skills. Among children with learning disabilities (LD), there is a high rate of comorbid attention-deficit hyperactivity disorder (ADHD). Children with LD and ADHD were found to have greater academic problems and were reported to have greater social skills difficulties than children with LD alone (Xin, Yu, & Shaver, 2014). Further, social dysfunction is particularly common in children diagnosed with ADHD. This may be attributed to their lack of interpersonal empathy (Wilkes, Cordier, Bundy, Docking, & Munro, 2011). The development of interpersonal empathy requires that a child be able to take another person’s emotional perspective in a relationship. Without this ability to see through another's eyes or feel with another's heart, these children can be unaware of how their comments and behaviors affect peers and others (Wilkes et al., 2011). In addition, if the LD results in failure to develop age-appropriate language skills, it may cause children to use inappropriate language in a given social situation, including asking inappropriate questions and failure to follow directions (Tarver-Behring & Spagna, 2004).

Low Self-Esteem

An important part of healthy child development is development of a positive and yet realistic view one's self. Positive self-esteem has been associated with good mental health, and poor self-esteem has been associated with a risk for increased anxiety and depression in children (Miyahara & Piek, 2006). To what extent a disability affects a child's self-esteem is dependent on many factors, such as whether the disability is easily observed or affects physical appearance. When a disability cannot be identified by observation, some children may experience a lack of understanding and empathy by significant others, who may attribute the child's difficulties to lack of effort or lack of attention. Many children whose disabilities are not easily observed, such as those with specific learning disabilities, tend to have low self-esteem and poor development of self-concept. These children may seek acceptance by their peers without disabilities to a degree that places them at risk for conflicts with law enforcement through gangs, drugs, or other juvenile crime (Tarver-Behring & Spragna, 2004). When children have more obvious disabilities, adults are more likely to have realistic expectations of the child and to provide more support, which can help the child to accept his or her limitations. Generally speaking, the more severe and obvious the child's disability, the fewer problems with self-esteem were reported in the literature (Miyahara & Piek, 2006).

Limited Experience With Success

Children with disabilities may have limited experience with success, and thus experience feelings of inadequacy. Children with disabilities may not be aware of their personal strengths or have a sense of mastery in comparison to peers without disabilities. Limited motor skills may prevent children from feeling successful in sport-related activities or other childhood pastimes compared to peers. Some children with disabilities may have difficulties with perceptual motor functioning and may have difficulties with writing, drawing, and other gross and fine motor skills. Academic achievement may also be much slower than peers. The experience of success increases when the child is encouraged to compete only with himself or herself, seeking to establish realistic goals and to develop strength areas (Tarver-Behring & Spagna, 2004).

Poor Emotional and Behavioral Regulation

Depending on the nature of the disability, some children may have difficulty with self-regulation, resulting in both internalizing and externalizing problems. They may experience severe
depression or suicidal ideation, which will affect academic achievement and social relationships. Alternatively, they may have behavioral outbursts or other inappropriate behaviors that result in rejection by peers and even adults. Outbursts of profane language and aggressive behavior toward peers and authority figures may result in discipline problems, suspension, or expulsion from schools.

PLAY THERAPY MODALITIES

Three types of play therapy interventions seem to be emphasized in the literature on work with children with disabilities: individual, filial, and group play therapy. Individual play therapy can be conducted using many different theoretical frames; however, they all focus on the child's one-on-one relationship with the therapist. In filial play therapy, significant adults in the child's life are taught to engage in a therapeutic play relationship with the child. Last, group play may also be conducted from any one of a number of theoretical orientations, but all emphasize the therapeutic benefit of therapist-guided peer interactions.

Individual Play Therapy Theories

Interpersonal relationship play therapies such as child-centered (Landreth, 2012), relationship (Moustakas, 1997), gestalt (Oaklander, 2006), and narrative (Taylor De Faoite, 2011) play therapy all tend to focus on relationship building and making emotional connections. They capitalize on the fact that play is considered to be the child's most natural method of communication, where concrete objects (toys) are used symbolically much like words (Landreth, Ray, & Bratton, 2009). Because children with disabilities may have difficulty expressing themselves, the inclusion of concrete objects they can manipulate to symbolically represent their experiences of the world allows the therapist to gain insight into the concerns and issues these children face. Play therapy has the ability to reach beyond children's cognitive, physical, and emotional developmental delays to reach them in their own worlds. Due to the immediacy of play, the therapist can actively work to help children express themselves in ways that are not otherwise available to them. Children can learn skills, address feelings, and solve problems.

Cognitive-behavioral (Knell, 1996), Adlerian (Kottman, 2002), and Reality (Davis & Pereira, 2013) Therapies emphasize correcting cognitive distortions and problem solving, and would therefore be more logically appropriate for children with disabilities who are having problems with judgment, social skills, and emotional control. These theoretical orientations tend to be more structured and directive in the therapist's interactions with the child. These theories may include using toys in role-plays to explore alternative problem solving and socially appropriate skills. The therapist may illustrate or actually teach skills for problem solving, social interaction, and emotional control using the child's play and the playroom items. In addition to cognitive interventions, these theories use adaptations of the classical behavioral techniques of systematic desensitization, contingency management, shaping or successive approximations, extinction, time-out, modeling, and behavioral rehearsal to varying degrees in the playroom.

Developmental therapy (Brody, 1997) and Theraplay® (Booth & Jernberg, 2010; Munns, 2000) emphasize the importance of experience in helping the child develop interpersonal attachments and the ability to self-regulate. Irrespective of the model, play therapists work with children where they are and share the belief that children need to experience empathic relationships in an atmosphere of safety.

Ecosystemic Play Therapy (O'Connor, 2000) offers several concepts that seem appropriate to the child with disabilities. The selection of toys is limited in number and is specifically chosen
based on the child's reported difficulty and developmental level. Logically, limiting the number and type of toys may help the child maintain focus in addition to better fostering experiences of success, competence, and challenge. Similarly, prescriptive play therapy (Schaefer, 2001) encourages the therapist to integrate a selection of play interventions into one inclusive, individualized treatment program for a specific child.

**Filial Therapy**

Filial Therapy was originally developed by Louise and Bernard Guerney (B. Guerney, 1964; B. Guerney, Guerney, & Andronic, 1966; L. Guerney, 1979). In Filial Therapy, therapists teach, supervise, and empower parents in the conduct of child-centered play sessions with their children (VanFleet, 2013). Filial Therapy is based on a psychoeducational model that draws on client-centered, dynamic, behavioral, and family systems interventions. The primary goal of Filial Therapy is to improve the caregiver–child relationship (Wickstrom, 2009). The caregiver training format in Filial Therapy is flexible. The therapist can make modifications that allow the caregivers to learn to have more reasonable expectations of their child given his or her disability. Caregivers can also be trained in techniques specific to their child's primary issues. Louise Guerney (1979) describes teaching caregivers of children with ADHD, physical and cognitive disabilities, as well as those with learning disabilities how to provide play therapy to their own children with positive results. VanFleet (2013) also discusses special applications to children with school problems, depression, chronic illnesses, anxiety and perfectionism, elimination problems, attention deficit problems, attachment disruptions, oppositional defiant disorder, and posttraumatic stress disorder. She has also discussed its application to various childhood concerns including social, emotional, and behavioral problems presenting in a variety of settings and situations.

The IDEA guidelines (U.S. Department of Education, 1997) discussed earlier recommend including the parents or primary caregivers in the treatment planning and treatment of their children, as well as providing them with caregiver training and other forms of support. Filial Therapy meets or exceeds all of these recommendations. Wickstrom and Falke (2013) note that caregivers in filial play therapy may wish to have continued support through refresher training sessions after formal treatment ends. The need for more support may be especially true of caregivers working with challenging situations with children with disabilities (Darling, Senatore, & Strachan, 2012; Gordon, 2009; Hughes & Cardwell, 2011; Morison, Bromfield, & Cameron, 2003). In addition to addressing all of these essential goals, Filial Therapy also improves the caregiver–child relationship. For all of these reasons, Filial Therapy is an excellent treatment choice for children with disabilities and their caregivers.

**Group Play Therapy**

Group play therapy may be the best option for those children with disabilities who also have social difficulties or difficulties that only manifest in the presence of other children. As in individual play therapy, the play therapist helps the children learn social skills and to express themselves and their emotions appropriately. Group work is known to have what is called a catalytic effect on children's behavior; that is, children's behavior rises or falls to the norm for the group. If most of the children are relatively well behaved, then the child with the most difficulties will rise to their level. If most of the children have serious difficulties, there is a chance the behavior of the higher functioning children may worsen. For this reason, it is suggested the group include children with a variety of both disabilities and social–emotional issues. Children who may create a threat of physical or emotional harm to others should be treated individually until such time as their
difficulties can be controlled to the point they will not endanger the children in the group. Last, it is important to note that the more severe the lack of social skills, the smaller the group should be and the more the therapist should direct and structure the play (Meany-Walen, Bratton, & Kottman, 2014; Trice-Black, Bailey, & Riechel, 2013).

PROCEDURAL MODIFICATIONS

Children with disabilities are as individual as the stars in the sky or pebbles on a beach. No two children with disabilities are alike. Providing play therapy to children with disabilities requires that the play therapist has a broad overview of disabilities and can creatively adapt the play therapy techniques to the unique needs of the individual child. In addition to the therapeutic competency of the play therapist, an expanded training experience and familiarity with the legal diagnosis, rights, and responsibilities for children with disabilities is required.

Therapist Qualifications and Training

First and foremost, a play therapist who will be working with children with disabilities needs to have adequate knowledge of the population itself. Federal legislation requires those who work in schools and agencies supporting children with disabilities to have specialized knowledge in the identification and special needs of this population (Tarver-Behring & Spagna, 2004). Beyond federal law, the professional and the ethical responsibilities of those working with children with disabilities are determined by a plethora of “legal precedents, scientific inquiry, professional organizations, parent groups and those working within the [special education] profession” (Trussell, Hammond, & Ingalls, 2008, p. 19). The play therapist needs to be familiar with these standards, laws, regulations, and imperatives to provide services to children with disabilities.

Play therapists, irrespective of their level or type of training, are included under IDEA 300.34(c)(10) (U.S. Department of Education, 1997) as providers of psychological services:

**Psychological services includes—**

i. Administering psychological and educational tests, and other assessment procedures;
ii. Interpreting assessment results;
iii. Obtaining, integrating, and interpreting information about child behavior and conditions relating to learning;
iv. Consulting with other staff members in planning school programs to meet the special educational needs of children as indicated by psychological tests, interviews, direct observation, and behavioral evaluations;
v. Planning and managing a program of psychological services, including psychological counseling for children and parents; and
vi. Assisting in developing positive behavioral intervention strategies. (IDEA 300.34(c) (10))

While this clearly identifies the purview of psychological services, the role of social workers in the schools is further defined by the Federal Register:

Including counseling in the definition of social work services in schools in §300.34(c)(14) is intended to indicate the types of personnel who assist in this activity and is not intended either to imply that school social workers are automatically qualified to perform
counseling or to prohibit other qualified personnel from providing counseling, consistent with State requirements. (71 Fed. Reg. at 46573-4).

The Federal Register also recognizes the roles and potential limitations of various other professionals who may work with children with disabilities:

There are many professionals who might also play a role in developing and delivering positive behavioral intervention strategies. The standards for personnel who assist in developing and delivering positive behavioral intervention strategies will vary depending on the requirements of the State. Including the development and delivery of positive behavioral intervention strategies in the definition of psychological services is not intended to imply that school psychologists are automatically qualified to perform these duties or to prohibit other qualified personnel from providing these services, consistent with State requirements. (71 Fed. Reg. at 46574)

These laws determine the roles of the various professionals and clearly require they have specialized training relative to the needs of children with disabilities. In addition, mental health practitioners who are providing play therapy should have had specialized training in this modality. The author has interpreted these guidelines to indicate that a play therapist would need to have formal coursework and supervised experience qualifying them to work in the field of special education under the certification or licensure laws of the play therapist’s state. In addition, adequate training in play therapy would mean being a Registered Play Therapist (RPT) or receiving play therapy supervision from someone with the appropriate supervisory credentials. Even with these specialty credentials, the play therapist needs to seek continuing education, and when working with a disability with which the play therapist is unfamiliar, the therapist should seek consultation or supervision from a more experienced play therapist.

Therapist Characteristics

Specific characteristics of play therapists who have been successful in working with children with disabilities could not be determined from the literature search. However, a study describing British “nurture teachers” (Syrnyk, 2012) appears to have relevance when discussing traits desirable in a play therapist for children with disabilities. The British nurture teachers are trained special education teachers who work with children with social, emotional, and behavioral difficulties. Beyond formal training, certain personal characteristics may make an educator, mental health worker, or medical personnel better suited to work with children with disabilities. Syrnyk (2012) found that nurture teachers in the British education system were described as having an inner strength, a calm empathetic nature, self-awareness, and objectivity. Nurture teachers were found to value tenacity, but could meet the demands of high-pressure situations while maintaining a relaxed and reasoned demeanor. These teachers were not easily frustrated or angered. The nurture teachers were open-minded about others, not judgmental, and worked within the limitations of the child’s disability. According to Syrnyk (2012), these personal attributes affected the outcome of treatment, as did the teacher’s knowledge and skill. Logically, these characteristics would be desirable in play therapists who wish to positively influence the growth of children with disabilities.

In summary, those who will be providing play therapy to children with disabilities need four things. First, they need to be well educated with respect to the diagnosis and conceptualization of disability. Second, they need to be well informed regarding the laws, guidelines, and ethics governing services to children with disabilities. Third, they need to be well trained in the field of
play therapy in general and its application to work with children with disabilities. Finally, play therapists, like the nurture teachers, need personality attributes that include being able to provide a calm, accepting environment in which the child can experience success.

Client Characteristics
Children with disabilities represent a broad and greatly varying population with divergent limitations and strengths. The dynamics of the child’s family, community, and availability of resources may greatly influence what brings a child with disabilities to play therapy. The severity of the disability and the level of interaction present a challenge to the play therapist. While play therapy has been used with most of the types of disabilities that children may face, modifications have had to be used in many cases to accommodate the special needs of the child.

Indications/Contraindications
Play therapy has been used and found to be effective as either a primary or as an adjunct intervention to address a broad range of behavioral, emotional, and social issues experienced by children with and without disabilities (Carmichael, 2006; Gil, 2010; Landreth, 2005). In addition to concerns related to the disability, such as pain, grief, and hospitalization, these children often have to cope with everyday stresses such as those related to divorce, relocation, abuse, domestic violence, and natural disasters, all of which have responded to play therapy interventions (Reddy, Files-Hall & Schaefer, 2005). Landreth (2012) suggests child-centered play therapy may be contraindicated for children who may not be able to establish a therapeutic relationship, such as those with severe autism spectrum disorders or those with schizophrenia. However, other, more structured forms of play therapy may be suited for work with these children.

Adapting the Play Room
Depending on the disabilities of the children being treated, the therapist may need to significantly modify the playroom. The room and materials need to be set up so as to be readily accessible in spite of the child’s limitations. For children with limited mobility, it can be helpful to include different types of pillows or beanbag chairs to allow them to change positions easily and to play comfortably. For comfort, the child can be placed over a wedge or pillow with the toys within reach. Alternatively, the therapist might provide large stuffed animals instead of pillows to provide physical support for the children. In addition, C-clamps can be used to stabilize a dollhouse on a table. Dolls can be placed on elevated trays to help children with limited range of motion. Sharp corners on tables, shelves, and other fixtures in a playroom may require installation of a rubber bumper or a cushion of foam taped into place to prevent accidents for children with coordination difficulties (Carmichael, 1994).

Traditionally, the toys are arranged on shelves and the child may see the total selection all at once. In the case of children with disabilities, one of a couple of modifications may be necessary. For example, the therapist may need to provide a way for even a wheelchair-bound child to access toys on higher shelves. When working with visually impaired children, it is important to keep the toys in the same place on shelves and within the room and to limit the addition or removal of toys to the playroom. For children who do not have the requisite skills to play or who have difficulty exploring their environments (e.g., for those who are visually or motorically disabled) it may be advantageous to limit the toy selection even to the point of introducing just one toy at a time. In particular, children with attention disabilities may find a playroom with lots of color and a wide selection of toys too stimulating. In his Ecosystemic model of play therapy, O’Connor (2000) suggests limiting the number of toys to just a few specifically chosen to address the needs of
the child and the goals of the therapy. In practical experience, the author has found that limiting the choices of toys and having a quiet, uncluttered space does help keep children with attention disabilities focused. The playroom she used had strong primary colors to emphasize shelving and a closet and a mural painted on the walls in bright and “cheery” colors. This combination of color and pattern appeared to be too stimulating for some children. When moved to another room that was mostly grey and brown and allowed five to seven toys they had chosen from the playroom, the children appeared much calmer and focused. Noise from the hall was also noted to be very disturbing to some children with ADHD symptoms. Most children could eventually function in the regular playroom with a noisy hall nearby, but some requested to return to the less stimulating room with chosen toys.

Adapting the Toys

Beyond adapting the playroom, it may be necessary to adapt the toys themselves to meet the needs of children with disabilities. When selecting toys for this population, the therapist should keep four things in mind. First, the toys need to be easy to manipulate, particularly in the case of children with motor control issues. Second, the toys need to be well suited to the child’s specific disability. Consideration should be given to whether either oversized or undersized toys will be easier for a given child to use. Third, the toys should not be so complex as to interfere either with children’s ability to play or with their ability to express themselves. And fourth, of course, the safety of the toys must be evaluated.

Adaptation of the toys or toy selection aids the child with disabilities in becoming more independent and confident in the playroom. There are many ways to adapt toys to make them easier for children to manipulate.

- Placing the sponges from foam curlers over the handles of paintbrushes by using double-sided tape makes the brushes easier to hold.
- Children who may not be able to grasp objects like paint brushes or drum sticks may benefit from having the brushes or drum sticks taped to their hands or elbows so they can paint or play drums in play therapy.
- A special glove could be devised by gluing Velcro or magnets to a cotton glove so the child might more easily manipulate metal toys or objects.
- Dress-up items can be chosen with the child with physical disabilities in mind. Items such as purses, hats, and scarves are easier for children with disabilities to manipulate than are capes or pull-on clothing items.
- Bean bags may be preferred over balls for throwing, as these mold to the child’s hand when caught and do not roll away from the child if missed. Many commercially available bean bags have unique and attractive shapes the child may find easy to handle (Carmichael, 1994).
- An easy-to-manipulate puppet can be made for children unable to work with traditional puppets designs. Stuffing would be inserted into the puppet’s head or body to support a wooden dowel. Then the bottom part of the puppet needs to be weighted so it hangs correctly over the child’s hand once he or she has grasped the dowel. If needed, the puppet could be further adapted by placing it in a rocking base so the child can move it with a simple touch.

Toys should also be selected to address the needs of the child’s specific disability. Suggested toys for children with motor control difficulties include activity boards with beads, sliding panels, bells, wheels, and lights; a rummage box with a variety of toys, textures, sizes, and shapes; and a sandbox.
A board with a collection of locks and latches has proved very popular in the author’s collection of toys. Musical instruments requiring only gross motor movement, such as bells, tambourines, drums, triangles, and wooden sticks are also good choices. From the author’s experience, children with visual disabilities tend to like toys that can be identified by shape and texture. Toys that make identifiable sounds such as musical instruments, a dinosaur that growls, or a talking action figure can all be especially attractive to these children.

The size of the toys must also be considered. Children with fine motor difficulties may need large, no-roll crayons; large primary pencils or carpenter pencils (a flat pencil available from home improvement stores); and larger pieces of newspaper print or butcher paper on which to draw or color. Other children may find the large-sized art supplies cumbersome and may find the smaller items such as the pencils used to keep score in golf or bowling easier to handle. Generally, the less mature the physical development of the child, the larger the toys and other supplies need to be.

Children who are cognitively challenged may prefer simple, easy to handle toys typically used by children younger than the chronological age of the child. On the one hand, the inclusion of more complex toys might both push the child to make needed developmental gains or might enable the therapist to teach the child how to deal with frustration. On the other hand, when toys are too complex or frustrating, they may inhibit a child’s ability to use them for self-expression through pretend play or to develop a sense of mastery. Generally, the therapist needs to determine the importance of both representational value of the toys and the ease with which they can be used when working with this population.

Finally, the toys selected must be both physically and psychologically safe and appropriate. Especially when it comes to work with children with aggressive tendencies, one must carefully consider the inclusion of weapon-type toys in the playroom. Again, on the one hand, children need avenues for expressing aggression appropriately (Landreth, 2012). Having a weapon like a rubber knife or a toy gun provides children with the opportunity to redirect their aggression toward inanimate objects and affords the therapist the opportunity to teach the child how aggression can be expressed appropriately. On the other hand, if the weapon is not there, then the aggression is not stimulated and there is less opportunity for children to engage in aggressive behavior. Having materials such as sponges or cotton balls for throwing, tissues for tearing, and craft sticks for breaking all make it easy for children to express anger in benign ways. Allowing a child to tear newspaper over the wastepaper container to dissipate anger may be useful especially when followed by relaxation exercises and calming music to help refocus the child. The author suggests the therapist consider the needs of each client when determining whether to make such toys available to a child in a given session, and to remember that not all children, just as not all therapists, view weapons in the same cultural context.

Other Accommodations

Although Sousa (2007, 2011) does not write specifically for play therapists or even psychotherapists, he does offer some other practical adaptations and accommodations the play therapist may want to consider. He recommends working with ADHD children “in a structured, predictable and welcoming environment” (2007, p. 59). He also suggests rules be simple and clear and be prominently displayed in the playroom. Children need to be given warnings about transitions (such as a 5-minute warning that the session is to end). Children with ADHD need to be prepared for schedule changes well in advance of their occurrence. Sousa (2007) continues to emphasize that the work space be adequate for all children with disabilities. He recommends using encouragement and assisting children in moderating their emotions and emotional expressions. Sousa’s (2007) observations about creating a learning environment for children with disabilities are parallel to the therapeutic conditions presented by the major play therapy theories (Carmichael, 2006).
Treatment Frequency and Duration

Work with children with disabilities does not necessarily require the play therapist to schedule longer or more frequent sessions or to conduct treatment over a longer period of time. Usually, therapy is scheduled either weekly or biweekly depending on the needs of the child, the setting, and the therapist’s access to the child. The duration of each session typically ranges from 30 minutes to 50 minutes. Shorter sessions are often a good idea for younger or more developmentally delayed children and are often necessary in school settings. Longer sessions allow the therapist to address more content and/or use part of the time to meet with parents and are usually favored by play therapists working in agencies or in private practice. LeBlanc and Ritchie (2001) found that the effects of play therapy reached their peak at about 30 sessions. However, Bratton, Ray, and Rhine (2005) found that play therapy sessions were effective for as many as 35 sessions. Longer periods of time may be needed in working with children with disabilities when they have trouble mastering the target skills or generalizing their gains to life outside the playroom.

Pretreatment Assessment and Treatment Planning

The most complete guide to pretreatment assessment and play therapy treatment and planning for children is the text, Play Therapy Treatment Planning and Interventions: The Ecosystemic Model and Workbook, 2nd Edition (O’Connor & Ammen, 2013). The pretreatment assessment includes interviews with teachers, caregivers, and other significant adults who interact with or provide care to the child. A series of both formal and informal assessments may be used to assess the child’s cognitive, social, emotional, and developmental functioning. The result is a comprehensive picture of the child’s strengths and weaknesses, as well as the level of support the family can reasonably provide. The treatment plan is similar to a detailed individual educational plan describing measurable goals and assigning the responsibility for meeting these goals of the significant adults including, of course, the child’s play therapist (O’Connor & Ammen, 2013).

Gitlin-Werner, Sandgrund, and Schaefer (2000) provide an extensive overview of assessment instruments used in play therapy preassessment. Of particular interest to play therapists working with children with disabilities is Westby’s (2000) scale for the development of children’s play. Her scale helps to identify developmental delays that may be particularly relevant to play therapy treatment planning. Lifter (2000) describes linking assessment to interventions for children at-risk for disabilities through the Developmental Play Assessment (DPA). The DPA involves evaluating children’s play activities during a 30-minute sample of spontaneous play activities while a familiar adult is in the room. Children are provided with four groups of toys and their play is assessed by examining qualitatively different categories of developmentally sequenced play activities. The DPA helps identify pervasive developmental disorder and other developmental delays. (Pierce-Jordan & Lifter, 2005). Bierman and Welsh (2000) and Welsh, Bierman, and Pope (2000) focus on the assessment of social dysfunction, which they state “is a core symptom of attention deficit hyperactivity disorder, conduct disorder, oppositional defiant disorder, and the pervasive development disorders” (Bierman & Welsh, 2000, p. 526) Vig (2007) suggests getting an overview of children’s developmental levels: “By observing children as they play, early childhood professionals can gain valuable insight about [the child’s] development” (p. 201). She provides a helpful review of the developmental assessment literature with charts indicating both average development characteristics by age group and characteristics of children with disabilities. Included in her discussion of disabilities are developmental delay, language impairment, hearing impairment, and visual impairment. In addition, Vig (2007) provides brief directions for using play observations in practice settings, identifying developmental ages and stages, identifying indications of disabilities, and discussing how to conduct a play observation session.
Play therapists who are considering using Filial Therapy in their treatment plans for children are referred to the *Child Parent Relationship Treatment (CPRT) Manual* (Bratton, 2006). In the appendices of the manual, there are a series of assessments for helping to determine the child’s problems from the caregiver’s point of view as well as the suitability of caregivers for inclusion in filial therapy. These are research instruments, but they can be useful in guiding the play therapist’s clinical judgment when working with children with disabilities. The three instruments were designed to be given pretreatment and posttreatment. The CPRT manual is also the basic guide for planning Filial Therapy with a caregiver–child dyad.

When using group play therapy with children with disabilities, it is important for the play therapist to screen the children to ensure they are placed in groups based on their having compatible strengths, weaknesses, and needs. In addition, children with disabilities may represent a more vulnerable group, and extra care may need to be taken to protect them from physical and psychological trauma in the group context, such as being overwhelmed by the interaction required or being bullied. As was stated earlier, the members of a group must be carefully selected so the natural catalytic effect peers have on one another can be harnessed to improve each member’s overall social functioning.

In summary, focused pretreatment assessment allows the play therapist to develop an individualized treatment plan for a child with disabilities. The treatment plan is a description of long- and short-term goals stated in a measurable manner and includes the methods to be used in addressing those goals. Most agencies have policies governing how these are to be written so they meet federal, state, and third-party payer requirements. A simple treatment plan needs to have contact and identifying information for the child and caregiver and statements of the problem/concern, long-term goal, short-term objectives, the treatment(s) chosen, and criteria for termination.

**RESEARCH/EVIDENCE BASE**

Guerney (1979) and Carmichael (1994) wrote about how play therapists might work with children with disabilities based on literature searches done at the time of each work. An extensive look at the play therapy literature from the early 1900s to the present finds an extensive selection of single case studies supporting the efficacy of play therapy for children with disabilities (University of North Texas Center for Play Therapy, 2014). The outcomes in these studies are based mostly on the reports of significant adults in the child’s world. While there is a large number of articles researching interventions with children with disabilities, there is a dearth of articles that expressly are focused on the outcome of play therapy with these children.

Bratton and colleagues’ (2005) and LeBlanc and Ritchie’s (2001) meta-analyses of the efficacy of play therapy included studies of children with disabilities. One of the difficulties with much of the current research is related to the narrow focus of many of the studies. For example, researchers might focus on just measuring behavior in children with ADHD. While helpful, these studies fail to give a global sense of the children’s functioning before or after treatment. The other problem has to do with the failure to specifically assess for, diagnose, or report specific disabilities in the populations under study. Children may be included who did, indeed, have specific learning disabilities, but these were not assessed as part of the study. These two oversights in the research literature make it difficult to examine the studies presented for specific interventions that can be recommended for use by play therapists working with children with disabilities. In spite of this dilemma, play therapy remains a well-documented approach for treating children with disabilities (Bratton et al., 2005; LeBlance & Ritchie, 2001; Muro, Ray, Schottlekorb, Smith & Blanco, 2006).
According to VanFleet (2013), 40 years of research support the effectiveness of filial therapy in general, with some evidence of its effectiveness with parents of children with disabilities. In a meta-analysis of play therapy, Bratton et al. (2005) found that filial play therapy was effective in helping children with learning disabilities and their parents. A sampling of studies found filial therapy effective for use with children with learning disabilities (Kale & Landreth, 1999), those who were deaf and hard of hearing (Smith & Landreth, 2004), and those with cerebral palsy (Cohen, Biran, Aran, & Gross-Tsur, 2008). Wickstrom (2009) agreed that many studies have demonstrated the effectiveness of the approach. However, the exact nature of the shift in the caregiver–child relationship produced in filial therapy has not been clearly defined. The findings from Wickstrom's study indicated a second-order change took place and that this could have a broad systemic effect. There seems to be a need for research into the long-term effects of Filial Therapy and the impact it may have on variables beyond the immediate improvement in the caregiver–child relationship.

Bratton et al. (2005) indicated that group play therapy was effective in the treatment of children. Tarver-Behring and Spagna (2004) advocate for the use of group work with children with disabilities to address social and emotional areas of difficulty. Specifically, they suggest that groups build positive self-esteem; model appropriate ways to express feelings, alternative problem solving, and appropriate positive behavior; and can be vehicles for providing education about specific disabilities. At this writing, an extensive search of the literature did not locate any studies that specifically assess the effectiveness of group play therapy for children with disabilities. Clearly, this is an area in need of research.

In general, play therapy has been shown to be effective in treating a wide range of problems. The classic meta-analysis of play therapy (Bratton et al., 2005) found play therapy was equally effective irrespective of the gender or age of the children or their presenting problems. The research continues to indicate the efficacy of play therapy to multiple disorders, disabilities, and difficulties of childhood.

CONCLUSION

In summation, when children with disabilities are referred for play therapy, they often present with complex mental health issues that require the therapist to have specialized training and necessitate adaptations of play therapy materials, activities, and even of the playroom itself.

While children with disabilities experience many of the same difficulties as their physically able counterparts, they also face some unique challenges. They may have academic issues or face both physical and social barriers in the world at large. The degree to which children are affected by these limitations is dependent on many factors, including the degree of disability, available accommodations, training and knowledge of the care providers, availability of familial and social support, and the child's inner strength and resilience. The interplay of the stresses created by the child's disability and all of the stresses of normal childhood often result in complex and multi-faceted clinical issues by the time children are brought to treatment, and the play therapist needs to be aware this complexity.

To be an effective play therapist for children with disabilities requires both some specialized training and some unique personality characteristics. Play therapists working with this population need to be well informed regarding the medical, legal, and mental health issues commonly faced by these children. They also need to have been trained and supervised in the specific play interventions best suited to children with disabilities. On a personal level, play therapists must be aware that children with disabilities pose unique problems that demand creative and patient interventions. Play therapists may find that the child struggles parallel their own struggle to find
ways to address the child's treatment goals within the unique frame of the child's abilities. It is important to be able to focus on the child's abilities and to be encouraged by small gains.

While play therapy appears to be an appropriate intervention for children with disabilities, play therapists may find they have to significantly modify many aspects of their clinical work to meet these children's needs. On a theoretical level, no one theory of play therapy appears to be best for all children with disabilities, but some play therapy theories may more readily accommodate the needs of this population. Secondarily, both the play materials and play activities may need to be adapted. Finally, the playroom itself may need to be set up to accommodate the diverse abilities and limitations with which these children present.

REFERENCES


University of North Texas Center for Play Therapy. (2014). *The world of play therapy literature: A definitive guide authors and subjects in the field.* Retrieved from https://cpt.unt.edu/researchpublications/literature-home/


Pthomegroup
CHAPTER 21

Play Therapy With Survivors of Interpersonal Trauma: Overcoming Abuse and Crime

CHARLES EDWIN MYERS

Our world is full of wondrous events, such as the laughter of children and sunsets, and conversely, our world is full of horrific events, including child abuse and other crimes against children. We expect childhood to be a time of fun, happiness, and play. However, for some children, childhood can be a time of fear, horror, and pain. A myriad of traumatic experiences can adversely affect children, including natural disasters, acts of mass violence, child abuse and neglect, and domestic violence. While natural disasters such as Hurricane Katrina and the 2010 Haiti earthquake can be traumatizing to children, the harshest of traumas on children are those involving interpersonal trauma, primarily child abuse and neglect, domestic violence, and acts of mass violence, such as the terrorist attacks of September 11, 2011, and the 2013 school shooting in Newtown, Connecticut. For the purposes of this chapter, *interpersonal trauma* is defined as any traumatic event a child experiences that is clearly caused by another person.

In this chapter, characteristics of interpersonal trauma, including child abuse and crimes against children, are defined, and it is illustrated why play therapy is an appropriate approach for working with child survivors of interpersonal trauma. Second, play therapy approaches with demonstrated effectiveness in alleviating the symptoms of child survivors of interpersonal trauma are reviewed. Third, procedural modifications needed to meet these children’s needs are described. Fourth, specific techniques and strategies known to facilitate growth and healing for child survivors of interpersonal trauma are explored. Finally, the research and evidence base for the use of play therapy in the treatment of interpersonal trauma are discussed.
DEFINING THE POPULATION

Interpersonal trauma is a silent epidemic affecting many children (Kaffman, 2009). In the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), the American Psychiatric Association (APA) described posttraumatic stress as being caused by exposure to actual or threatened death, serious injury, or sexual violence. Children can develop posttraumatic stress by directly experiencing or witnessing a trauma, learning of a trauma experienced by family or friends, or repeated or extreme exposure to aversive details of a trauma (APA, 2013). In the case of interpersonal trauma, direct experience can include child physical or sexual abuse, kidnapping, being held hostage, torture, human-made disasters, and severe motor vehicle accidents. Witnessing can include threatened or serious injury, unnatural death, physical or sexual abuse of another person due to violent assault, domestic violence, accident, and trauma happening to others, particularly a primary caregiver. Learning of a traumatic event or accident happening to a close friend or family member may include hearing about a violent personal assault, suicide, or a serious accident or injury. Repeated or extreme exposure to adverse details may include hearing the story reiterated or seeing the traumatic event repeatedly on television or the Internet. The effects of interpersonal and intentional traumatic events can be especially severe or long lasting (APA, 2013, pp. 273–274).

Characteristics and Special Needs

Children are relational beings. They learn about themselves and the world around them through their interpersonal relationships with significant others in their lives. Younger children desire close relationships with adults, in particular with their parents and teachers. In mid-childhood, children begin to develop social hunger, the desire to build significant relationships with peers, which continues to grow through adolescence. One of the most serious aspects of interpersonal trauma is the damage it can do to children’s and adolescents’ desire to form and maintain such relationships. Furthermore, interpersonal trauma can have a pervasive and long-lasting impact on children’s neurological development because their brains are still developing (van der Kolk, 2005). The effect of interpersonal trauma on brain development may result in lasting brain dysfunction, affecting children’s health and quality of life throughout their lives (Anda et al., 2006). Recent advances in neuroscience provide insight to the effects of trauma, supporting much of what play therapists have noted anecdotally.

Interpersonal trauma is a form of psychological trauma that involves the breaking of trust due to death, abandonment, abuse and neglect, or domestic violence (Findling, Bratton, & Henson, 2006). Interpersonal trauma response is an individual child’s reaction to an unexpected relationship-based traumatic event that is experienced intimately and forcefully (Everstine & Everstine, 1993). Interpersonal trauma overwhelms a child’s internal resources (Briere & Scott, 2006), resulting in internalized feelings of helplessness and vulnerability and a loss of safety and control (James, 1989). Relational trauma, a specific form of interpersonal trauma, involves the rupturing or severing of interpersonal relationships with significant others, and in the case of children, interpersonal trauma frequently involves a primary caregiver (Dayton, 2000).

Children who experience relational trauma may feel isolated and experience a range of feelings, thoughts, and physical sensations that are both confusing and frightening (Gil, 2010). In response to interpersonal trauma, children often experience a sense of betrayal as result of a person they love either being the source of their pain or failing to protect them from pain (Shaw, 2010). Interpersonal trauma can have profound effects on children’s current and future development, resulting in lifelong challenges.
Effects of Interpersonal Trauma

Exposure to childhood trauma is extremely common (D’Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; Kisiel et al., 2014). The effects of interpersonal trauma can be pervasive and profound. Young children are particularly vulnerable to traumatic events (Shaw, 2010) because they lack the cognitive ability to process intrusive and distressing experiences (Dass-Brailsford, 2007). In addition, childhood is a time of great development across all domains of growth (i.e., behavioral, cognitive, emotional, psychological, physical, social). Trauma affects children holistically, and traumatic events can severely interrupt their development (van der Kolk, 2005). This interruption can have a devastating effect when the trauma occurs during sensitive periods—periods when the body and mind are hardwired for expansive growth (Berk, 2009). When children experience trauma during a developmental sensitive period, their opportunities to achieve full development in that area are greatly inhibited; in more severe cases, children may never reach their full potential.

Interpersonal trauma may result in dysregulation of affect and behavior, disturbance of attention and consciousness, distortion in attributions, and interpersonal difficulties (D’Andrea et al., 2012). Similarly, Kisiel and colleagues (2014) found children who experienced interpersonal trauma had significantly higher levels of affective/psychological, attentional/behavioral, and self-regulation challenges. Furthermore, Edelson (1999) found child witnesses of domestic violence had increased difficulties with behavior and emotional functioning, cognitive function and attitudes, and long-term developmental problems.

Children with interpersonal trauma may experience feelings of anger, anxiety, betrayal, depression, fear, guilt, helplessness, and of being overwhelmed and ashamed (Damon, Todd, & McFarlane, 1987; Edelson, 1999; Finkelhor, 1986; Kaufman & Wohl, 1992; Lisak, 1994; McMahon, 1992; Namka, 1995; Ruma, 1993). Furthermore, these children may struggle with hostility, insecurity, interpersonal relationships, self-esteem, self-image, sexuality issues, social isolation, trust, and withdrawal (Brier & Scott, 2006; Edelson, 1999; Finkelhor, 1986; Hall-Marley & Damon, 1993; Lisak, 1994; Martin & Beezley, 1977; Middle & Kennerly, 2001). Due to the sense of betrayal and break in trust, children who experience interpersonal trauma frequently have difficulties with separation and abandonment (Cattanach, 1992; Damon et al., 1987), experience confusion and loss, and are often hypervigilant (Cattanach, 1992; Martin & Beezley, 1977; White & Allers, 1994). In addition, interpersonal trauma can negatively affect school performance by causing cognitive and behavioral challenges. Students may experience cognitive difficulties including problems with attention, concentration, and functioning. They may also experience behavioral difficulties such as problems with problem solving and conflict resolution, negative and uncooperative attitudes, opposition and defiance, and running away (Edelson, 1999; Finkelhor, 1986; Hall, 1997; Ko et al., 2008; Martin & Beezley, 1977).

Child Abuse and Domestic Violence

Children play out their personal experiences of child abuse and domestic violence when they experience safety in a therapeutic relationship with a play therapist. Maria, a 6-year-old Latina girl, played with the dollhouse in her school counselor’s office and moved the little girl doll into the bedroom, making an audible click as she pretended to lock the door (Myers, 2007). She picked up two adult dolls, one female and one male, and held them before the bedroom door. She then had the mom doll slap the dad doll and screamed at him, “Don’t ever touch my daughter again!” André, a 4-year-old African-American boy spoke with a squeaky voice due to scarring of his vocal chords. The scarring developed as a result of him having cried all night when his parents abandon him night after night to feed their drug addiction. André would nurture the baby doll with the
love and tenderness that he himself had not experienced and had desired. He would end each session by pulling the dollhouse over in a crash, symbolic of his experience of his family. These stories are examples of the kind of abuse- and neglect-related trauma many children endure and play out.

The Child Abuse Prevention and Treatment Act (CAPTA, 2010) defined child abuse and neglect as:

Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm. (p. 6)

Child abuse is a pervasive societal problem (Kaffman, 2009). Child abuse affects millions of children each year (Children's Bureau, 2013). In 2012, more than 3.8 million U.S. children were the subject of at least one child abuse report (Children's Bureau, 2013), and in 2013, there were 681,000 confirmed reports of individual children suffering child abuse or neglect and 3.3 million children received protective services (Children's Bureau, 2014). These children experienced neglect (78.5%), physical abuse (17.6%), sexual abuse (9.1%), psychological maltreatment (9.0%), medical neglect (2.2%), and other/unknown types of issues (10.6%). Child abuse occurs across gender and race. Reported demographics reflect the national population with a gender breakdown of 51% girls to 49% boys and a racial breakdown of 44% White, 21.8% Latino, and 21% African American.

Finkelhor, Turner, Shattuck, and Hamby (2013) conducted a national study of 4,503 children under age of 18 years. They found 54.5% of these children had suffered physical assault, 9.5% endured sexual victimization, 25.6% experienced child maltreatment, 40.2% underwent property victimization, and 39.2% experienced indirect victimization. At least 48.4% of participants reported experiencing more than one type of victimization (polyvictimization) in the previous year. Finkelhor and colleagues (Finkelhor, Ormrod, & Turner, 2007; Finkelhor, Ormrod, Turner, & Hamby, 2005; 2009; Turner, Finkelhor, & Ormond, 2010) found similar results across a series of studies on child abuse. While these numbers are alarming, many cases of child abuse never reach the authorities; for example, researchers estimate that only 10% of child sexual abuse is ever reported (Besharov, 1994; Ledesma, 2011; London, Bruck, Ceci, & Shuman, 2005; Paine & Hansen, 2002; Shaw, 2010).

The National Institute of Justice (NIJ, 2003) discovered comparable results in their study on youth victimization (i.e., sexual assault, physical assault, physically abusive punishment, and witnessing an act of violence) when interviewing 4,023 U.S. adolescents. Participants reported experiencing sexual assault (8.1%), physical assault (17.4%), and physically abusive punishment (9.4%) and witnessing violence (39.4%) (NIJ, 2003, p. 4). Unfortunately, the occurrence of child abuse is probably higher. Participants revealed that 86% of sexual assaults and 65% of physical assaults were never reported to authorities (NIJ, 2003, p. ii).

Other important statistics are those related to child abuse perpetrators. Perpetrators of child abuse and neglect do not belong to a specific demographic; they can be found in all ethnicities, races, and socioeconomic levels (Douglas & Finkelhor, 2005; Finkelhor et al., 2005; NIJ, 2003), making all children vulnerable. The Children's Bureau (2013) analysis of perpetrators across all 50 states disproved the stereotypical image of child abuser being a stranger. Out of 512,040 perpetrators, 80.3% of child abuse and neglect cases were perpetrated by the children's caregivers, 88.5% of those being biological parents. In addition, 53.5% of perpetrators were female, 45.3% male, and 1.1% unidentified. These facts create a disconnection for many children; the person who is a source of love is also a source of pain, resulting in one of the worst forms of interpersonal trauma.
Domestic violence was the unspoken secret in many families for decades; people did not want to acknowledge domestic violence occurred, especially not in their family (Myers, 2008). If domestic violence did occur in a family, the attitude often was “what happens at home stays at home” (Carlson, 1984). Since the 1970s, Americans are more willing to acknowledge the existence of domestic violence and are more open to talking about how domestic violence affects our society and impacts our children (Kot, Landreth, & Giordano, 1998). Increased awareness and acknowledgment of domestic violence has resulted in higher levels of reporting; for example, more than 25% of couples reported at least one physical aggression occurring in their homes (Straus & Gelles, 1990). Domestic violence, like child abuse and neglect, crosses all social class, education, and socioeconomic demographics (Lloyd, 1990). The effects of domestic violence on children are invasive and pervasive, resulting in chaotic home settings (Tyndall-Lind, Landreth, & Giordano, 2001) and jeopardizing the physical and emotional well-being of the children in home, as well as their safety and development.

Why Play Therapy Is Appropriate

Play is an important and vital element of childhood. The pervasiveness of play in childhood is evident in its appearance in all cultures across the globe, regardless of location, race, or socioeconomic status. Play occurs in unlikely circumstances, such as in the concentration camps of the Holocaust (Glazer, 1999) or following a devastating earthquake in Haiti (Myers, 2011). Play serves many purposes, including the healthy development and healing of children.

Role of Play in Childhood and Development

In the 1700s, Rousseau postulated that play is essential to the healthy development of children (Bratton, Ray, Rhine, & Jones, 2005). Much later, in the 1900s, the United Nations Committee on the Rights of Children (United Nations, 1990) proclaimed play as a universal and inalienable right of childhood and emphasized the importance of play to the development and wholeness of children. Furthermore, according to the American Association of Pediatrics, children learn how to interact with the world around them through play (Ginsburg, Committee on Communication, & Committee on Psychosocial Aspects of Child and Family Health, 2007). Landreth (2012) described play as being the central activity of childhood, in which children learn about themselves, others, and the world around them. Children learn to respect themselves, to control their feelings responsibly, and to be creative in confronting problems. Children are able to imagine new ways of being through play, explore their identity in relation to others (Cattanach, 1992), and learn and practice new skills in safe and supportive environments (Boucher, 1999).

Child development theorists, educators, and mental health specialists widely recognize the importance of play in childhood (Baggerly & Landreth, 2001). Play has a direct association with a child’s cognitive, affective, and social development (d’Heurle, 1979) and is a developmentally appropriate learning strategy in working with children (Bredekamp, 1987; Erikson, 1963; Montessori, 1964; Piaget, 1952).

Play and activity are the natural mediums of communication for children (Axline, 1947/1969; Ginott, 1959; Landreth, 2012) and are a young child’s primary modes of emotional expression (Hall, 1997). Through play, children can communicate what they are unable to say in words. Children use toys to express emotions about their self-perceptions, about others, and about significant events they have experienced (Ater, 2001). Young children, ages 2 to 6 years, are in Piaget’s (1952) preoperational stage, and older children (7 to 12 years) are in the concrete operations stage. During these stages, children use concrete expressions of internal experiences and symbolism to express those internal feelings and thoughts. According to Piaget (1962), play provides a bridge between children’s concrete expressions and their abstract experiences.
Healing Properties of Play

Play is the most natural and healing process in childhood. Play provides a means for children to play out their feelings, thoughts, and experiences, similar to how an adult might “talk out” difficulties (Mader, 2000). Erikson (1963) believed children have the capacity to find recreation and to self-cure when engaging in play. Play can be a particularly valuable mode of communication and processing for children who have experienced interpersonal trauma because it presents a safe mode of expressing their innermost feelings and fantasies (Mann & McDermott, 1983). The power of play in the healing and growth of children and its therapeutic value is well established (Caplan & Caplan, 1974). Play therapy provides a natural conduit for the healing nature of play for children with a history of interpersonal trauma within a safe and supportive environment.

The Effect of Interpersonal Trauma

Children with a history of interpersonal trauma often experience a sense of great loss of trust and betrayal. This loss of trust and betrayal may occur when a bond with a caregiver is severed, especially due to child abuse or domestic violence where a child loses trust in the ability of caregivers to keep them safe. Acts of mass violence can also cause a since of loss of trust in caregivers ability to keep them safe. For example, many children were killed or injured in the 1995 bombing of the federal building in Oklahoma City that housed a day-care center and the 2012 school shooting in Newtown, Connecticut, and many children lost caregivers in the 9/11 terrorist attacks.

Posttraumatic Play Behaviors

Play therapists working with children who have experienced interpersonal trauma need to be knowledgeable of the characteristics of posttraumatic play behaviors, effective play therapy approaches, and play therapy research related to working with children who have experienced interpersonal trauma. In 1976, three men hijacked a school bus in Chowchilla, California. They kidnapped the 26 children, ages 5 to 14, and their bus driver and drove them around in two vans with blacked out windows until late into the night. The kidnappers then forced the children and bus driver to climb into a hole in the ground that lead to a buried moving van, leaving their hostages buried alive for 16 hours, until they were able to escape. The children recalled how scared they were, thinking the men were going to kill them, hearing the sound of men shoveling of dirt on top of the van, and being held in a dark, small space for hours with no ventilation and with temperatures reaching up to 110 degrees inside (Terr, 1981, 1983).

In her work with the children of the Chowchilla kidnapping, Terr (1983) observed the children exhibited specific posttraumatic behaviors in their play. Children exposed to this trauma respond in one of four ways: (1) intense and repetitive thought of the trauma, (2) reenactment of the trauma, (3) fear of things highly correlated to the traumatic event, and (4) a sense of futurelessness (Terr, 2003, p. 234). Other childhood trauma experts and researchers (Gil, 1991, 2006, 2010; James, 1989, 1994) have noted similar posttraumatic play in their clients and subjects. Findling and associates (2006), in their review of the professional literature on children and trauma, identified and defined five specific posttraumatic play behaviors: (1) intense play, (2) repetitive play, (3) play disruption, (4) avoidant play, and (5) negative affect.

Intense play has a compulsive and driven quality. Posttrauma children can be so absorbed in their play they shut out the world around them. To the play therapist, it may feel sometimes as though the child forgets the therapist is in the room. During her play therapy, Jana, a 7-year-old, African-American girl who survived Hurricane Katrina and relocated to Texas, displayed two examples of intense play. One example occurred when she was at the easel and painted a picture
that was almost entirely blue water with the exception of a little sky at the top and a little figure in the middle of the water calling for help. The other example occurred in the sandbox as she buried dolls, animals, and other objects (representing the things lost to the flood waters). She did both of these in focused silence.

Repetitive play is a specific play or play theme the child feels compelled to play out the exact same way each time. Repetitive play may occur both during a single session and across sessions. During her play, Karina, a 6-year-old Latina girl, would go to the sand tray, take a toy cauldron, and place a little sand in it. She would repeat this play behavior a few times each session and continued to do so for several sessions. This was her attempt to understand and accept what had happened during a tragic accident when her 3-year-old cousin reached into a bucket of water in which she had placed glitter and drowned. While repetitive play may be reparative in allowing the child to make sense of an experience and to develop a sense of mastery over the outcome (Terr, 2003), it may also be retraumatizing when a child becomes stuck in the repetitive play. Play therapists need to be sensitive to how repetitive play is affecting a child and may need to intercede with a more directive, problem-solving approach (Gil, 2006, 2011a).

Play disruptions are a form of dissociation during which traumatized children suddenly switch their play to protect themselves when the emotions and thoughts represented in their play became too intense for them. John was an 8-year-old European-American boy whose mother had left him to be raised by her mother. Whenever the ideas of family and his mother arose in the course of play therapy, he would suddenly switch his play to something less threatening.

Avoidant play is a child's disconnectedness or avoidance of the play therapist. Children and play therapy are both relational; however, when children have experienced a trauma, especially an interpersonal trauma, they are often distrustful of others and will avoid or disconnect. Lupita, a 6-year-old Latina girl, had witnessed the rape and murder of her mother. During the few sessions, Lupita would enter the playroom and stand by the door, looking at the floor with her fists clenched. Through gentle reflection and tracking, she eventually began to feel safe enough to engage in play and talk to the play therapist.

Negative affect is the physical representation of children's emotions that are either flat or incongruent to their play. For example, after the 9/11 terrorist attacks, children built towers out of blocks and then knocked them over with toy planes. Their affect was completely flat, showing no emotion while playing out what had to be a terrifying event.

Research strongly supports the fact that children with interpersonal trauma do play differently from other children. Findling and colleagues (2006) compared two treatment groups of children receiving play therapy, one group presenting with a history of interpersonal trauma and the other group presenting with other concerns. The researchers defined interpersonal trauma as trauma involving the interpersonal loss of trust in a significant caregiver through abandonment or abuse. Myers, Bratton, Findling, and Hagen (2011) continued this study with the addition of a normally developing group with no known history of interpersonal trauma who were receiving play sessions. Researchers in both studies used the Trauma Play Scale (TPS; Findling et al., 2006). The TPS is an observational assessment of the five posttraumatic play behaviors previously described. The TPS assesses these behaviors in 5-minute increments across eight consecutive sessions, excluding the initial session. Using repeated measures, Findling et al. (2006) found clinical significance for the average TPS score and for all posttraumatic play behaviors, with the exception of repetitive play, as well as statistical significance between the two clinical groups for the average TPS score after having omitted repetitive play. The researchers omitted repetitive play because the raters were blind to the children's histories and this inhibited their ability to determine the literalness of the play and whether the play was posttraumatic, mastery, or self-grounding. Myers et al. (2011) found large effect sizes and statistical significance between children with
Table 21.1 Summarization of ANOVAs on Pilot and Present Studies' Findings

<table>
<thead>
<tr>
<th></th>
<th>Findling et al., 2006</th>
<th>Myers et al., 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trauma versus Nontrauma&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Trauma versus Normally Developing&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Average TPS Score</td>
<td>( \eta^2 = .28 ), ( p = .080 )</td>
<td>( \eta^2 = .74 ), ( p &lt; .001 )</td>
</tr>
<tr>
<td>Average TPS Score, Omitting Repetitive Play</td>
<td>( \eta^2 = .41 ), ( p = .025 )</td>
<td>( \eta^2 = .77 ), ( p &lt; .001 )</td>
</tr>
<tr>
<td>Intense Play</td>
<td>( .31 ), ( p = .062 )</td>
<td>( .86 ), ( p &lt; .001 )</td>
</tr>
<tr>
<td>Repetitive Play</td>
<td>( .00 ), ( p = .836 )</td>
<td>( .40 ), ( p = .020 )</td>
</tr>
<tr>
<td>Play Disruptions</td>
<td>( .20 ), ( p = .148 )</td>
<td>( .56 ), ( p = .003 )</td>
</tr>
<tr>
<td>Avoidant Play</td>
<td>( .26 ), ( p = .094 )</td>
<td>( .57 ), ( p = .003 )</td>
</tr>
<tr>
<td>Negative Affect</td>
<td>( .26 ), ( p = .094 )</td>
<td>( .65 ), ( p = .001 )</td>
</tr>
</tbody>
</table>

<sup>a</sup>Clinically referred children with a history of trauma (n = 6) vs. clinically referred children with no known history of interpersonal trauma (n = 6).

<sup>b</sup>Clinically referred children with a history of trauma (n = 6) vs. children normally developing with no known history of interpersonal trauma (n = 7).


interpersonal trauma and normally developing children on the average TPS score and on all five posttraumatic play behaviors. See Table 21.1 for the specific significance for each study.

THEORIES BEST SUITED TO WORK WITH THIS POPULATION

In working with child survivors of interpersonal trauma, it is important to use developmentally responsive approaches that meet their individual needs. Perry and Szalavitz (2006) proposed that recovery from childhood interpersonal trauma requires the rebuilding of trust, regaining of confidence, returning of security, and reconnecting to love. Bratton (2004) added that children need to release and regulate emotions and gain or regain a sense of mastery, coping, and competence. Play therapists can best meet these needs by including reparative experiences in the therapeutic relationship (Benedict, 2006; Bratton, 2004). Four approaches that meet the needs of children with interpersonal trauma in developmentally responsive and relationship-based approaches are child-centered play therapy (Landreth, 2012), child–parent relationship training (Landreth & Bratton, 2006), Cognitive-Behavioral Play Therapy (Cavett & Drewes, 2012), Ecosystemic Play Therapy (O’Connor, 2007), and trauma-focused integrated play therapy (Gil, 2011a).

Child-Centered Play Therapy

Child-centered play therapy (CCPT) is a nondirective, play-based approach that provides children with a voice (Guerney, 1983, Landreth, 2012; Myers, 2008). CCPT has a strong research background (see Research/Evidence Base section later in chapter). Axlne (1947/1969) pioneered CCPT in her work with children in the 1940s. As a student of Rogers, Axlne applied Rogers’s (1957) nondirective principles of empathy, genuineness, and unconditional positive regard in her work with children. Many other play therapists (Guerney, 1983; Landreth, 2012; VanFleet, Sywulak, & Sniscak, 2010) have subsequently contributed to the development of CCPT.

CCPT includes a philosophy toward the attitudes and behaviors in living one’s life with children (Landreth, 2012). The philosophy involves a deep and abiding belief in the constructive, self-directing ability of children (Landreth & Sweeney, 1997). Play therapists using CCPT strive to relate to children in ways that release their inner directional, constructive, forward-moving,
creative, and self-healing powers (Landreth 2012). Within this relationship, CCPT therapists create an environment that empowers children to engage in self-exploration and self-discovery, resulting in their ability to express their inner experiences and engage in constructive growth (Landreth & Sweeney, 1997).


Child–Parent Relationship Training

Child–parent relationship training (CPRT; Landreth & Bratton, 2006) is a 10-week filial therapy model developed by Landreth. Guernsey (1964), a CCPT therapist, originally developed filial therapy. Guernsey believed many children’s problems resulted when parents lacked parenting knowledge and skills (Landreth & Bratton, 2006). However, Guernsey also viewed parents as allies in the therapeutic process and as potential therapeutic agents of change in the children’s lives and sought to train parents in the basic principles of CCPT. Originally, Guernsey would meet parents weekly for about a year, but later reduced the treatment time down to 5 or 6 months. Landreth (Landreth & Bratton, 2006) saw a need for a more streamlined and structured approach that still provided parents with skills they needed but within a time frame to which parents would be comfortable committing themselves.

Central to CPRT is the training of parents in basic CCPT skills so they can conduct weekly, 30-minute play sessions with their children (Landreth & Bratton, 2006). Parents learn the skills of reflective listening, recognizing their children’s feelings, self-esteem building, tracking, and therapeutic limit-setting. CPRT therapists use a variety of methods to train parents in these skills, including dyadic instruction, play session demonstrations, role-playing, and group supervision of parents’ play sessions.

Of particular importance in working with children who have experienced abuse or neglect is the common experience of betrayal, harm, loss, or rejection by a caregiver. CPRT’s strength in working with this population is the power to restore healthy relationships between children and caregivers, whether with a caregiver who may have caused harm to the child or a caregiver who either (in the eyes of the child) did not protect the child from harm or is a remaining caregiver after the loss of a caregiver. Following an external familial event, such as a school shooting, CPRT provides caregivers an avenue for helping to restore a sense of safety and security within their children. By enhancing the caregiver–child relationship, caregivers are able to establish or reinforce a healthy attachment and safe place for their children. Play therapists have conducted CPRT with many children with interpersonal trauma, including with children in domestic violence shelters, with nonoffending parents of children who have experienced child sexual abuse, and with parents who are incarcerated (Costas & Landreth, 1999; Harris & Landreth, 1997; Smith & Landreth, 2003).

Cognitive-Behavioral and Ecosystemic Play Therapy

In contrast to CCPT, some play therapists see the value of sometimes using a more therapist-directed approach in order to address specific concerns related to the abuse or
trauma a child has experienced (Bethel, 2007). O’Connor (2007) reported the possibility that child survivors of abuse who are treated in nondirective play therapy approaches may be in therapy for extended periods of a half year or more without ever approaching content in their play or engaging in any verbalizations related to their traumatic experiences. He contended these children might become overly comfortable with therapy and adapt to avoiding their feelings and thoughts related to the trauma rather than more actively coping and recovering. Ruma (1993) identified two advantages in using cognitive-behavioral play therapy (CBPT) over nondirective play therapy approaches. In contrast to the CCPT belief that children, through their innate self-actualizing nature, will address their traumatic experiences, CBPT play therapists direct, or structure, play sessions in ways that address the trauma. Within the structure set by the CBPT therapist, children have control as to how, what, and when they address the trauma (Ruma, 1993). In addition, CBPT provides children who have learned not to express their feelings, particularly in families of abuse and domestic violence, with a framework (e.g., systematic desensitization, contingency management, modeling, behavioral rehearsal, positive self-statements) in which to relearn how to express their full range of emotions.

Ecosystemic Play Therapy (EPT) is an integrative approach to play therapy utilizing existing theories and techniques and incorporating cognitive developmental theory as an organizing framework (O’Connor, 1991, 2007). The use of the word “ecosystemic” indicates the importance of considering the interaction of the child and all of the systems in which he or she is embedded when conceptualizing the child’s difficulties and developing a treatment plan (O’Connor, 2007). O’Connor identified two elements of EPT that differ from most play therapy theories: the way in which a child’s underlying motivation is understood and a developmental focus. EPT therapists view children’s behavior as their best attempt at meeting their basic needs while avoiding consequences. By understanding a child’s motivation, EPT therapists help children learn to effectively meet their needs. EPT therapists also focus on any delays in the child’s developmental progress and how those delays might relate to the child’s ability to meet his or her needs. The overarching goal of EPT is to help children resume developmentally appropriate functioning in all aspects of their lives.

O’Connor (2007) identified two primary curative elements of EPT: the therapeutic relationship and the therapist’s ability to engage the child in developing problem-solving strategies. Through the relationship, EPT therapists create a safe environment in which they can provide children with the experiences and explanations needed to alter their understanding of traumatic events. EPT can engage children in active problem solving geared toward enabling them to get their needs met in developmentally appropriate ways that take into consideration the degree to which the systems the child is embedded in support or impede the child’s efforts.

Trauma-Focused Integrated Play Therapy

Gil (2011a) introduced a structured, integrated treatment model called trauma-focused integrated play therapy (TF-IPT). It is based on her years of working with child survivors of traumatic experiences. Starting with a nondirective model, Gil integrated evidence-based practices such as trauma-focused cognitive-behavioral therapy (TF-CBT) and Herman’s (1997) three-phase trauma treatment model. Gil (2011b) wove creative therapies (i.e., play therapy, art therapy, sand therapy) and attachment-based principles (i.e., understanding the need to conduct treatment within social and familial context) into the TF-IPT curriculum. TF-IPT provides children (ages 5 to 17 years) with opportunities to engage fully into their own treatment and reparative work while sensitively recognizing the natural need for children to protect family members and other trusted individuals when discussing interpersonal trauma (Gil, 2011a).
The primary goal of TF-IPT (Gil, 2011a) is to facilitate management of the child’s traumatic experience. Gil emphasized the importance of breaking the cycles of denial and secrecy, correcting traumatic memories to decrease posttrauma symptoms, encouraging improved social interactions, and preventing the need for unhealthy coping strategies. Gil (2011a, p. 1) identified the specific treatment goals of TF-IPT to be (a) creating an environment of safety, trust, and comfort; (b) processing traumatic material; (c) encouraging social reconnections; and (d) returning to pretrauma levels developmental functioning. Gil (2011a, 2011b) laid out the TF-IPT three-phase model as follows: Phase one focuses on the establishment of safety and relationship building, phase two facilitates the child’s processing of traumatic material, and phase three prepares a child for termination of counseling and assists him or her in reconnecting socially.

PROCEDURAL MODIFICATIONS

Child survivors of interpersonal trauma frequently present with substantial emotional and behavioral concerns. For example, the behaviors of these children are often survival responses they have learned either to avoid abuse or to control it. Ziegler (2002) stated some abused children push their abusers into abusive action as a way of relieving the tension of always being on guard. Conducting play therapy with this population requires a number of considerations and modifications.

First, play therapists working with children in interpersonal training need to have a solid foundation in play therapy and a strong understanding of interpersonal trauma and the effects on children. Second, they need to be compassionate and understanding. Third, play therapists need to be self-aware, particularly of their own issues related to interpersonal trauma. Children who have experienced interpersonal trauma bring emotionally laden experiences and stories into the therapeutic session, and these may trigger something within the clinician. Play therapists who have worked through their own similar issues in counseling or supervision reduce the likelihood of overidentification with their child clients and countertransference. And, last, because child abuse, neglect, and other crimes against children can raise strong emotions in the play therapists who work with them, it is necessary to seek supervision and consultation, or even counseling, periodically.

The characteristics of a child survivor are an important consideration in determining the course of treatment. Considerations include the severity and type of presenting behaviors. A central goal in working with this population is repairing shattered relationships with significant others, if possible. Depending on the severity of damage to those relationships, a child may be better suited for an approach that directly focuses on repairing relationships, such as child–parent relationship training or Theraplay® (Jernberg & Booth, 1999; Landreth & Bratton, 2006). However, sometimes a child’s presenting behaviors may be so severe the play therapist may determine that working with the child and the parent together from the beginning may be overwhelming for the parent and/or the child. In such cases, the therapist may choose to work with the child one-on-one in an approach like child-centered play therapy, Ecosystemic Play Therapy, or trauma-focused integrated play therapy. Another important consideration is determining the appropriateness of including children with a history of sexual abuse in group play therapy. While group play therapy can be beneficial for these children, it is important to ensure none of the children are acting out sexually in order to protect all of the children in the group. Again, an initial period of one-on-one play therapy may be useful in preparing children to benefit from group work.

1 Theraplay is a registered service mark of The Theraplay Institute, Evanston, IL.
Logistical concerns include playroom setup, toys, and materials, as well as treatment frequency and duration. While the specifics of these concerns may vary between approaches, there are some common threads. Children with interpersonal trauma may come from chaotic environments, and need predictability and stability in order to reestablish a sense of safety. Play therapists provide predictability and stability through the way they are in the playroom and the way they structure the play session and the playroom. Play therapists provide a nurturing and supportive environment for children through caring acceptance of the child and through being consistent and predictable in their being with the child (Landreth, 2012). Play therapists provide predictability in the playroom by grouping toys according to the emotions they typically engender (e.g., aggressive, control, nurturing), thus facilitating children's ability to express themselves. Toys serve as a child's words in play therapy; when children are unable to find the toys they need to express themselves, it is analogous to when adults have trouble finding a right word. In addition, providing toys with a connection to a child's trauma (e.g., planes and blocks to create buildings after 9/11) may facilitate the child's ability to express and work through internal emotions and experiences. Play therapists also need to consider the duration and frequency of the play sessions. Usually, play therapy sessions last 45 to 50 minutes. Developmentally, younger children (ages 3 to 6 years) may be able to attend to the therapeutic process for only 30 minutes, whereas older children may be comfortable with 45 to 50 minute sessions. Traditionally, play therapy sessions occur once a week; however, some children may need more or less frequent play sessions. For example, children living in a domestic violence or homeless shelter may require frequent sessions because the period of time during which they will be able to access treatment may be short as their living arrangements change. On the other hand, children who are approaching the end of treatment may start to meet every two weeks or once a month in preparing for termination while still receiving support.

Play therapy theories have various views on how play therapists approach intakes, assessments, and treatment planning. Regardless of theoretical approach, play therapists need to have an understanding of a child's personal and trauma history, as well as the child's relationship with caregivers. With child survivors of interpersonal trauma, play therapists need to be aware of the type of interpersonal trauma and the nature of the relationship between the child, caregivers, and trauma. Understanding how a child experienced the trauma and caregivers, particularly if a caregiver was a perpetrator of the trauma, provides play therapists with important insight in understanding a child's play, planning treatment, and accessing change and growth.

**POPULATION-SPECIFIC TECHNIQUES AND STRATEGIES**

Interpersonal trauma significantly alters the ability of children to perceive their daily experiences accurately and inhibits their ability to cope effectively (Bratton, 2004). Child survivors of interpersonal trauma need reparative experiences to regain their innate ability and potential. There are number of specific techniques/strategies to consider in meeting the needs of children of interpersonal trauma.

Perry and Szalavitz (2006) outlined four recovery needs of child survivors of trauma that are particularly poignant when considering the needs of children who have experienced interpersonal trauma. First, play therapists need to rebuild these children's ability to trust. Interpersonal trauma involves the rupturing of a relationship between children and significant figures in their lives, often due to abuse or abandonment or the experiencing of the world as an unsafe place following an event such as a school shooting or terrorist attack. These children often believe others will let them down, and become distrustful of others. Play therapists rebuild trust through
being genuine, empathic, and accepting in the play sessions. Second, play therapists need to help children regain their confidence. Interpersonal trauma turns a child’s life upside down. These children often feel powerless as others inflict pain through either action or inaction. Play therapists can help child survivors of interpersonal trauma regain their confidence by encouraging children’s efforts. In addition, play therapists promote children’s development of decision making and problem solving by encouraging them to lead the play session. Third, play therapists need to facilitate these children in regaining a sense of security. Children who experience abuse and crime view the world as an unsafe place, not knowing when the perpetrator may strike them again. Play therapists create a sense of security by providing a safe environment in which they communicate genuine caring for their child clients. Furthermore, play therapists create a sense of security by setting limits when necessary. These children often need to believe the adults in their lives will keep them safe; through limit-setting, play therapists let children know they will keep them safe both physically and psychologically. Fourth, play therapists help children reconnect to love. Love is healing, and play therapists facilitate and promote supportive and reparative caregiver–child attachment. This reconnection to love is particularly important when children of interpersonal trauma experience a loss of love through trauma; for some children this loss of love is repetitive (e.g., ongoing abuse and neglect).

Bratton (2004) presented a similar list regarding the use of play therapy with severely traumatized children, overlapping with Perry and Szalavitz (2009) regarding the need to establish or reestablish physical and emotional safety and to build or rebuild trust and relationships. Bratton added three additional goals. First, play therapists help children to establish a healthy sense of self. Often children survivors of child abuse and crime develop a poor sense of self, viewing themselves as broken, dirty, or worthless. David Pelzer (1995) presents this internal viewpoint in his recounting of his own childhood abuse in his book, A Child Called “It.” Play therapists facilitate the development of a healthy sense of self through caring acceptance, encouragement, and validation. Second, play therapists assist children of interpersonal trauma to release and regulate emotions. These children frequently have difficulty expressing their emotions in healthy, nondisruptive ways, or they may have learned to hide their feelings in fear of further abuse. Play therapists facilitate the healthy release and regulation of emotions by communicating an acceptance of all emotions and by using therapeutic limit setting to help them learn self-control and to redirect them to acceptable means of expressing their emotions. Third, play therapists help child survivors of interpersonal trauma to gain or regain a sense of mastery, coping, and competence. These children commonly develop self-doubt, particularly in cases of emotional abuse, which often accompanies other forms of abuse, neglect, and crime. Play therapists facilitate the development of mastery, coping, and competence through encouragement.

Bratton (2004) described several aspects of the role of play therapists in working with children of severe trauma. Play therapists recognize these children’s critical need for safety both in and out of the therapy session; this may include the development of a safety plan for when a child feels unsafe. Safety plans include how to: get away from dangerous situations, identify people who are safe and how to reach them, find safe locations, and perhaps create a “safety kit” that contains emergency numbers and items the child may need when escaping a dangerous situation. Play therapists need to be patient with the process. The healing process can feel painstakingly long, particularly with children who have experienced chronic or extreme abuse or neglect. Ziegler (2002) described how chronic and extreme abuse creates deep-seated neural pathways. As a result, it may take repetitive positive experiences to recreate healthy neural pathways. Play therapists must also serve as witnesses to the child’s story. Children of abuse often keep their stories to themselves, whether from a fear of further pain or from fear created by threats from and manipulation by their abusers. Play therapists serve as witnesses to children’s stories of abuse,
neglect, and crime using their reflective skills to communicate an acceptance and understanding of children's stories.

A note of particular importance is that play therapists serve a therapeutic role, not an investigative, forensic role. The primary focus of play therapists is the treatment of their child clients and improved emotional and psychological healing. In therapy, “the facts” of the case matter less than the child's experience and perceptions. On the other hand, being in an investigative role requires the professional to be as objective as is humanly possible. Simultaneously treating (therapeutic) and evaluating (forensic) creates a role conflict. The therapeutic–forensic conflict can result in compromised therapy (Greenberg & Shuman, 1997; Strasburger, Gutheil, & Brodsky, 1997). This sort of conflict often becomes an issue in contested custody cases in which the children were subjected to interpersonal trauma by one of the caregivers. In such cases, the nonoffending parent may place pressure on a play therapist to be an evaluator. For the sake of everyone concerned, play therapists need to both communicate and maintain clear role boundaries.

Finally, play therapists need to involve children's families in the therapeutic process. The time play therapists spend with a child represents a fraction of the time the family spends with that child. Developing a supportive relationship with caregivers and providing them with the tools they need to support the work the child is doing in the play therapy session increases its effectiveness.

RESEARCH/EVIDENCE BASE

Play therapists need to be knowledgeable and skilled in approaches found to be the most helpful in the treatment of children who have experienced interpersonal trauma. A large body of research exists that supports the use of the approaches previously described. Following are some studies regarding CCPT, TF-IJT, and CPRT that directly relate to their use in the treatment of interpersonal trauma.

Child-Centered Play Therapy

Several studies document the value of CCPT with this population. Kot, Landreth, and Giordano (1998) examined the use of intensive CCPT with 22 child witnesses of domestic violence residing in a shelter. The treatment and control groups each consisted of 11 children. Parents of the treatment group reported statistically significant decreases in both their children's total behavior problems and their externalizing behavior problems. The children exhibited statistically significant increases in their self-concept and their physical proximity to the therapist in the session. Tyndall-Lind and colleagues (2001) also explored the use of intensive CCPT with child witnesses of domestic violence residing in a shelter. The study included 32 children in two experimental groups (n = 10 in CCPT sibling groups and n = 11 in individual CCPT) and a no-treatment wait group (n = 11). Both treatment groups exhibited statistically significant increases in their self-concept and decreases in reported behavior problems, externalizing behaviors problems, aggressive behaviors, and anxious and depressive behaviors as compared to the control group. In another study, Scott, Burlingame, Starling, Porter, and Lilly (2003) explored the use of CCPT with child survivors of sexual abuse. Participants included 19 girls and 7 males, ages 3 to 9. After 12 sessions, results indicated children experienced a statistically significant increase in their feelings of social competency and self-concept.
Trauma-Focused Integrated Play Therapy

Gil (2011a) developed the TF-IPT curriculum as part of a multisite outcome study designed to compare the effect of TF-CBT and TF-IPT on children's self-reports and parents' reports of the child's behavior. Krueger (2013) further compared TF-CBT and TF-IPT by examining trauma-related beliefs, emotion regulation, and verbal engagement and their relations to symptoms in 42 children with complex trauma histories. Krueger reported significant changes in both treatment groups in the decrease of negative trauma-related beliefs and symptomology and an increase in verbal engagement. Furthermore, only children in the TF-IPT group experienced significant improvement in their cognitions related to their trauma. TF-IPT received a High rating on the Child Welfare System Relevance Level (California Evidence-Based Clearinghouse for Child Welfare, 2013), indicating TF-IPT meets the needs of children, youth, and families receiving child welfare services.

Child–Parent Relationship Training

Landreth and Bratton (2006) reported that, as of 2006, researchers had conducted 27 outcome studies on the efficacy of CPRT, or the 10-week filial model developed by Landreth that became CPRT. Four specific CPRT studies relating directly to interpersonal trauma are Harris and Landreth (1997), Landreth and Lobaugh (1998), Costas and Landreth (1999), and Smith and Landreth (2003). These are summarized in the following paragraphs.

The incarceration of a parent is a form of interpersonal trauma because it forces a break in the child–parent relationship when the child is unwillingly separated from the parent. In a randomized study of 22 incarcerated mothers, Harris and Landreth (1997) trained 12 mothers with children ages 3 to 10 years in CPRT. Harris and Landreth adapted the once a week for 10 weeks format to twice a week for 5 weeks to accommodate the women's relatively short length of stay at the county jail. The treatment group received 2-hour filial therapy training sessions twice a week for 5 weeks and they conducted biweekly 30-minute play sessions with one of their children during scheduled visitation times at the jail. Compared to the control group, mothers in the treatment group demonstrated a significant increase in their empathic interaction with their children. In addition, the mothers reported statistically significant gains in parental acceptance and decreases in their children's behavior problems. In a randomized study of 32 incarcerated fathers, Landreth and Lobaugh (1998) trained 16 fathers with children ages 4 to 9 years in filial therapy. Sessions were held in a medium-security prison during the children's scheduled visitations with their fathers. Results showed the fathers in the treatment group, as compared to the control, reported statistically significant increases in their acceptance of their children and significant decreases in their stress related to parenting and in their children's behavior problems. Their children reported increased self-esteem.

Children who experience sexual abuse at the hands of one caregiver may blame the other caregiver for not protecting them. Costas and Landreth (1999) examined the effect of filial therapy with 26 nonoffending parents of children (ages 5 to 9) who had experienced sexual abuse. Researchers assigned parents to groups based on geographical convenience. The treatment group of 14 parents, as compared to the control group, demonstrated statistically significant increases in their empathic interactions with their children, their acceptance of their children, and decreases in their children's problem behaviors, anxiety, emotional adjustment, and self-concept, as well as statistically significant decreases in parental stress.
Experiencing or witnessing domestic violence can shatter a child’s trust and sense of safety. Smith and Landreth (2003) examined the effectiveness of CPRT with mothers and children (ages 4 to 10) in a domestic violence shelter. The researchers merged the training and play sessions into twelve 1.5-hour training sessions across 2 weeks to match the average 2-to-3-week stays of most families in the shelter used for the study. In comparing the results of the treatment and control groups, the 11 mothers experienced a statistically significant increase in their self-concept and in their acceptance and empathic interactions with their children. The 11 children in the treatment group demonstrated statistically significant decreases in their overall behavior problems, internalizing and externalizing behaviors problems, and aggression, anxiety, and depression and statistically significant increase in self-concept.

CONCLUSION

Children are amazingly resilient, but unfortunately many children face challenges even adults would have difficulty managing and overcoming. Children are naturally relational, and when those relationships are shattered due to interpersonal trauma resulting from child abuse and neglect or other crimes against them, the result can be devastating. Caring and skilled play therapists can best help these children through developmentally responsive approaches that incorporate both play, as children’s natural form of communication and healing, and a healthy and supportive interpersonal relationship. Play therapists do make a difference in the lives of children.

REFERENCES


Play Therapy With Survivors of Interpersonal Trauma: Overcoming Abuse and Crime


DEFINING THE POPULATION

The umbrella for children who have chronic illnesses is large, with illnesses ranging from asthma with acute, intermittent episodes to diabetes, an illness that is long-term and chronic in nature (Last, Stam, Onland-van Nieuwenhuizen, & Grootenhuis, 2007). Chronic illnesses require at least 6 months of medical care and continual adaptation to the waxing and waning symptoms associated with long-term illness. Children face a range of medical issues that lead to short-term hospitalizations, such as an emergency room trip for a breathing treatment for an asthmatic child or a child with end-stage renal disease who requires ongoing dialysis treatments while awaiting a transplant. Many children with chronic illnesses face “diseases with no known cures (e.g., cystic fibrosis, inflammatory bowel diseases), but [that] can be managed medically. Some illnesses like childhood cancer are acute in their manifestation, but chronic in their late effects” (Last et al., 2007, p. 101).

The range of illnesses and related medical issues is large and complex (e.g., cancer, asthma, traumatic injury) and includes both acute and long-term psychological approaches. The course of chronic illnesses is often unpredictable, and symptoms increase and decrease over time. Children who have chronic illnesses are living longer. Technology has not only improved life span and medical outcomes, but also the ability of children to become involved in their lives at school and community levels (Nabors & Lehmkuhl, 2004; van der Lee, Mokkink, Grootenhuis, Heymans, & Offringa, 2007).

CHARACTERISTICS AND SPECIAL NEEDS

Children with chronic illnesses face a variety of specific emotional issues, such as anxiety, worry, distress, trauma reactions, and feelings of isolation and grief. They often experience sadness
related to missed social opportunities. They may be at risk for being less involved in extracurricular and other play activities with peers as the result of attending multiple medical appointments or following a complex medical regimen. These regimens include many components, such as dietary and activity restrictions, medication schedules, numerous medical visits, and multiple hospital stays and emergency room visits. Children with chronic illnesses frequently cope with chronic pain, and play therapy provides a venue to address related anxiety and stress. Rae and Sullivan (2005) conducted a review of the play therapy literature and found play was an effective method for helping children with anxiety, stress, and depression related to having chronic illnesses. Therapists interact with children managing acute and chronic medical conditions in a variety of settings besides the hospital and emergency room, including private practice, community mental health, and school settings.

WHY PLAY THERAPY IS APPROPRIATE

Play is defined as pretend play, involving an as-if mindset that allows for the use of “fantasy and make-believe, and the use of symbolism” (Moore & Russ, 2006, p. 237). Pretend play can be a mechanism for healing as children have opportunities to express and cope with anxiety, facilitating their adjustment (Moore & Russ, 2006). Play is a way to build caregiver–child relationships and coach the caregiver to learn to support the child with an illness. It is also a method for helping children prepare for hospitalization or medical procedures. It is a safe haven for children to rework experiences that were frightening to them. Through play, the therapist can engage in children’s worlds, where they can recount experiences, play through upsetting feelings and anxiety, and find ways to tackle difficult problems related to their chronic illness.

Play therapy can also be a venue to build children’s self-esteem and confidence in their ability to tackle illness, both in terms of fighting to be well and following medical regimens, when the therapist or the child interjects positive outcomes and coping strategies for characters in the make-believe world of play. Rae and Sullivan (2005) described hospital-based play as focusing on “preparation for specific medical procedures or events as well as helping the child cope with untoward feelings about the hospitalization or illness.” (p. 128). Play is a routine activity for children and provides a familiar environment for them to express anxiety and fears as well as to gain mastery when coping with feelings related to the stress of multiple medical settings and events.

Play therapy for children with chronic illnesses facilitates emotional growth and development. Play therapy can be short or long term and is a dynamic technique that assists children in expressing their emotions as they cope with illness. Play therapy sessions address a wide variety of medical concerns, such as fears related to procedures and needle sticks and the importance of adherence to medical regimens, and it also provides the opportunity to cope with distress and grief related to dealing with a medical condition.

During a play therapy session, the child often is retelling experiences in a way that is meaningful to him or her through medical play (Clark, 2007). Nabors et al. (2013) also discovered children told stories through their play, and this allowed them to work through feelings related to their previous hospital experiences. The repetitive stories that unfold in play can be like scripts for children as they recount their knowledge of previous events (Nelson & Nelson, 1990). When replaying scripts, children may change their roles and endings to ensure the ending is happy, accounting for their hopes for a positive outcome related to their illness experiences (Nabors et al., 2013). This allows for control and mastery over traumatic and upsetting experiences. These repetitive stories often are replayed by children until they work through feelings of distress. Children may repeat themes and stories in their play, each time working through feelings and having
opportunities to experience growth in their sense of self. Over the course of play sessions, children are developing their own theory of experiences and the meanings they entail.

THEORIES BEST SUITED TO WORK WITH THIS POPULATION

Virginia Axline's nondirective play therapy is a very effective treatment modality for children experiencing medical illness. Axline, a student of Carl Rogers, applied key concepts in his theory to working with children during play sessions. In her book titled Play Therapy, Axline (1974) stated, “Non-directive therapy grants the individual the permissiveness to be himself” (p. 15). She believed nondirective play therapy offered the child chances to grow in a positive direction under optimum circumstances. Specifically, she states that by playing through feelings and playing out one's feelings, a child

“brings them [feelings] to the surface, gets them out in the open, faces them, learns to control them, or abandons them. When he has achieved emotional relaxation, he begins to realize the power within himself to be an individual in his own right, to think for himself, to make his own decisions, to become psychologically more mature, and, by so doing, to realize selfhood. (Axline, 1974, p. 16)

We believe a therapist with a nondirective approach (Axline, 1974) is well suited to working with children who have chronic illnesses. This stance allows the therapist to meet the child where he or she is and allows the child to process grief and stress on his or her own terms. If a therapist is willing to follow the child's lead in play and is curious about the child's opinions and feelings, the therapist creates an open atmosphere that enables the child to be free to express fears and ask for clarification about medical experiences. A therapist who establishes a strong rapport with the child and allows for the expression of emotions in a safe environment acts as a support and guide (Axline, 1974; Landreth, 1991). The play therapy room and the therapist's accepting attitude make the play therapy session a good place to grow (Axline, 1974). The child is the most important person in the room, is accepted, and can express him- or herself fully. Axline reported some children may experience doubt at the first play contact because they are no longer being told what to do and how to be. The child is thus challenged to be and develop his or her own self in a secure place. Nondirective therapy is a valuable tool, and, at times, with disorders such as anxiety, its value can be increased with the implementation of cognitive behavioral techniques.

PROCEDURAL MODIFICATIONS

Use of medically related toys and medical equipment to review upcoming procedures helps children cope with anxiety related to the medical procedures. Providing information in this manner can be especially meaningful for children whose personality characteristics influence them to value information (i.e., be information-seekers) about what is happening or will happen to them during medical procedures. The toys and materials also serve as a “stage,” if you will, providing the child with an indirect mechanism to work through difficult and traumatic experiences using a familiar and beloved medium.

When working with a child with medical complications, it is important to work around the child's medical issues. This can entail meeting the child in his or her hospital room or accompanying the child to a medical procedure to help manage the anxiety related to the procedure.
When conducting sessions at the child's bedside or other places outside the therapist's office, it is useful to have medical toys or drawing materials available. It is also critical to work around and respect the needs of the medical team, making sure that one fits in with the child's medical needs and regimen in the health care setting. Thus, a session may need to continue around medical visits, stopping and starting to meet the medical professionals' and the child's needs. In this unique position, the therapist needs to understand that session length may be truncated and not reach the standard therapy hour.

In a consulting role, the therapist simultaneously provides education about illness care, reflects feelings, helps the child understand medical procedures, and supports the child unconditionally. Medical education and support are also crucial for caregivers. The play therapist also should be ready to explain the process of play therapy. The therapist should explain that play therapy "puts the ball in the child's court" so that he or she can express feelings and grow and develop. Moreover, explaining to caregivers that children's play can help them reenact wishes to become well and be a mechanism for gaining mastery over feelings of trauma can help them understand the important work that occurs in play sessions. Teaching them to play with their child in a relaxed manner is important, as worried caregivers who are experiencing grief over the loss of their child's childhood (e.g., a childhood free of illness) may be forgetting the importance of play to child healing and growth.

**Therapist Qualifications and Training**

The therapist should have appropriate training and supervised practica and internship experiences in play therapy. Training is gained through clinical practicums, classes on child therapy development, and courses in play therapy. These classes are offered as part of graduate training experiences or acquired through seminars and continuing education programs. The play therapist should be well-versed in play therapy techniques with children experiencing medical trauma and illnesses, as well as have expertise in the potential medical complications and treatment regimens for the child. This allows the therapist to engage in the children's experiences and help them and their caregivers make sense of what is happening. In addition, play therapists must have a thorough understanding of the psychological issues typically faced by children coping with illnesses (e.g., loss of control, fear, depression, and medical trauma). Ongoing training through workshops, reading, and review of relevant research on play therapy with children will allow clinicians to continue to update and expand their knowledge base in this complicated and dynamic field.

**Therapist Characteristics**

We will describe several characteristics beneficial for the play therapist, many of which were mentioned by Axline (1974). Therapists should strive to create rapport and a supportive environment. Learning to recognize and reflect what the child is feeling is an essential aspect of a competent play therapist. The therapist should maintain an attitude of respect for the child, establishing only those limits that are necessary. The limitations are primarily regarding time limits and safety (i.e., playing safely and being safe in the play setting). Limitations should be reviewed by the therapist when the need to do so arises. The play therapist's approach should also be flexible. Within a flexible approach, the therapist remains open to integrating other techniques, such as anxiety management strategies (i.e., relaxation skills), into the play therapy session. The therapist should also have expertise in stress and pain management techniques as well as expertise in implementation of cognitive-behavioral play therapy techniques.
Because children and their caregivers will ask medically related questions, it is advisable for the play therapist to have strong communication skills in order to consult with the child’s pediatrician, surgeon, and medical providers in order to gain knowledge about medical and treatment issues. Ensuring that one is educated in the area of health issues for children and has gained practical experience consulting in hospitals is a key step in learning the role of a play therapist in medical settings. Furthermore, a keen interest in child health and wellness, as well as the ability to tolerate injury and surgery recovery, are important factors in therapist readiness for provision of play therapy in medical settings.

Pediatric play therapists often serve as consultants, and as such may work with children for a relatively limited amount of time. In the consulting role, the therapist can estimate children’s language and cognitive abilities, albeit in broad brush strokes, during play sessions. There also are opportunities to assess children’s fine motor skills. Assessment of pain, coping strategies, and emotional issues evolve over play therapy sessions. The play therapist can gain an understanding of the child to communicate to others who work with the child, while also gathering information about potential referrals for additional support. The therapist needs to be able to communicate his or her procedures and findings to the medical team, so that the information can benefit the team in their interactions with the child.

**Client Characteristics**

Children who have had negative hospital experiences may benefit from engaging in play therapy to help them relieve anxiety related to these experiences and to prepare for future experiences if they have a serious chronic illness that involves multiple medical stays or surgeries (Nabors et al., 2013). Factors related to negative perceptions of hospitalization include previous negative hospital experiences with staff or procedures, the child’s coping style, the nature of the interventions the child has undergone, caregiver reactions to the child’s hospitalization, and the child’s developmental level. Young children may benefit from play therapy, as will children who are not able to verbally express their emotions related to previous negative hospital experiences. Play therapy may be a way to gain an understanding of the world of a child who is resistant to traditional talk therapy. It allows children to express feelings of depression and anxiety related to having a chronic illness in a safe setting. It is also a mechanism for relieving and managing stress, which builds when children are hospitalized and face difficult procedures and do not have their usual play outlets.

**Indications and Contraindications**

Play therapy may not be a treatment of choice for adolescents per se, as they may be more comfortable with a more traditional talk therapy approach. However, an accepting attitude and openness to participate in play therapy can be beneficial to children of all ages. Although the toys might not be present, being open to playing games and being very accepting of the adolescent are critical to establishing rapport and creating an atmosphere where adolescents can grow and establish a strong sense of self as they cope with a chronic illness.

In addition, engaging in play therapy for the purposes of verbalizing concerns may be contraindicated for children with significant language and/or cognitive delays. While the therapist may not be able to verbally follow the messages in the play of young children with developmental delays, play therapy is a powerful modality for all children, as it provides the opportunity to work through issues nonverbally. Play therapy may be contraindicated if the child is very ill and cannot
fully participate in or enjoy the play. In these cases, stories and music or other creative activities may be advisable ways to help children process their feelings.

Logistics

Playroom Setup, Toys, and Materials

A variety of materials can be used during the play therapy session. Actual medical equipment, such as syringes or bandages, can be used, as well as pretend play toys. Playmobil™ has a variety of hospital toys, including an operating room, hospital, figures of doctors, wheelchairs, ambulances, casts for figures, hospital beds, and more. Other toys include doctor's kits with toy stethoscopes, surgical tools, masks, and shots. When using toys, children can feel mastery, change outcomes, express emotions, and have some sense of control related to painful medical procedures and equipment. Anatomically correct dolls, such as, Claudia's Kids (http://www.claudiaskids.com/) are a great way to explain anatomy and how the body works and to review how medical procedures will be conducted and affect the body. Children also may view the television show "Doc McStuffins," which shows a girl, who is a toy doctor, fix the medical needs of toys. Talking about this television show and allowing children to discuss their own show about doctors is a good way to prompt children to feel comfortable about telling their own stories.

The play therapist should also provide a variety of other toys typical to play therapy settings, such as Legos™, art materials (e.g., crayons, markers, colored pencils, paints, paper, sketch books), dolls, finger puppets, cars, animal families (e.g., toy animals that can be perceived as a family), a telephone or toy cell phone, games (e.g., checkers), and other play materials which allow children to release their emotions and be creative through familiar materials (Axline, 1974). Clark (2007) also has noted benefits when children bring their own play materials to play sessions, facilitating their ability to infuse meaning into their play as they learn to cope with experiences and feelings related to their chronic illness. When using toys and play materials, the children are actively coping with their emotional experiences. The therapist can understand and address children's misconceptions and negative coping strategies that hinder their ability to cope with an illness or related medical procedures. If children have difficulty beginning to play with toys, one might comment, as Axline (1974) recommended, “You don't know quite what you would like to do” (p. 93). She also recommended providing the child with permission not to play, as many may not expect to be able to do this in a therapy session.

Treatment Frequency and Duration

The timing and duration of the play therapy sessions can vary based on child interest and other setting factors related to being in a hospital. The pediatric therapist is often in a consulting role in a hospital setting, where play therapy can be interrupted for a number of medical and other reasons. Therapists should educate children that sessions can be short in duration or vary in length. The therapist should be honest with the child if a shortened session cannot be continued at a later time. Training caregivers in the use of play is a method for ensuring children have multiple opportunities to express their emotions through medical play. Sessions also may be longer than the traditional therapy hour that is adhered to in other community or private practice settings. The duration of sessions should be determined by presenting problems and child and family needs. The duration of treatment may be longer when children have exposure to trauma related to their illness.
As mentioned earlier, children are living longer and undergoing more medical procedures as technology advances (van der Lee et al., 2007). Therefore, pediatric play therapists need to consider a long-term developmental perspective as they assist children and families in coping with an illness. A flexible therapy approach is recommended, in which a therapist has multiple periods of treatment as required by exacerbation of symptoms or based on developmental needs.

**Pretreatment Intake and/or Assessment and Treatment Planning**

The play therapist should assess whether a child would benefit from play therapy after conducting a thorough pretreatment clinical intake and understanding the child's family structure, history, coping skills, and previous experiences, along with obtaining a description of the child's personality and typical manner of coping with stressors (Rae & Sullivan, 2005). Observations during play therapy sessions provide key information for assessing children's functioning in terms of their language, cognitive, emotional, and motor functioning.

Clark (2007) recommended therapists be creative in designing assessment tools and consider using multiple methods for measuring change in children's behaviors. In our work we have used surveys to assess change in child anxiety and emotional functioning. We also use structured assessments, informal child and caregiver report, and observations. Other functional areas to assess include emotional expression, emotion regulation, and abilities to relax and control pain. We believe there are several key areas to assess when conducting play therapy with children. Table 22.1 presents a summary of potential areas to assess to determine change in child functioning as a result of participation in play therapy.

<table>
<thead>
<tr>
<th>Area</th>
<th>Skill Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Functioning</td>
<td>Levels of anxiety and depression</td>
</tr>
<tr>
<td></td>
<td>Ability to tolerate painful procedures</td>
</tr>
<tr>
<td></td>
<td>Relaxation and sleep</td>
</tr>
<tr>
<td></td>
<td>Ability to express emotions, such as sad and angry feelings</td>
</tr>
<tr>
<td>Behavioral Functioning</td>
<td>Behavioral regulation, such as reductions in angry outbursts or angry behaviors</td>
</tr>
<tr>
<td></td>
<td>Improvement in behaviors toward family members, peers, medical staff</td>
</tr>
<tr>
<td></td>
<td>Improved adherence with the varied aspects of the child's medical regimen</td>
</tr>
<tr>
<td></td>
<td>Expressive language skills, including skills for expressing emotions</td>
</tr>
<tr>
<td>Change in Creativity and Imagination Used in Play</td>
<td>Does the child's play become less repetitive?</td>
</tr>
<tr>
<td></td>
<td>Is the child able to include others in play?</td>
</tr>
<tr>
<td></td>
<td>Do the child's play stories become more positive?</td>
</tr>
<tr>
<td>Social Adjustment</td>
<td>Play with family members and siblings</td>
</tr>
<tr>
<td></td>
<td>Peer relationships</td>
</tr>
<tr>
<td></td>
<td>Social skills</td>
</tr>
<tr>
<td></td>
<td>Play with peers in school and other contexts; is the child more peer oriented and less isolated?</td>
</tr>
<tr>
<td></td>
<td>Parent–child interactions</td>
</tr>
<tr>
<td></td>
<td>Interactions with medical team during regular visits and procedures</td>
</tr>
</tbody>
</table>
Bratton, Ray, Rhine, and Jones (2005) conducted a meta-analysis and found that the effect sizes for play therapy across studies indicated that it had a positive impact on child emotional and behavioral functioning. We recommend assessment of multiple behaviors and emotions to determine the effect of play therapy within this specific population. It is important to use multiple informants, such as the child, medical team, caregivers, and teachers, to determine whether positive change in child functioning is occurring.

While it is suggested that the play therapist use a variety of assessment tools, there may not be an opportunity to purchase standardized measures in many clinical settings. Even when standardized assessment tools are not available, repeated assessment of change in the child’s emotional, behavioral, and social functioning over time is possible. This change can be assessed by brief caregiver interviews, teacher interviews, and observations of the child’s play by the aforementioned informants as well as observation by the therapist. Children may also provide subjective ratings of improvement in their skills, such as abilities to manage pain and adhere to treatment regimens. These ratings can be on formal measures or visual analog scales where the children assess change in their own functioning at different points during treatment. In experimental studies of play therapy, it is recommended that those observing for possible change in play behavior be blind to the purpose of the observations (i.e., the nature of play therapy or the type of intervention), so they may make more objective judgments about changes in children’s behaviors (Bratton et al., 2005).

It also is advisable that observations be repeated over time. For example, if play sessions occur at different phases in the child’s development, it may be important to examine the relationship between changes in cognitive functioning and change in children’s emotional, behavioral, and social functioning each time the child returns for additional treatment. Also, if the child has intensive treatments that may affect cognitive development or functioning, it will be important for the therapist to assess the child’s cognitive functioning and development. Child cognitive development and emotional and behavioral functioning change over time, and the therapist may be asked to interact with children at different points in their development, as disease progresses, or as symptoms wax or wane.

In this chapter, we elected to focus on discussion of strategies for humanistic and nondirective play therapy (Axline, 1974) because research has shown that these approaches are effective for children (e.g., Bratton et al., 2005), and we have found this approach to be effective in our own clinical work and observations of the play of children who have chronic medical conditions (e.g., Nabors et al., 2013). However, within nondirective play therapy sessions, therapists can also address child problem-solving skills and teach coping strategies. For instance, the play therapist can teach children ways to cope with medical procedures and ask questions of doctors and other medical professionals, which could improve their ability to cope with pain or behavioral adjustment in the medical setting. If problem solving were an intervention within play therapy sessions, the therapist could use interviews and self-report measures to assess change in child problem solving and use of coping strategies when the child is dealing with the medical team, adherence to her medical regimen, or coping with pain. Because change can have a cascading effect, the therapist could also see positive change in emotional functioning or relationships with others, such as caregivers and siblings, when children are better able to cope with medical procedures and issues related to their medical condition.

**Treatment Stages and Strategies**

The first year after diagnosis of a medical illness may be an especially difficult time in the life of the child and family as they adjust to the child’s disease (Barlow & Ellard, 2005). This is a time when the therapist might expect to be more intensively involved, offering regular sessions. Grief
Play Therapy With Children Experiencing Medical Illness and Trauma 445

reactions are common, and many children must adjust to a disruption in their routine activities. The therapist should be present in the sessions, listening to children and the stories in their play and assisting them in processing feelings as well as in gaining a greater knowledge about how to manage their illness. It also is important for therapists to be available to meet with children when they face various medical procedures or experience difficulty coping with an intensified course of disease-related symptoms.

POPULATION-SPECIFIC TECHNIQUES AND STRATEGIES

This section of our chapter reviews several studies presenting information about specific techniques and strategies for children who have chronic illnesses and their caregivers. Specially, we present information in six key areas: (1) caregiver training in play therapy; (2) the use of play therapy in preparing children for hospitalization and medical procedures; (3) play therapy as a tool in understanding adherence issues; (4) play therapy as a tool for allowing children to work through and cope with traumatizing and upsetting experiences in an environment where they can control the unfolding of events; (5) play therapy as a technique for assisting children in coping with anticipatory grief; and (6) the use of imagery and fantasy play during sessions.

Caregiver Training in Play Therapy: Filial Therapy

Therapists may also serve in a training role, utilizing filial therapy to coach caregivers to help their children work through feelings related to coping with illnesses. During filial therapy, caregivers and the child have an opportunity to reconnect and reestablish their relationship. The caregiver and child typically participate in play sessions that are supervised by the therapist. During play sessions, caregivers and children have a chance to play and focus on normal interactions that decrease the emphasis on the child's illness. A goal of sessions is to strengthen the caregiver–child relationship. Caregivers are partners with the child in the play therapy process, and the caregiver is focused on having positive regard for the child, empathy for what the child is experiencing, and promoting child growth. The caregiver also focuses on allowing the child to create solutions to problems encountered in play, while working to understand what the child is communicating (VanFleet, Ryan, & Smith, 2005). The idea guiding a filial approach is that caregivers who learn the role of a nondirective therapist can have a positive impact on their child's coping and development. Through coaching and practice, caregivers learns to generalize their role in interactions with the child in the home setting, taking on a therapeutic role in promoting child coping with trauma and stress related to his or her illness (Ray, Bratton, Rhine, & Jones, 2001).

Preparing Children for Hospitalization and Medical Procedures

Play with hospital toys and open sharing of information with caregivers can help prepare a child for hospitalization and thus reduce tendencies for negative emotional reactions related to hospitalization (Rae & Sullivan, 2005). Children can use equipment and/or toys to learn about what might be happening in upcoming medical experiences. A child experiencing an upcoming medical procedure can learn about the steps of the procedure through reenactment with a therapist using dolls and play equipment. Athanassiadou, Tsiantis, Christogiorgos, and Kolaitis (2009) suggested that puppet play that allows children to review the steps in their hospital procedures is a great method for preparing children who will be undergoing hospitalization and related procedures. Athanassiadou et al. (2009) presented results of a study assessing a program that used puppet play to prepare children for elective ear, nose, and throat surgery. Findings indicated improved
behavioral adjustment of children (they showed fewer behavioral problems postsurgery) in the puppet play program compared to children in a comparison group who did not participate in the preparation program. Other play therapy interventions using dolls or puppets are also helpful in preparing children before a hospitalization.

For example, the play therapist can show children how an intravenous line works, using a doll to show how the needle will be put in the top of the hand and explaining medicine will come from a bag with a tube that transfers the medicine into the child’s hand so that it can flow through the child’s veins and reach her brain and body. Next, the doll can be placed on a toy bed and go to an operating room, breathe through a mask, and then go to sleep. The therapist can explain the surgery will happen when the child is asleep, and after the surgery is completed, the doll will go to a recovery room and then possibly home. During play with dolls representing the child and the medical staff, the therapist and child can review the steps to the procedure and discuss how a child might feel and questions the child might ask at each stage in the process. When used in this manner, play is an avenue for teaching children about medical procedures to reduce fears and uncertainty over what will occur. Children can also learn about taking pills and caring for surgical sites through enactment of different situations and positive actions in each situation through play. Similarly, play can be used to teach and highlight the importance of adherence to the child’s medical regimen after a surgery.

**Facilitating Coping With Adherence Issues**

Children can process their feelings about following medical recommendations through play therapy experiences. Jones and Landreth (2002) examined change in emotional and behavioral functioning and adherence (defined as children’s ability to follow their medical recommendations) for children with Type 1 diabetes who were attending a summer camp and were assigned to either an intervention (play therapy) or a control group. The play sessions were based on Landreth’s (1991) child-centered play therapy approach and included regular play therapy materials and medical equipment appropriate for children with diabetes, such as blood glucose monitors. Jones and Landreth (2002) assessed change in child emotional functioning and adjustment using child and caregiver perceptions. Caregiver ratings, but not child reports, indicated children in the intervention group were better adjusted than those in the control group. Differences in anxiety level were not discovered between groups, but these researchers noted children in both groups had anxiety levels within the normal range at the outset of the study. Therapists noted the play sessions offered the children opportunities to express their feelings about having diabetes. Overall, findings provided support for the intervention as improving child adjustment.

**Working Through Upsetting Emotions After Procedures**

Children can use medical toys and play to work through feelings of upset or trauma related to previous medical experiences. This is a positive way for children to reexperience and release upsetting emotions from the past. Clark (2007) reported that during play with toys, children often reenact the role of doctors through role reversal (the patient assumes the role of the doctor, thereby taking control of the experience) as a way to cope with trauma related to undergoing medical procedures and surgeries. Children can process their feelings from a place of control and then safely release emotions through play. They can gain a sense of the care-taking role and perhaps greater appreciation of the role of doctors or nurses by taking their perspectives during reenactments. The play therapist can also understand and address children’s misconceptions and negative coping strategies that hinder their ability to fully cope with a past illness or related medical procedures.
Similarly, play therapy is a great avenue for assisting children in coping with anxiety, sadness, loneliness (feeling isolated), and trauma related to repeated exposure to medical treatments (e.g., multiple chemotherapy administrations, lab draws). Play provides an indirect means to express feelings so children do not have to directly confront issues. This reduces the chance they might be retraumatized in the retelling of what occurred during hospital experiences or when undergoing medical procedures. In the world of play, children can learn to cope with their problems and feelings “within an emotionally safe environment” (Jones & Landreth, 2002, p. 120). In other words, the trauma and upset feelings associated with past illness and medical procedures can be overwhelming for children, and the indirect nature of play therapy can safely allow for self-expression through play, a realm where children often experience mastery. Caregivers also benefit from watching play because they can learn about their child’s perceptions of his or her experiences (Murphy-Jones, 2001).

Play helps children work through troubling experiences at their own pace and in their own voices. In the play environment, children can stop and start the action in different play scenarios, which allows them to experience some control as they work through previously upsetting events and related feelings of worry over future medical procedures that may have to be repeated (Clark, 2007).

Finally, children also may enact positive scenes using toys to enhance their imagination of control during past treatment experiences or to bolster a positive outlook and hope about the outcomes related to their illnesses. In order to work through negative experiences and to begin to see positive aspects of life again, therapists can guide play stories or imaginative play to have positive endings. This can be through the play therapist reflecting characters that are coping positively with a problem or using problem-solving techniques to find some effective solutions to problems in their lives.

**Play and Creative Activities Assist Children in Coping With Anticipatory Grief**

Through play or other creative activities, the therapist may have opportunities to help a child who is dying cope with anticipatory grief. Adamo and DeFalco (2012) discussed play therapy for a 7-year-old child who eventually died from his cancer. He completed drawings when his psychotherapist visited him. They reported that his drawings of houses were rickety, depicting his own physical state. The drawing activities allowed him to express grief and upset in a contained way, so he could safely release his feelings of anxiety and anger related to his cancer. Similarly, Gariépy and Howe (2003), described play as a process during which a child could express “aggression and feelings that would not be possible in the real world” (p. 525). Through play, children have opportunities to assimilate what is happening to them medically and use play materials as objects to transfer their anxieties (Gariépy & Howe, 2003).

**Imagery as an Additional Tool in Play Therapy**

We propose that imagery helps children cope with many facets of their medical trauma and illnesses. Guided imagery is an external verbal structure provided to the children to help manage events. It allows for reflection as well as opportunities to promote positive outcomes if the scenes are positive and uplifting in nature. Children may use imagery to help them cope with pain related to undergoing medical procedures, such as venipuncture and shots (Johnson & Kreimer, 2005).

In terms of addressing pain experiences, relaxation techniques (e.g., deep breathing, progressive muscle relaxation, and imagery) can help distract the child from a focus on pain and invoke a relaxed state, which further reduces the pain experience for many children. Imagery is a relatively
inexpensive tool; the therapist needs a quiet place where she can talk and/or use play materials with children to guide them through their own fantasies.

Imagery can also be used to guide a child through a positive scene. We have used imagery with children coping with chronic pain related to their Juvenile Idiopathic Arthritis, which involves painful flare-ups and swelling of joints similar to those experienced by adults battling arthritis. Children have developed their own imagery to distract them from focusing on their pain, including some developing a visual image involving a movie in their mind of superheroes battling pain (pain is often depicted as an evil doer) and triumphing over pain by reducing or eliminating it in a heroic battle. Other children select their favorite place, which may be something like a trip to an amusement park, to help them push through or distract their minds away from the pain experience.

Child-directed, spontaneous imagery can also be a coping tool for some children. Their images may be either positive or negative in nature. Negative images may be a way to release anger over the medical condition or other feelings related to missing family or having to deal with an illness. Releasing angry and upset feelings allows the child a sense of catharsis. Positive images generated by the child may be a way to build self-esteem or enhance feelings that the child can cope with his or her medical condition. Consequently, both positive and negative images can improve coping.

Guided fantasy play originates from the child and is observed, interpreted, and supervised by the therapist. The role of the therapist is variable, depending on the child's creations and the intent and symptoms addressed through fantasy play. If toys are not available, stories and imaginative play may be a way to help children express themselves and identify their feelings about different key issues in their lives. When the play process involves the release of worry related to the illness, fantasy play can assist the child in releasing unsettling emotions, with a resulting increase in relaxation and anxiety management.

Case Study

Annie is a kindergartener with diabetes, whose parents were divorcing. She was having difficulty coping with her parent's separation and managing her diabetes regimen. Her mother brought her to play therapy to “work out her feelings about what is happening to our family.”

During the first session, the play therapist interviewed Annie's mother to gain insight into Annie's early development and current psychosocial functioning, as well as any additional presenting problems. Her early history was unremarkable, except for having been diagnosed with Type I Diabetes at 2 years of age. Annie's father participated in a telephone session, and his views about Annie's development and current issues closely paralleled those provided by Annie's mother. Annie spent many weekends and some weekdays with her father. She was doing very well in her kindergartenclass.

Annie was an only child and was used to spending a lot of time with both her mother and father. She had seen verbal arguments between her parents, and both parents agreed that the situation was conflictual. She recently had more difficulty testing her blood sugar, becoming very fearful of finger pricks, crying whenever it was time to test, and wanting to be held. She was doing well with managing the rest of her diabetes regimen and her parents were each doing very well in managing her regimen as she moved between homes.

Annie's introduction to the play therapy setting occurred at the second session. She came into the therapy room hesitantly, but was able to separate from her mother. She was told the purpose of the therapy was to help her understand her feelings about her parents not being together and do better with testing her blood sugar. The room had many options for play, including dolls, a sandtable, art supplies, blocks, stuffed animals, and a doctor's kit.
Annie first gravitated toward some plastic fish that could squirt water. She acted out a play with the fish. In the play, the big fish (“the mommy and daddy”) were angry. They yelled and blew air at each other. The little girl fish was afraid and wanted to run away. She asked the big fish to stop yelling and fighting. They could not do this and it scared the little girl fish.

In order to address the fear of finger pricks for blood sugar testing, the therapist asked Annie to show her how to do the blood testing procedure on a stuffed animal in the playroom. Annie assumed the parent role and guided the bear through pretend the finger prick. The therapist showed Annie how to model deep slow breathing to the stuffed animal to help him relax before the finger prick. The therapist then met with Annie and her mother and instructed them to have Annie engage in this play with a stuffed animal at home as a prelude to her own testing. After Annie showed the bear the procedure, then her parents would let her know, “It’s your turn to test your blood sugar.” Annie would take some deep, slow breaths and let them know when to prick her finger. Annie rehearsed this routine in the session with her mother and agreed to try this at home. Her parents were to record the success of this routine on a monitoring chart they would share as Annie moved between their homes.

Session three began with a report from Annie’s mother about diabetes testing. It had gone better in that Annie no longer cried, but she still required quite a bit of hugging time with both parents after testing. Annie’s mother wondered, as did her father, based on notes on the monitoring chart, if she was gaining additional attention from her parents and expressing her upset about the family situation during her blood sugar testing.

In the playroom, Annie immediately began replaying her story from the previous session. She talked about the angry fish yelling and blowing air at each other and about the scared little girl fish who wanted to “run away.” The therapist asked if the little girl fish had “used her words to say how she was feeling.” Annie said, “No, she hasn’t; she is scared.” The play therapist talked to her about how her parent’s anger was not her fault. Annie said that she knew about the divorce and her parents splitting up. She wanted them to get back together. The therapist let Annie know that this might not happen, and there were other children whose parents were divorced. The therapist described how the parents loved their children but could not live together anymore. Annie’s facial expression showed relief when she discovered that the parents still loved the child and this became part of her storyline in play.

Next, Annie practiced discussing her feelings using feelings words. Her fish said, “I feel sad that my parents are not living together. I feel sad when they fight and yell.” Intervention, through role-play with the fish, continued with a therapist fish as a coach. As the coaching fish whispered to Annie, the girl fish told her parents she loved them, but she was sad and upset when they were fighting. She asked the parent fish not to fight in front of her. The parent fish listened to the little girl. The therapist fish asked the parents not to fight in front of the girl and both parent fish assured the girl they loved her.

The play therapist and Annie developed a storybook she would take home, based on her play in the sessions. Annie illustrated the story, which told the story of the girl’s upset over the parent fish being angry, expressing her feelings words, and understanding that both parent fish loved her even though they couldn’t stay together. Annie was to read the fish story at both homes with each parent.

During session four, the therapist addressed the hugging after needle sticks, which had persisted, although Annie was doing better using the previous interventions. As they played with the fish in a toy house, the therapist fish asked the little girl fish why she needed so much hugging after each blood test. Annie replied, while holding the girl fish, “this little girl is afraid her mommy and daddy will leave her since they left each other so she asks for extra hugs.” The therapist fish was able to let the little girl fish know she could talk with
her parents about her worries and ask for extra hugs if she felt worried about them. Then, Annie practiced on her own, being the voice of the mommy fish and the little girl fish.

At the end of the session Annie did her play for her mother. Her mother’s eyes lit with understanding as the little girl fish told the mommy fish she was scared she would leave her. Annie seemed relieved and asked if she could have more hugs, too, when she worried about her parents. Her mother assured Annie she could have more hugs. The play therapist then explained the link between the hugs after testing and Annie’s worries about being abandoned.

Over the course of several weeks, Annie’s mother reported a reduction in asking for hugs after testing, and both parents indicated there were no more issues with her blood testing. Annie’s pretest practicing with her bear was discontinued. Her parents reported increased communication between themselves and Annie. Both parents felt Annie was more at ease and adjusting to their current situation.

This case study represents an example of how emotional concerns can become intertwined with disease management for young children with a chronic illness. Play therapy became a forum to address emotional concerns as well as disease management. The play therapist used key knowledge about disease management, monitored progress, and utilized play to uncover Annie’s thoughts and feelings about her parents’ separation. Pretend play and a relaxation strategy were implemented as a warm-up activity prior to testing blood sugar level, providing Annie with much needed control over the testing situation. Her issues with blood testing acted as a proxy for her feelings of a lack of control over her parents’ separation. Play therapy was a valuable means to facilitate diabetes management as well as uncover a link between upset over life events (i.e., parental divorce) and Annie’s reaction to testing her blood sugar.

EMPIRICALLY SUPPORTED RESEARCH

The majority of research on the effect of play therapy in this population has focused on how play helps children cope with stress and anxiety related to illness and the experience of medical procedures. Moore and Russ (2006) reported play can help children deal with stress and anxiety, is a vehicle through which children can express emotions, and is an effective tool in mitigating the impact of pain, thereby improving the behavioral functioning of children with chronic illnesses. They also stated creative thinking can occur while children are at play that helps facilitate problem-solving in the face of anxiety related to having a chronic illness. When using toys and play materials, children are actively coping with their emotional and experiences. Children can feel mastery as they change outcomes, express emotions, and have some sense of control (Clark, 2007).

Glazer-Waldman, Zimmerman, Landreth, and Norton (1992) reported an intervention study in which filial play therapy was used with five sets of caregivers and young children (aged 4–8 years) with a variety of chronic illnesses. These authors examined changes in child anxiety and caregiver–child relationships before and after the play sessions. After participating in play therapy sessions, children’s reports of their anxiety remained at similar levels; however, parents were better able to estimate their children’s emotional states. Glazer-Walman et al. (1992) also reported caregivers valued the play sessions and felt they afforded opportunities to restore close and positive relationships with their children. In a more recent study, Tew (2010) investigated the influence of filial play therapy versus parent training for caregivers and children with a variety of chronic illnesses. Parenting stress and caregiver ratings of their children’s emotional and behavioral functioning were assessed. Results indicated parenting stress was lower and caregivers
reported fewer emotional and behavioral problems for children in the intervention (filial) versus the comparison (training) group.

Proczkowska-Björklund, Gustafsson, and Svedin (2010) examined the play of 49 preschool-age children 2 weeks after undergoing surgery. They videotaped children’s reactions while they were playing with equipment used during the procedure (e.g., anesthetic equipment, including a “laryngoscope, needles, anesthetic masks, syringes, EKG electrodes, and stethoscope,” p. 172) that was set up in a room. There also was a “TV-bear dressed in operating theatre clothes, a toy anesthetic machine and clothing (the same kind that were used by the parent and personnel,” p. 172) as well as drawing materials and a puzzle. Observers recorded whether the children’s behaviors were characterized by approach or avoidance in terms of how they started playing with the equipment, answered questions about the play materials in the room or about what had happened to them, and the kinds of memories they recounted to the play therapist.

Findings suggested children’s postsurgery play was related to their specific behaviors/reactions and premedication outcomes before the surgery. Specifically, they found approximately 50% of the children exhibited signs of avoidance during the play session. Children were likely to avoid playing with the materials or answering questions about their experiences. Proczkowska-Björklund et al. (2010) concluded children who had a negative start to their experience could react negatively and avoid procedures and become more anxious, creating a negative, “vicious cycle” (p. 176). Moreover, they suggested that an “avoidant reaction during play may be a more direct way of studying a negative experience during the anesthetic process” (p. 176). They also concluded younger children and shy children may be at risk for experiencing more anxiety and negative reactions when faced with surgery.

Our literature search revealed research on the use of imagery to facilitate coping in children with chronic medical conditions. For instance, Walco, Varni and Ilowite (1992) used imagery, muscle relaxation, and breathing to assist children with Juvenile Idiopathic Arthritis in coping with pain related to their disease. These researchers also had children assign colors to their pain and then imagine the color space where the pain was located was shrinking and eventually going away. Older children could imagine pain as being switched on and off and then visualize flipping the switch to turn off their pain. In addition, Kazak and her colleagues (1996) used imagery in conjunction with breathing and counting techniques to help children with leukemia cope with painful procedures. Children were randomized into groups receiving either pharmacotherapy or pharmacotherapy plus guided imagery and concurrent strategies (e.g., breathing and counting). Their parents practiced using imagery with the children (e.g., going to their favorite places, such as a magic forest or enchanted garden). Children who received the therapeutic intervention were observed to experience lower levels of procedural distress compared to children receiving only the pharmacologic interventions.

GUIDELINES FOR FUTURE RESEARCH IN THE FIELD

Play therapy is an effective intervention for children experiencing medical trauma and illnesses, but it needs to be compared more systematically to other clinical interventions used with this population (Bratton et al., 2005). It is our contention that researchers and clinicians should use play as a therapeutic tool in combination with other cognitive-behavioral techniques. More information is needed on the mechanisms through which play therapy can enhance the effectiveness of problem-solving techniques, pain management strategies, and other cognitive-behavioral interventions that have been determined to be successful in enhancing the coping of children who face medical trauma and illnesses.

Moore and Russ (2006) provided several recommendations to guide future research of play therapy’s effect on the social, emotional, and behavioral functioning of children coping with
illnesses. Their recommendations include: (a) conducting more research with children who have a variety of specific medical conditions; (b) examining the impact of play on the myriad of situations and complications for children with illnesses, such as preparing for hospitalization or medical procedures, coping with the waxing and waning symptoms of a life-threatening chronic illness, facing acute symptoms related to less severe medical conditions (e.g., mild asthma), and understanding how children experience pain either related to their illness or medical procedures; (c) documenting interventions and how they work—specifically, play protocols should be carefully recorded and potentially annualized so that research can be replicated; and (d) documenting the effect of different aspects of play therapy interventions to enhance understanding of the mechanisms through which different techniques work. Our recommendations for future research on play therapy also include using a variety of measurement techniques to assess and record change in child functioning, as well as utilizing case studies and other research methods appropriate for small sample sizes, to obtain a more complete picture of the course and impact of play therapy for children who have chronic medical conditions.

CONCLUSION

Play is a tool that can connect children to their day-to-day world so they can share medical experiences and the experience of their illness with others. Sharing grief and emotions can be a powerful release, allowing children to enhance their ability to cope with uncertain courses for their illness and the multiple medical procedures that can make them feel different from their peers because they do not have control over their chronic illness.

Play therapy is a dynamic technique for assisting children with chronic medical conditions in coping with their illnesses and adjusting to the multiple stressors they face in coping with pain and medical procedures. Play is a way to express emotions, and can be an indirect method for releasing upset and sad feelings that may be difficult to express at home as children strive to protect their family members from further grief related to their medical conditions. Children's play is their world, and they can reexperience and release their emotions and process trauma in settings in which they have control over the actions of characters and the outcomes of different play situations. Because they have control over the unfolding play, it can help them mediate their level of intense emotions so they can deal with their feelings in their own time and in their own ways. This enhanced control and ability to express emotions through a safe medium is empowering for children and facilitates emotional expression and problem-solving skills. Finally, through play, therapists enter children's worlds and help them express emotions, learn to be positive and problem solve, and develop coping skills.

REFERENCES


CHAPTER
23

Play Therapy and Crisis Intervention With Children Experiencing Disasters

JENNIFER N. BAGGERLY

Children who have experienced disasters are a unique population due to their vulnerability and potential trauma symptoms. Play therapy is needed to help children overcome these symptoms and thrive developmentally. The innovative approach of Disaster Response Play Therapy (DRPT), which integrates child-centered play therapy and cognitive-behavioral psychoeducation, is one treatment for children who have experienced disasters. The purpose of this chapter is to prepare play therapists to work with children after disasters by: (a) defining the population, particularly characteristics and special needs, including potential neurophysiological, physical, cognitive, emotional, behavioral, and spiritual symptoms; (b) explaining why play therapy is appropriate; (c) describing theories best suited for this population, including Psychological First Aid and DRPT, as well as their procedural modifications; (d) discussing population-specific strategies; and (e) identifying research and evidence base.

DEFINING THE POPULATION

The population of children who experience natural and human-made disasters encompasses millions of children worldwide each year. In 2012, a total of 357 natural disasters (e.g., earthquakes, tornadoes, floods, wildfires, and epidemics) across the globe resulted in 9,655 deaths, 124.5 million victims, and $157 billion of damage (Guha-Sapir, Vos, Below, & Ponserre, 2013). These natural disasters disrupted the lives of millions of children, regardless of their age, gender, race, ethnicity, religion, or nationality. Human-made disasters (e.g., war, terrorism, mass shootings, oil spills, plane crashes) also disrupted the lives of an estimated 14.5 million children who were either refugees or displaced from their homes due to armed conflict (UNICEF, 2007).
By the end of 2013, over 11,420 children were killed in the Syrian conflict alone (Salama & Dardagan, 2013). In the United States of America, thousands of children have been exposed to human-made disasters such as oil spills and mass shootings. The combination of natural and human-made disasters has impacted an estimated 3 million U.S. children in the past year, based on the finding that 14% of a representative sample survey of U.S. children ages 2 to 17 reported a lifetime exposure to a disaster, and 4.1% reported exposure in the past year (Becker-Blease, Turner, & Finkelhor, 2010).

Characteristics and Special Needs
When working with children who experienced a disaster, play therapists must consider their unique characteristics and special needs. Particularly, play therapists should be mindful of children's vulnerability, typical symptoms, and atypical symptoms.

Vulnerability
The most prominent characteristic of children exposed to a disaster is their vulnerability. Children are vulnerable after a disaster for several reasons. First, they are in a critical developmental period in which their brains and bodies can be altered by environmental experiences (Gaskill & Perry, 2012). Second, their ability to recover from disasters is largely influenced by the quality of caregiving they receive (Scheeringa & Zeanah, 2001). Finally, children are limited in their interpersonal and institutional power to advocate for their own needs and obtain resources. Thus, children need special attention during and after a disaster to ensure their physical and psychological well-being.

Typical Symptoms
Both natural and human-made disasters can result in a range of minor to severe typical short-term or atypical long-term symptoms in children. Most children will only experience temporary symptoms after a disaster (LaGreca, 2008). These short-term symptoms may occur in some or all categories of neurophysiological, physical, cognitive, emotional, behavioral, and spiritual symptoms (Baggerly & Exum, 2008).

In the category of neurophysiology, perceived or actual threat of a disaster can cause children's brainstem and diencephalon to activate a coping response or a fight or flight reaction. In his seminal research, van der Kolk (1994) explained “the simultaneous activation of corticosteroids and catecholamines could stimulate active coping behaviors, while increased arousal in the presence of low glucocorticoid levels may promote undifferentiated fight or flight reactions” (p. 256). Perry, Pollard, Blakely, Baker, and Vigilante (1995) expounded that children's lower brains may activate an arousal response of fight or flight or a dissociative response of freeze and surrender. Consequently, disasters can disrupt the abilities of children's limbic systems to regulate emotions, mood, behavior, and learning. Their cortices' functions of insight, planning, time sequence, self-awareness, and social emotional competence can also be disrupted.

Due to this neurophysiological fear response in the lower brain, children can experience numerous physical symptoms. Children may have headaches, stomachaches, decreased appetite, sleeplessness, bedwetting, or fatigue (Brymer et al., 2006; LaGreca, 2008; Vijayakumar, Kannan, & Daniel, 2006). The most common short-term problem children experience after a natural disaster is sleep disturbance. Nearly 80% of parents questioned after an earthquake in the San Francisco Bay Area reported sleep disturbances for their children (Vogel & Vernberg, 1993). Comparable results from a hurricane disaster indicated that more than 50% of their parent sample
of preschoolers reported sleep refusal or sleep resistance as a problem for their children (Sullivan, Saylor, & Foster, 1991).

In the category of cognitive symptoms, disasters can change children’s beliefs and judgments, such as believing all rain storms will destroy their home (LaGreca, 2008). Children may have difficulty concentrating or making decisions, which can impact academic performance. Pane, McCaffrey, Kalra, and Zhou (2008) found that students displaced in Louisiana after the 2005 hurricanes had negative changes in their standardized test scores. McFarlane, Policansky, and Irwin (1987) found significant decreases in academic achievement among children exposed to a devastating bushfire 8 months post disaster. Over time, the rate of underachievement actually increased, as almost a quarter of the sample was not performing at full potential 26 months post disaster.

In the category of emotions, disasters may hinder children’s abilities to manage their feelings of fear and anger, connect with others, feel worthy of life, and maintain a healthy self-esteem (LaGreca, 2008). Frequently, young children will experience separation anxiety after a disaster. In fact, separation anxiety from a parent or caregiver was reported to be more stressful than the actual disaster itself (Yorbik, Akbiyik, Kirmizigul, & Sohmen, 2004). Children may exhibit fear of trauma reminders, such as rain. For example, after a hurricane, a boy refused to take a bath for over a month because the family was hunkered down in the bathtub when the hurricane destroyed the roof of their house.

In the category of behavior, children affected by disasters may experience social withdrawal, hypervigilance, bed-wetting, belligerence, aggressiveness, or school refusal (Brymer et al., 2006; LaGreca, 2008). Children may also engage in traumatic play reenactments in an attempt to gain a sense of mastery over the overwhelming experience (Terr, 1990). For example, boys in a hurricane shelter played by spinning around and knocking things over.

In the category of spirituality, disasters can cause children to change their beliefs about God and their worldviews (Baggerly & Exum, 2008). Children may view God as being angry at them and view the world as a dangerous place. For example, one girl in a hurricane shelter used a dart gun to shoot a cross, saying “I’m zapping God like he zapped my family during the hurricane.”

Fortunately, most of these typical symptoms will resolve within a short time. Speier (2000) stated, “Generally, most children recover from the frightening experiences associated with a disaster without professional intervention. Most simply need time to experience their world as a secure place again and their parents as nurturing caregivers who are also again in charge” (p. 9).

Atypical Symptoms

Although these reactions to disasters typically resolve within 30 days, some children may experience severe and ongoing symptoms, such as depression, anxiety, and posttraumatic stress disorder (PTSD) for months and years, if left untreated (Kronenberg et al., 2010). After Hurricane Andrew, moderate to very severe symptoms were reported by 55% of school-aged children 3 months post disaster and by 34% at 10 months post disaster (LaGreca, Silverman, Vernberg, & Prinstein, 1996). Similarly, 1 year after Hurricane Katrina, 61% of elementary school children living in high-impact areas screened positive for elevated PTSD symptoms (Jaycox et al., 2010). Approximately 2 years after Hurricane Katrina, 31% of parents surveyed reported their children had clinically diagnosed depression, anxiety, or behavior disorders, and 18% reported notable decreases in academic achievement (Abramson, Stehling-Ariza, Garfield, & Redlener, 2008).

To predict which children are most likely to have atypical long-term symptoms after disasters, play therapists need to assess disaster characteristics, disaster exposure, and child characteristics (Rosenfeld, Caye, Ayalon, & Lahad, 2005). Disasters that are longer in duration and of higher intensity result in more severe symptoms (LaGreca, 2008). Human-made disasters tend to result
in more serious mental health problems because people's trust in social order has been violated (U.S. Department of Health and Human Services, 2004). Children who had closer exposure and perceived life threat during the disaster tend to experience more severe symptoms (LaGreca et al., 1996). With regard to children's characteristics, females and younger children tend to have more severe symptoms than children with prior abuse or victimization (Becker-Blease et al., 2010).

Play therapists can screen children for atypical ongoing symptoms by using assessments such as the Child's Reaction to Traumatic Events Scale-Revised (Jones, Fletcher, & Ribbe, 2002) or the Disaster Experiences Questionnaire (Scheeringa, 2005). PTSD symptoms can be measured by the Trauma Symptom Checklist for Young Children (Briere, 1996). Other recommendations for assessment instruments are available from the National Children Traumatic Stress Network (www.nctsnet.org).

WHY PLAY THERAPY IS APPROPRIATE

Play therapy is appropriate for children who have experienced disaster-related trauma for three reasons. First, the neurophysiological impact of a frightening event such as a disaster can decrease brain functioning within Broca's and Wernke's areas, which control speech production and speech comprehension (Van der Kolk, 2007). As a result, children can literally become scared speechless. The nonverbal symbolism of play allows children to express their experiences. Toys become children's words, and play becomes their language to communicate their reactions to the frightening event (Landreth, 2012). As the play therapist tracks children's play, the frightening implicit memory becomes an externalized explicit memory that can be processed.

Second, play therapy facilitates the processing of the explicit memory of disaster reminders through systematic desensitization. Children become relaxed through the experience of play and gradually approach items, such as toy ambulances, or gradually recreate scenes, such as running to a shelter (Baggerly, 2012). If the disaster reminders become too overwhelming, children can self-direct their play by switching to a soothing activity such as rocking a baby doll. Repeating this pattern of gradual exposure through children's self-paced play gives them the courage to interact with the disaster reminders without anxiety.

Third, the play therapist's therapeutic responses, such as reflecting feelings and enlarging the meaning, help children reach an emotional understanding of the disaster (Terr, 1990). When play therapists express empathy during children's play, children's mirror neurons are activated, their awareness increases, and adaptive neural networks are ingrained, thereby cultivating a sense of well-being (Siegel, 2006, 2007). Through this process, children make meaning of the frightening experience. The implicit and explicit memory becomes integrated into the self-structure so that energy is no longer spent in avoidance of trauma reminders. Rather, children have freedom to use their energy to continue typical development.

PLAY THERAPY THEORIES

Mental health interventions for children are selected based on the phase of disaster (LaGreca & Silverman, 2009). Some play therapy theories are more conducive for certain phases of disasters than others. In the immediate postimpact phase, all children should receive psychological first aid (PFA) and large-group interventions to increase coping and reduce typical symptoms. PFA is rooted in cognitive-behavioral theory (CBT) with a solution-focused approach whose goal of coping and stabilization can be accomplished in a time-limited single interaction, often only
In the short-term recovery phase (i.e., a few weeks to a few months), children should also receive small-group play therapy based on CBT (Baggerly & Mescia, 2005; Brymer et al., 2006) in order to reinforce coping strategies in numerous children within a limited time (Felix, Bond, & Shelby, 2006).

In the return-to-life phase (i.e., a few months to a year), children with persistent symptoms should receive individual Disaster Response Play Therapy (DRPT) (Baggerly, 2007). DRPT is based on the theory of child-centered play therapy (CCPT) with cognitive-behavior interventions integrated into the last 15 minutes of the session. The integrated approaches of CCPT and CBT facilitate the three stages of trauma recovery: establishing safety, restorative retelling of the trauma story, and reconnecting with family, peers, and social supports in the community (Herman, 1992). The CCPT playroom and procedures help establish safety and facilitate the restorative retelling of the trauma story. The CBT strategies cultivate coping strategies to help children reconnect with others.

**Procedures Based on Disaster Stages**

**Immediate Postimpact Phase: Psychological First Aid**

During the immediate postimpact phase, disaster survivors congregate at shelters or facilities. The focus is on immediate needs and physical safety. Psychological interventions are brief and focus on reducing symptoms and long-term difficulties (LaGreca & Silverman, 2009). In this phase, PFA is considered the treatment of choice (LaGreca & Silverman, 2009). “PFA is an evidence-informed modular approach to help children, adolescents, adults, and families … designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping” (Brymer et al., 2006, p. 5). This intervention is delivered one-on-one in about 15 to 20 minutes, usually at a disaster relief center, medical facility, or near the site of the disaster after safety has been established. Baggerly and Mescia (2005) developed a modified PFA approach for children in the C³ARE model.

**Child C³ARE Model: Initial Individual Intervention**

The C³ARE model is an initial individual intervention that helps children to stabilize after a disaster (Baggerly & Mescia, 2005). In this six-step procedure, play therapists will check, connect, comfort, assess, refer, and educate as follows:

1. **Check** the scene to ensure it is safe to enter, the structure to identify the head authority on scene, self to ensure own preparation, and the survivor to ensure the child is physically safe.
2. **Connect** with the child by being calm, getting on the child's eye level, and using a puppet to establish rapport; with the child's guardian by introducing yourself; and with specialized services that are needed immediately such as emergency medical services. For example, play therapists could say, “Hello, my name is ______, and I'm helping out here today. This is my puppet named __________. Is this your family member or friend? Is it okay if I visit with you? Does anything hurt or feel bad? What do you need right now?”
3. **Comfort** the child with calm, reassuring words; provide food, drinks, and blankets; guide in body relaxation through deep breathing, blowing bubbles, and progressive muscle relaxation; and encourage the child to draw a safe, happy place. For example, say, “You've been through a difficult time but you are safe right now. Would you like something to
eat or drink? I know some ways to help you be calm. Blow these bubbles. Now tense your muscles like a soldier and relax like a rag-doll. Draw a safe and happy place on this paper.”

4. Assess (informally through observation) child’s coping and functioning; monitor physical and behavioral status; identify child’s risk and resiliency factors; and determine current and potential needs. Play therapists can ask, “What do you think you need right now and in the future to help you get along? In a little while, I’ll help your family find out how to get those things.”

5. Refer the child and guardian to needed services and resources, connect them with indigenous helpers and safe peers, and provide written handouts of typical trauma symptoms and coping strategies. Say, “You said you needed ______. This information may help you and your family. What questions do you have? Let me know when you have other questions or need help with something.”

6. Educate children and guardians about typical trauma responses, normalize these responses, and encourage positive coping strategies such as thought stopping, distraction techniques, singing, praying/meditating, and playing with other children. Play therapists can say, “Many children notice changes in their body or in the things they do after something scary happens. Some have bad dreams or cry a lot or don’t like to play outside. Here is a paper with different changes that happen to some kids. What changes have you noticed in you? These are normal changes that happen in normal kids like you when something different and scary happens. What do you usually do to feel better when you feel bad? I know some other things you can do. Would you like to learn? Try this…. Here’s a paper that tells you lots of things you can do. I’m going to get kids together later to play games. Would you like to come? I’m going to visit some other kids now. I’ll come back later to let you know when the games start. Thank you for visiting with me. It was nice to meet you. Bye.”

Throughout this intervention, the play therapist should use basic skills of listening carefully, reflecting feelings, communicating clearly, focusing on concerns, and maintaining confidentiality (Baggerly, 2006). Play therapists can learn details on how to implement stabilization and trauma recovery tools from Baranowsky, Gentry, and Schultz (2011).

**Short-Term Recovery Phase: Small-Group, Play-Based Interventions**

Given that crisis intervention requires a more active directive stabilization approach than typical counseling and play therapy (Brymer et al., 2006), play therapists need to integrate play therapy techniques into small group counseling sessions with children experiencing ongoing symptoms during the short-term recovery phase. Teaching children cognitive behavioral skills will help them establish safety and stabilization in their body, cognitions, behavior, emotions, and social relationships (Baggerly, 2006). Felix, Bond, and Shelby (2006) adapted several strategies from PFA (Brymer et al., 2006) protocol for preschool and elementary school children who experienced disasters.

**Normalize symptoms**

Many children may be embarrassed of their disaster reactions, such as bed-wetting, and adults may be distressed by children's reactions, such as aggressiveness or avoidance of disaster reminders. Play therapists should normalize children's responses to disasters by informing adults and children
of typical reactions. This information can be conveyed through children’s storybooks (Holmes, 2000; Shephard, 1998) and puppet shows created to address local concerns. For example, after the 2004 tsunami, Sri Lankan teachers were distressed that some children refused to play outside for fear that another tsunami would come. Play therapists developed a puppet show that explained this as a normal response and reminded them how to look at physical evidence to determine when another tsunami is imminent (Baggerly, 2006).

Manage hyperarousal

Some children experience ongoing hyperarousal in their bodies because they are unable to deactivate their fight or flight responses after a disaster (Perry et al., 1995). As a result, many children have general agitation and may avoid reminders of the disaster, such as being near the water, in an attempt to manage their anxiety. Play therapists should teach children self-soothing, relaxation techniques to calm their bodies. These procedures include (a) taking deep breathes through playful activities, such as blowing soap bubbles or pinwheels; (b) progressive muscle relaxation by tensing like a tin man and relaxing like a rag doll; (c) focusing on positive images by drawing happy places, engaging in mutual story-telling with a positive ending, or meditating on peaceful places; and (d) teaching parents and guardians to conduct soothing sessions that might include massaging, rocking, and singing to their children (Felix et al., 2006). For example, in Sri Lanka, many children were afraid to go to the beach after the tsunami. Play therapists taught children and teachers deep breathing and positive images through the following song, which is to the tune of “Twinkle, Twinkle, Little Star”: “I am safe and I am strong. Take a breath and sing this song. I’m growing stronger every day. I know that I will be okay. I am safe and I am strong. Take a breath and sing this song” (Baggerly, 2006). Gradually, children returned to the beach to help with chores of fishing and clothes washing.

Manage intrusive reexperiencing

Some children experience intrusive thoughts of disaster-related events because brain alterations during a trauma encode indelible pictures in their implicit memories (van der Kolk, 2007). Play therapists should teach children methods of containing these images and grounding themselves. These procedures include: (a) “changing the tape” by replacing the thought with a predetermined song, story, or saying, such as “I’m safe right now and I know it because I have...” and (b) grounding activities such as rubbing their stomachs or rubbing their hands together (Felix, et al., 2006). Play therapists can also amend the 3-2-1 sensory grounding and containment procedure (Baranowsky et al., 2011) by asking children to play a 3-2-1 game. For this game, ask children to identify three objects above eye level, three sounds everyone can hear, and three things they can touch; then two things they see, hear, and touch; followed by one thing they see, hear, and touch. Implementing this activity with children in Hurricane Katrina shelters helped them refocus on the here and now as well as to realize their surroundings were safe (Baggerly, 2006).

Increase accurate cognitions

Due to their egocentric and concrete cognitions, some children may have misattributions of the cause of disasters, such as their bad dreams or someone’s bad behavior. Play therapists should assess misattributions and give accurate or at least alternative explanations. These procedures include: (a) making a Q-sort of possible reasons for the disaster and asking children to sort by
true and untrue; (b) creating a blame box for younger children to put in drawings of who or what they blame and then drawing the correct reason together; (c) developing a puppet show in which puppets ask about misattributions and another puppet gives accurate reasons; and (d) acting out a radio show of people calling in with questions and an expert giving correct information (Felix et al., 2006). In Sri Lanka, play therapists performed a puppet show in which a small puppet timidly asked if the tsunami was caused by bad dreams or by someone putting something in the ocean, while a larger puppet calmly explained that an earthquake under the water caused the tsunami (Baggerly, 2006).

**Increase effective coping**

Young children have not had the life experience to develop a wide range of coping strategies and do not have the cognitive ability to accurately evaluate the effectiveness of their coping strategies. Because negative coping strategies of social withdrawal and self-blame have been correlated with increased depressive symptoms (LaGreca et al., 2010), play therapists should help children differentiate between effective and ineffective coping strategies and develop numerous adaptive coping strategies. Matching children's preferred coping styles (“attenders” who focus on the stimulus versus “distractors” who focus away from the stimulus) with corresponding interventions has been shown to be more effective in decreasing symptoms (LaGreca, 2008).

Procedures to increase effective coping include: (a) writing or drawing maladaptive coping strategies on cards and telling children to “pass the trash”; (b) playing card games in which children find pairs of adaptive coping strategies and throw out maladaptive strategies; (c) playing coping charades, in which children act out positive coping strategies; and (d) organizing developmentally appropriate, cooperative play or games, such as duck, duck, goose and relay races (Felix et al., 2006). For example, after the Oklahoma tornados, play therapists guided children in making a coping bracelet of five colorful cards on which they drew effective coping strategies.

**Seeking social support**

Many young children socially withdraw or cling to their parents after a disaster. Some older children withdraw from healthy social support by engaging in disruptive behavior with peers or dissociating via video games. Play therapists should teach children appropriate ways of seeking healthy social support and decreasing unhealthy social withdrawal. These procedures from Felix et al. (2006) include: (a) role-playing how to ask for social support from four different sources, such as peers, parents, staff, and teachers; (b) making support coupons by writing or drawing a request for help on paper and giving it to a trusted peer or adult when help is needed; and (c) creating a paper doll support chain in which linked images of dolls are labeled with names of people who provide support. For example, after Hurricane Katrina, some children were angrily demanding adults play with them, so play therapists helped the children role-play ways to politely ask for adults to play (Baggerly, 2006).

**Foster hope**

When disasters destroy homes, schools, communities, and lives of loved ones, children lose their framework for safety, order, and meaning. Consequently, many children lose a sense of hope. Play therapists can be a part of the compassionate humanitarian response that reignites children’s hope and positive images for the future. Procedures from Felix et al. (2006) to increase hope include: (a) role-playing family and community rebuilding efforts; (b) creating stories, poems, or songs
Play Therapy and Crisis Intervention With Children Experiencing Disasters 463

that express hope; and (c) identifying community support projects that children can participate in, such as making thank-you cards for police officers or building a rock garden. For example, in Sri Lanka, play therapists guided children in finding natural objects on the beach and placing them in a sandbox to symbolize the rebuilding of their community (Baggerly, 2006).

Before administering these interventions, it is important to be aware of children’s prior mental health history and/or trauma issues, which may become salient after a natural disaster. For example, when play therapists provided interventions after the tsunami, some Sri Lankan children stated their parents were killed by landmines during the civil war (Baggerly, 2006). While working with families after Hurricane Katrina, some parents indicated that their children’s ADHD symptoms were more pronounced. Play therapists should use discernment in implementing interventions during the short-term recovery phase so prior trauma issues are not triggered. Again, the goal during disaster response is stabilization. If prior mental health history and/or trauma issues are salient, the play therapist should focus on grounding and containment interventions to stabilize the child and give a referral to a local mental health professional for follow up.

**Long-Term Recovery: Disaster Response Play Therapy**

DRPT integrates child-centered play therapy with CBT strategies that were previously described (Baggerly, 2007, 2012). Child-centered play therapy (Axline, 1947), as described by Landreth (2012), is implemented for the first 35 minutes of the session to help children establish a sense of safety and play out a restorative retelling of their trauma narrative. Play-based CBT psychoeducational strategies are implemented for the remaining 15 minutes of the session to help children decrease symptoms, increase coping, and reconnect with family and community members. DRPT is illustrated in the following composite case study.

**Case Study**

Jonah is a 7-year-old Caucasian boy with ADHD who experienced a tornado while he was at school. The tornado ripped off the school’s roof while Jonah, his classmates, and the teachers were crouched in the hallway. Unfortunately, Jonah’s teacher and a classmate were killed from falling debris. Two months after the tornado, Jonah continued to exhibit symptoms of hyperarousal (i.e., sleeplessness and aggression), avoidance of trauma reminders (i.e., school refusal and fear of rain), and intrusion (i.e., nightmares and flashbacks during rain). Jonah lived with his grandmother because his mother was addicted to drugs.

Jonah had several risk factors that predicted his ongoing symptoms. His risk factors were prior mental health concerns of ADHD, prior trauma of abandonment by mother, close proximity to the disaster, and intensity of witnessing death. Jonah’s scores on the Trauma Symptom Checklist for Young Children were in the clinical range for Intrusion, Avoidance, Arousal, Anger, and Posttraumatic stress-Total.

Jonah participated in six individual DRPT sessions. The playroom was equipped with toys representing the categories of (a) nurturing (e.g., bendable doll families, dollhouse, dishes, baby bottle, doctor’s kit, blankets); (b) aggressive release (e.g., a 4-foot Bobo blow-up punching doll, dart gun, knife, toy soldiers); and (c) creative expressive (e.g., sandbox, farm and zoo animals, police and fireman outfits, cars, crayons, paper, scissors). To facilitate
disaster reenactment, specific toys were added including a toy school house, school bus, and a Thunder Tube (a special drum with a wire that makes a tornado sound).

Standard child-centered play therapy skills were implemented, including tracking play behavior, reflecting feelings and content, returning responsibility, encouragement, building self-esteem, setting therapeutic limits, facilitating understanding, and enlarging the meaning. During the first two sessions, Jonah's play themes were exploration of toys and aggression of punching Bobo doll. The psychoeducational part of the sessions centered on demonstrating deep breathing by using soap bubbles, stabilizing techniques of the 3-2-1 game, thought-stopping by clapping and rubbing hands together, and normalizing symptoms through puppet shows.

During the third and fourth sessions, Jonah began to reenact the trauma scene first through gross motor activities and then through fine motor activities in the sandbox as illustrated in Table 23.1.

Table 23.1 Play Therapy Transcript and Analysis

<table>
<thead>
<tr>
<th>Child and PT Comments</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child: Picks up and hits Thunder Tube. Jumps back in startled response.</td>
<td>Toys are an important part of systematic desensitization. When children are ready, they will approach a toy that represents a trauma reminder. Gradual exposure allows for a sense of mastery. Reflection of feeling increases awareness and connects visceral body response with feeling words. The safe setting and warm relationship with PT gave him sense of safety to try again. Providing encouragement and building self-esteem facilitates his sense of mastery. Since he experienced safety and encouragement, he developed the courage to begin the trauma reenactment in his own time. Reflection of content helps child know PT understands his play. PT enlarged the meaning by connecting present play with past experience to facilitate mastery over the trauma. Children reenact trauma scenes in an attempt to reach an emotional understanding about what happened and to create meaning. Reflection of feeling is directed toward the dolls rather than the child because his projection onto the toys provides a safe psychological distance. An esteem building statement gives him credit for knowing safety skills. His tone and words reveal an incongruence or cognitive dissonance between his ideal wishful outcome and what actually happened.</td>
</tr>
<tr>
<td>PT: “You were startled by that sound.”</td>
<td></td>
</tr>
<tr>
<td>Child. “Yeah, that scared me.” Looks at it a minute. Hits Thunder Tube again without jumping.</td>
<td></td>
</tr>
<tr>
<td>PT: “You were brave in making the sound again. This time you were not scared as much.”</td>
<td></td>
</tr>
<tr>
<td>PT: “You are warning them. You know that siren sound. You heard that before.”</td>
<td></td>
</tr>
<tr>
<td>Child: “Yup.” Then yells in a panicked voice, “Everybody duck and link arms so the tornado won’t suck you away!” Kicks play school so that furniture and dolls fall over.</td>
<td></td>
</tr>
<tr>
<td>PT: “Something very scary is happening to the people at school. They know something they can do to try to stay safe.”</td>
<td></td>
</tr>
<tr>
<td>Child: Continues to yell in a panicked and angry voice, “Yes, but it does no good because look, a kid and teacher die anyway.” He drops a block onto some of the dolls.</td>
<td></td>
</tr>
</tbody>
</table>
Table 23.1 (Continued)

<table>
<thead>
<tr>
<th>Child and PT Comments</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>PT: “It’s so terrifying and so sad that they died. So very, very frustrating that no one could protect them. Sometimes bad things just happen and people can’t control it.” Child: Looks down at the school and sighs. Then slowly moves toward the sandbox. He places his hand in the sand to smooth it over. PT: “You slowed down your body and breathing. You’re calming yourself by smoothing the sand.” Child: Gathers dolls from the play school and puts them in the sand. Buries some dolls. Then places soldiers and police on the edge of the sandbox. PT: “Some of them are below the sand. Those [pointing to soldiers and police] are next to the wall.” Child: Quietly says, “Yes, here come the heroes to save them all!” PT: “The heroes really want to rescue them.” Child: With slightly more energy says, “They are all saved this time!” PT: “They always try, and this time they saved them. It’s important for people to do what they can to help and hope for the best.”</td>
<td>Reflection of feeling is delivered in the tone of the stated feeling to convey empathy. PT used a soft and sad tone to bring to awareness the lack of control in an attempt to facilitate understanding. The child’s energy shifts to slower activity level. He appeared to be integrating the new the awareness while self-comforting by soothing the sand. PT’s response is intended to increase child’s body awareness and encourage his ability to self-regulate. Children often shift from a gross motor trauma reenactment to a fine motor trauma reenactment to gain a different perspective. PT tracks play behavior without naming objects or assuming they are dead to allow the child to lead the play and promote his creativity. Play allows children to experience in fantasy what they long for in reality. PT facilitates understanding by reflecting the play theme of rescue. Child is creating a restorative reenactment of the trauma to restore his sense of personal hope and power. PT enlarges the meaning by connecting the immediate play with the child’s internal longing to rescue and maintain hope with realistic expectations.</td>
</tr>
</tbody>
</table>

After the 35 minutes of CCPT in the third and fourth sessions, the PT directed the child in a psychoeducational activity of creating “My Storybook” that describes the events before, during, and after the tornado. Jonah drew the pictures and the PT transcribed what his thoughts and feelings were during each event. This storybook activity revealed which parts of Jonah’s thought process were accurate and which parts needed some attention. For example, Jonah stated a thought that “if I had been sitting next to the teacher, I could have saved her.” The PT reflected his desire to protect her and added a realistic expectation. “You really wanted to protect her. Unfortunately, even if the strongest man in the world had been sitting next to her, he still could not have saved her, even though he would have really wanted to do so.” Bringing this fact to his awareness helped Jonah accurately interpret the experience so he could integrate into his self-structure that he is a caring, protective boy rather than a weak, guilty boy.

In sessions five and six, Jonah’s rescue play theme became shorter in duration and less intense. He focused his play on building “strong houses” out of blocks. These play themes of mastery and creativity indicated movement toward resolution. Psychoeducation during the last part of these sessions reinforced symptom management and social skills strategies of appropriately engaging peers and adults when he was upset.
During the last session, Jonah’s grandmother was invited into the session to view the puppet show Jonah had created, which demonstrated how to ask for help when he was upset. He also demonstrated his coping strategies and shared his “My Storybook.” His grandmother affirmed his gradual improvement by reporting he had been brave in attending school and had not been in fights for 2 weeks. The PT concluded the sessions by teaching Jonah's grandmother some bonding activities (Bailey, 2010) and provided her with a postdisaster parenting resource (LaGreca, Sevin, & Sevin, 2005).

**POPULATION-SPECIFIC TECHNIQUES AND STRATEGIES**

Populations of children who may need specific techniques and strategies are those with certain interpersonal, cultural, and social contexts. With regard to interpersonal contexts, children tend to mimic their parents and significant adults’ reactions to a disaster. Parents who display excessive anxiety tend to have children who do so as well (LaGreca et al., 1996). Therefore, an added strategy for this population is intensive parent consultation to teach parents their own self-soothing strategies. One creative approach is to invite parents into the end of the play therapy session so their children can teach them self-soothing strategies. This strategy allows for children and parents to support each other in managing their anxiety.

Cultural context influences children’s interpretations of the causes of disasters, as well as their coping strategies (Rosenfeld et al., 2005). Some cultures may attribute the disaster to God’s will or punishment, whereas others attribute it to scientific reasons. In order to honor these differences, it is imperative for the play therapist to ask children’s parents, cultural informants, or religious representatives their perspective on why the disaster occurred. For example, some Tamil children in Sri Lanka believed the 2005 tsunami was due to God's punishment for the civil war. Play therapists acknowledged this interpretation and focused on their strength in surviving. Likewise, since cultures emphasize various coping strategies, play therapists can ask children and their families which strategies they use the most. For example, Tamil children were adept at yoga and meditation, and their parents were pleased to see them using this strategy.

With regard to social context, children from groups with less economic and sociopolitical power, such as ethnic minorities and other marginalized populations, tend to have more severe symptoms (LaGreca, 2008). Play therapists may need to provide social justice advocacy in order to meet a family's needs. For example, if a family does not have immigration documentation, they may not seek disaster relief services. Play therapists can contact the relief agencies to arrange for needed services.

Children's responses may also vary based on the wider, social, political, and economic contexts, including disaster planning and relief efforts. Children who perceive and receive more support and resources from community members, government agencies, and nongovernment organizations tend to have less severe symptoms. In contrast, children who perceive the government is against them may have more severe symptoms (Abramson et al., 2008). Play therapists may need to provide children the CBT strategy of reattribution. One strategy for doing this is to play the garbage or treasure game, in which children distinguish ideas regarding disasters as either true (treasure) or false (garbage). For example, the idea that “children and government agencies can help in disaster recovery” is treasure, while the idea that “the government caused the disaster” is garbage. Play therapists help children identify the reason the idea is treasure or garbage.
RESEARCH/EVIDENCE BASE

Research on the effectiveness of PFA in general (i.e., with adults or children) is lacking for several reasons. First, compared to other psychological interventions, PFA is relatively new, with wide distribution of the PFA field operations guide occurring in 2006. Second, because disaster survivors are considered a very vulnerable population, it is difficult to obtain institutional review board approval in a timely fashion. Even if it is obtained, people in such a distraught situation may be reluctant or even offended that researchers are asking them to be research participants. Finally, the chaotic nature of a disaster and the disbursement of people make it practically impossible to conduct a needed randomized treatment control group design. Consequently, a research analysis of peer-reviewed literature from 1990 to 2010 found “adequate scientific evidence for psychological first aid is lacking but widely supported by expert opinion and rational conjecture” (Fox et al., 2012, p. 247).

DRPT is also subject to the same difficulties in research implementation. Despite numerous case studies, there are only two published control group research studies on CCPT after disasters. Fortunately, both of these studies show evidence that CCPT is effective after a disaster. Shen (2010) found that after child-centered play therapy, elementary school-age Taiwanese children who experienced an earthquake had significant decreases in their anxiety and suicide risk in comparison to the control group. In their randomized control study, Schottelkorb, Doumas, and Garcia (2012) found that children who were war refugees had significant decreases in posttraumatic stress symptoms in both the CCPT and TF-CBT groups. Schottelkorb et al.’s finding was important because it showed that CCPT was as effective in decreasing trauma symptoms as the evidence-based TF-CBT. Based on these findings, it is rational to surmise that DRPT, which combines CCPT and CBT would also be effective in reducing trauma symptoms. Such studies are planned after future disasters.

CONCLUSION

Millions of children experience natural or human-made disasters every year. Children are the most vulnerable population during a disaster due to their critical developmental period and their lack of power and resources. Although most children experience only temporary symptoms, some children will have ongoing neurophysiological, physical, cognitive, emotional, behavioral, and spirituality symptoms. Play therapists can be a key part of a disaster response approach by providing the C’ARE model in the immediate postimpact phase; small-group, play-based interventions during the short-term recovery phase; and disaster response play therapy during the long-term recovery phase. In so doing, play therapists can promote recovery and resiliency in children affected by disasters.

REFERENCES


Scheeringa, M. S. (2005). Disaster experiences questionnaire (Unpublished measure). Tulane University, New Orleans, LA.


PART

5

Play Therapy in Nontraditional Settings
Pthomegroup
A typical pediatric medical setting encompasses a wide range of patients, presenting concerns, and disciplines. Many children are all too familiar with such contexts. Recent studies estimate 7% to 18% of children have a chronic health condition (Cousino & Hazen, 2013), and 5 out of 100 children are hospitalized annually for an illness, injury, or disability (Fuhrmann, 2010). Studies also demonstrate an increasing trend of families using the emergency room for primary care or routine visits (Amerigroup Real Solutions in Health Care, 2011). Clearly, in any given year, large numbers of children find themselves in a pediatric medical setting. Fortunately, many top-ranked pediatric hospitals now ensure they have psychological services in addition to the medical services provided, opening up an opportunity for play therapy to exist in this specialized and nontraditional setting.

In a pediatric medical setting, children are exposed to a very abstract and adult world of medicine and are forced to navigate its avenues with the cognitive understanding and limited coping skills belonging to their developmental stage. Citing Sourkes (1982), Goodman (2007) notes “children often have two versions of an illness; the medical version they can repeat verbatim, and their own private version” (p. 206). One of the many jobs of the therapist in the pediatric medical setting is to help a child explore this private version and make sense of his or her new world. The pediatric medical setting often presents a unique challenge as the therapist works with not only the primary patient, but also the entire family system. This unique element brings forth different obstacles and considerations than those of other more traditional counseling settings.

DEFINING THE SETTING

Characteristics of the Setting

One of the defining characteristics of the medical setting is the breadth and complexity of presenting cases. A child recently diagnosed with heart failure might also experience bullying at school, parents in the middle of divorce proceedings, academic struggles, or a comorbid psychiatric diagnosis. The child’s medical diagnosis only exacerbates such issues rather than lessening
the impact of other psychosocial stressors. As therapists, we know children do not exist in a vacuum, and the same is true for children in a hospital setting. Such medical diagnoses are not the only thing happening in their worlds. In light of this, many hospitals are designed to provide additional ambulatory services through clinic settings, with some providing primary care avenues for both patients and families. These settings allow the therapist to provide a contextually sensitive treatment modality: one that fits the child’s diagnosis as well as other psychosocial and filial factors.

Another unique feature of a pediatric medical setting compared to a more traditional setting is children and adolescents often present to the hospital for acute or chronic reasons. Lengths of admissions can vary based on presenting concerns, causing the window of opportunity for intervention to vary from case to case. In addition, larger hospital settings often treat children from a wide geographic area due to a hospital’s specialty clinics or certifications. In such contexts, a therapist must discern whether he can provide consistent, effective treatment, or if his patient needs to be referred elsewhere. These choices are especially important in cases in which the patient is either briefly or infrequently on campus. While some of these children might benefit from short-term work, other patients are better suited to a long-term setting with a consistent provider. In such cases, fostering a therapeutic relationship with a child struggling with attachment concerns and a trauma history, or a patient who cannot commit to consistent therapy sessions due to geographical constraints, would not be in the best interest of the child. Instead, identifying community resources and educating caregivers on the goals and importance of treatment might be the therapist’s only role with the family.

Hospitals have invaluable multidisciplinary resources for patients and families. This is a setting where a given patient might receive physical therapy, speech therapy, occupational therapy, massage therapy, music therapy, and school services. The play therapist is an integral member of this team. This being the case, communicating with a variety of staff members and identifying when to involve other departments is an essential role of the play therapist in the medical setting.

Finally, play therapy programs within the hospital provide an important opportunity to capture children who might not be able to be seen by community providers due to lengthy admissions or frequent cancellations due to medical symptoms. In such cases, a treatment program that can provide care on both an inpatient and an outpatient basis allows for the best continuity of care. On any given day, the play therapist might interact with patients and their families in a hospital room, a waiting room, an oncology clinic, or a playroom.

**Why Play Therapy Is Appropriate**

Medical events are often frightening, confusing, and painful. It is important to note children experience these stressors through their own perceptions and filters. One child may find a finger prick to be the most stressful medical procedure, whereas another may find swallowing pills to be the most stressful. Assessing a child's subjective perspective is critical to determining which events are the most traumatic and anxiety provoking. However, it can be difficult, if not developmentally impossible, to verbalize such feelings, especially with younger children. Even older children with higher verbal and cognitive skills may find the discussion of these events to be retraumatizing or too overwhelming. The metaphors and symbols latent in the playroom allow for a gradual and safe exposure regulated by the child or adolescent. In the safety of the therapy room, play bridges the gap between the abstract concepts of illness and a child's concrete cognitions. This provides an increased understanding and mastery over the foreign medical world. Play changes "what may be unmanageable in reality to manageable in fantasy" (Landreth, 2002, p. 12).

Play therapy is a developmentally sensitive approach to assessing and treating children in the medical setting. It can provide the mechanism for assessing and correcting younger children's
distortions of their illnesses and medical experiences. For instance, when a child uses the medical items in the playroom to demonstrate how a baby doll receives a shot “because he was bad,” the therapist has the opportunity to intervene with therapeutic limit-setting and appropriate psychoeducation to correct the child’s perceptions. In the hospital setting, the normal tasks and course of development are often impeded. Infants struggle to make appropriate attachment connections; preschoolers demonstrate regression with previously mastered skills such as toilet-training; and school-aged children experience decreased levels of self-esteem. Adolescents experience decreased independence, a lack of privacy, and a decrease in quality time with their peers. Learned helplessness is observed in many hospitalized children and adolescents as they come to rely heavily on caregivers and begin to struggle with even minor tasks. Often, caregivers unknowingly enable a child’s helplessness because they are overwhelmed by their own grief and inability to resolve or fix the issues that brought the child to the hospital. Play therapy provides the chance for the child to regain a sense of control, to gain an increased sense of competence and mastery, and to begin to return to the normal tasks of development. For adolescents, group interventions should also be considered to facilitate a therapeutic environment to meet their needs for peer interaction. In all cases, it is essential to conceptualize what a child or adolescent would be doing if they were able to be outside the walls of the hospital, while being careful to not overgeneralize or rely on a “norm” based on chronological age or stages of development (see Ray, 2011, pp. 17–19 for further cautions on the potential misuses and misunderstandings of developmental models).

**Potential Roadblocks to Implementing Play Therapy in This Setting**

One of the main obstacles to implementing a play therapy program in a pediatric medical setting goes back to one of its defining characteristics: the breadth of diagnoses and comorbidities seen in this environment. Mental health professionals in the hospital might encounter anything from a consultation on a child with conversion disorder to a child with limbic encephalitis. Physical traumas, rare medical illnesses, mood and anxiety disorders, adherence difficulties, pain disorders, and bereavement concerns are all part of the population served within a pediatric hospital. Often, a new medical diagnosis is comorbid with a preexisting psychiatric diagnosis. When this happens, the therapist could be called to the patient’s bedside or to a clinic with only a small window of time to assess, intervene, or make recommendations to the medical team. Flexibility and the ability to continually learn are defining characteristics of a successful play therapist operating within a medical setting. Such therapists often joke their specialty is “anything that brings a child through the doors of this hospital.” While this is an exaggeration, as one cannot wear all hats for all children and families, and we all have our areas of specialty, it captures the variety and complexity hospital practitioners face on a regular basis. Play therapists in the medical setting need to continually educate themselves about new diagnoses, treatments or medications, and potential interventions in order to best understand the world of their patients. It is crucial to understand the objective medical events a patient experiences in order to best appreciate and conceptualize his or her subjective perspective. It is also important to remain thoughtful and conscious of the ethical considerations of undertaking a case one feels is outside her scope. Seeking peer consultation, referring a child to another therapist, and using the multidisciplinary resources available in the hospital are all potential, and often necessary, options.

When presenting to graduate students on play therapy in the hospital setting, I often advise them to revel in the joy of being surrounded by people who speak the language of play therapy, because this will abruptly end once they enter the world of therapy outside the university setting. This is particularly true in the hospital, where one is vastly outnumbered by attending physicians, fellows, residents, and medical students. Medical facilities operate within a model focusing on
diagnosis and treatment. While our goals and those of medical professionals are often harmonious, because both medical providers and mental health providers want to return children to their optimal functioning, we need to be able to communicate with providers whose expertise and knowledge are different from our own. Discussing a child's need for emotional expression is not likely to be the most effective way to communicate to a medical team how you plan on helping the 7-year-old who just kicked and bit a nurse. You need to be able to both articulate your own goals and adjust your treatment goals based on the input of other providers, whether they be doctors, psychiatrists, speech therapists, or social workers.

Another challenge unique to the medical setting is that therapy sessions do not always occur in the play therapy room. They often take place in a clinic exam room, or at the bedside if a child is admitted to the inpatient medical floor. This is perhaps one of the most intimidating aspects of learning play therapy in the medical setting. Interns often struggle with this when they begin their internships because they are used to the safety and comfort of a traditional play therapy room. In a bedside session, one faces a number of unique distractions. Nurses or other staff might wander in and out of the room, a caregiver may wish to remain in the room for the session, and confidentiality can be compromised. In these cases, the therapist will likely need to set unique limits with the television and other electronics, as well as play items from the child's home she might not normally encounter or desire in a traditional setting.

Since "toys are used like words by children" (Landreth, 2002, p. 16), you may begin to feel like you are choosing the child's words for them. This is especially true for an initial session when you select which items to bring to the bedside. I will often meet with a child briefly first in order to garner some ideas of what toys the child might like to come "visit" from the play therapy room. This allows me to pick items that are more consistent with what the child might have chosen if given the freedom of the playroom. In the hospital, there are also some restrictive guidelines for infection control that might limit what items you can bring to a child's bedside. In my hospital setting, all items used at bedside must be fully cleanable or be brand new and intended for use by that patient alone. This often means expensive, highly specific therapeutic items are not utilized. I rely heavily on what can be accomplished with more inexpensive and versatile items such as markers, glue, and paper.

Another unique aspect of bedside play sessions is children might be on illness precautions requiring you to wear a mask, gloves, and gown for infection control. It is essential to be mindful of how much of one's nonverbal expression is lost when a mask covers one's mouth and nose, as well as how similar each provider begins to look to the child. A play therapist must ensure he can communicate to the child that the therapist is different from the other staff and will not be involved in pokes or medicine. One mother communicated to me she had counted 49 individual staff members she had met during the first 24 hours of her child's admission to an inpatient medical floor. The play therapist must strive to remain consistent and predictable for a child and her family. In the medical setting, it quickly becomes clear what matters most is not that one comes equipped with the latest and greatest therapy technique or material, but that the therapist becomes the most therapeutic tool in the room.

Furthermore, a medical setting operates on its own time frame, which does not always align with a therapist's schedule. Oftentimes, I will attempt a bedside session with a patient just to discover he has been taken for a procedure or is asleep. Other times, I might be halfway through a session when we must end abruptly due to the need for a medical procedure or intervention, or very simply the patient's fatigue level. In a more traditional setting, a healthy child requesting to end a session early would likely be met with a therapeutic limit and reminder of the remaining time. However, in the medical setting, a child who has just endured a round of chemotherapy or who was up all night with emesis should be granted her request to end a session early due to
fatigue or pain. I will often provide the child the choice that I remain at bedside even if the child chooses not to engage with the play materials provided. Frequently, the child emotionally desires the continuance of the session and connection with the therapist, but physically cannot remain actively engaged.

DEFINING THE POPULATION

Most often play therapists are consulted in the hospital for a child who is exhibiting difficulty coping, difficulties with adherence to aspects of the medical regime, behavioral concerns, or mood symptoms. These issues manifest in different ways across the developmental spectrum. A 3-year-old will often present with aggressive behaviors such as hitting or biting, while a 16-year-old might present with medication refusal. As a play therapist, my main goals are to help the individual adapt and adjust to the medical and emotional stressors taking place. As a member of the multidisciplinary team treating this individual in a medical setting, I am also accountable to the medical team to ensure my goals can encompass facilitating care for the “whole child.” This means assisting with not just the emotional dynamics at play but working to minimize any barriers to the patient’s medical treatment. If a child with a needle phobia has just been diagnosed with diabetes and must now undergo daily glucose checks and insulin shots, the medical team will want me to be focused on helping this child achieve adherence with his new medical requirement in order to be discharged and go home. As a the child's therapist, I must also address the larger dynamics of a new diagnosis of a chronic illness, including how this child now views himself and how this impacts his functioning with peers. These are all important goals, but must be sought in conjunction with ensuring the child can be ready to go home as quickly as possible.

THEORETICAL ORIENTATIONS BEST SUITED FOR THE MEDICAL SETTING

Once again, taking into consideration the breadth and variety of clients in the medical setting, it is important to note using an evidence-based and informed practice is crucial to ensuring the needs of one’s clients are being adequately addressed (Kazdin, 2008; Kenney-Noziska, Schaefer, & Homeyer, 2012). It is not a one-size-fits-all approach in the hospital or outside of it. An integrated theory and model of empirically supported treatment seems to be the best approach (Drewes, Bratton & Schaefer, 2011), wherein a therapist can “incorporate evidence-based directive and nondirective models to address the diverse needs of the clinical population” (Kenney-Noziska et al., 2012, p. 247). This does not mean one is not grounded in his or her theoretical orientation. You cannot simply grab at the latest and greatest technique without considering the conceptualization of your client, the rationale behind the utilization of an intervention, and your comfort and expertise in implementation of the intervention. A given intervention might be proven effective in research, but it will often fail in clinical practice. All practitioners, and definitely those in a medical setting, need to understand not only the potential empirically supported treatments available, but also the mechanisms of change behind the treatments and the contextual variables of the setting and patient in order to ensure the appropriate implementation or adaptation of a technique (Kazdin, 2008; Schaefer & Drewes, 2014). Theoretical orientations and approaches in the medical setting need to accommodate skill-building and coping strategy development, use psychoeducation, and create therapeutic space for emotional exploration and expression. A play therapist in this setting must have a high respect for the power of the relationship between
therapist and child, the impact of unconditional acceptance of the child, and the therapeutic powers of play.

**PROCEDURAL MODIFICATIONS**

The hospital setting often creates obstacles for therapy sessions not characteristic in other more traditional settings. Certain modifications can help create a therapeutic environment outside the play therapy playroom. First, one should obtain small baskets or bins that can be wiped clean in order to collect and transport items from the therapy room to bedside. When preparing for an initial bedside session, I take into consideration the developmental age of the child, goals for the session, and anything I may have learned from the child, family, or staff regarding the child's interests. Subsequent sessions with a child are often easier because the child can provide more input on materials desired. On the other hand, at times the play items should remain the same to afford the consistency and predictability inherent in the playroom. Due to the fact we share the playroom between several therapists at our hospital, the portable playroom kit we use in teaching filial sessions is also helpful for grabbing a bag of army men or toy cars without taking items another therapist might need. Some suggestions for good bedside items include washable paint in small, disposable containers or dot paints useful with smaller children. These tools provide a way to make things both more portable and adherent with infection control policies. Miniature containers of Play-Doh or individually sealed model magic are also preferable so they can be given to each child in order to maintain appropriate infection control. Rice can be a disposable substitute for sand, and small Styrofoam trays work nicely as miniature sandtrays. In a hospital setting, it is also imperative to have brand new items for patients, such as those in the bone marrow transplant population, and it is therefore essential to have a system in place to ensure those supplies are not intermingled with supplies other children have used.

Creating a play therapy program in the medical setting can be difficult, especially given the current climate in health care and the disparity between the amount of evidence-based and quantitative research in pediatric health psychology versus play therapy. Grants or donors can be very helpful in starting a program, and therapists must gather outcome data and assess the effectiveness of their program in order to ensure its continued growth and presence in this setting. Monitoring outcome data is not only crucial for program funding and development, but it should be considered a best practice that could be used to fuel future play therapy specific research. Providing education to medical staff and recruiting doctors to advocate on a program’s behalf are also essential.

**TECHNIQUES AND STRATEGIES IN THE MEDICAL SETTING**

Due to the multitude of resources available in some pediatric medical settings, it is important to discuss not only play therapy techniques but also additional resources accessible through other psychosocial providers that could benefit a patient in conjunction with what the play therapist might be providing. First, play therapy playrooms in the medical setting should be equipped with play materials specific to the medical population, even if some might be stress-inducing to the child. In the same manner you would not remove all dog puppets or figurines from your playroom when seeing a child after a traumatic dog attack, you would not remove all medical items for a child in the hospital. By offering materials specific to the setting, the therapist provides the patient with an opportunity for desensitization and mastery, a chance for reenactment and formation of a trauma narrative, and an important occasion for assessment by the therapist for any
distortions related to the child’s understanding of his medical experiences. Play materials available should include basic items any child in the medical setting might be exposed to, such as gloves, thermometers, bandages, masks, and stethoscopes. Providing real materials and pretend materials can provide an important range for a child who is too anxious to approach the real-life items first. Other more specific items can be brought out as needed for children who are working on specific goals, such as anxiety during lab draws or surgery preparation.

Medical Play

One strategy often applied in the hospital is medical play. Frequently utilized by certified child life specialists, medical play involves the use of medical materials specific to the child’s illness or experiences to help familiarize a child with medical items, prepare a patient for an upcoming procedure, or increase a child’s comfort with certain medical items or procedures (Boling, Yolton, & Nissen, 1991; McCue, 1988). It is an effective way to desensitize and lower a child’s anxiety at the pace the child is capable of going as well as to help the child further understand his or her diagnosis or medical requirements. Even if the play therapist has not sought training in traditional medical play, having some medical play items in the playroom is essential. Needles and other potentially harmful materials would not be included unless formal training is acquired. Children should be allowed to approach the materials at their own pace, with access to both real and pretend materials. It is important to note that children should not be permitted to conduct medical play on the therapist’s body and instead should be directed to utilize a doll or other substitute item. This protects them from potential feelings of guilt (Landreth, 2002) and allows for a better assessment of their understanding and possible distortions regarding their medical care.

Nonpharmacological Anxiety- and Pain-Management Strategies

In conjunction with pharmacological interventions, there are a multitude of nonpharmacological strategies used to enhance pain management, decrease anxiety, and improve a child’s sense of control and mastery over her medical experiences. Interventions can include distraction, deep breathing techniques, muscle relaxation, guided imagery, and comfort measures, as well as more specialized interventions such as biofeedback, hypnotherapy, acupuncture, and massage. Often the play therapist is in the position at bedside to promote these strategies. At other times, the therapist might be a part of a patient’s session as she learns skill-building or coping strategies for future events.

Distraction is widely recognized in the medical setting as an effective pain management strategy, and can be accomplished in multiple ways. These range from iPads to “I Spy” books. However, not all distraction techniques are created equal. Research suggests interactive distraction is more effective than passive distraction, and it can be used effectively with children as young as 3 years old (Wohlheiter & Dahlquist, 2012). Interactive distraction involves the use of cognitive resources such as selective attention and executive functioning, combatting one’s “bottom-up” neural response (the brain and body’s tendency to pay the most attention to the most salient stimuli, such as pain), and allowing one’s focus to be directed to the distraction task at hand (Legrain et al., 2009; Wohlheiter & Dahlquist, 2012). Ideal interactive distraction tasks engage the brain at a developmentally appropriate level and allow the child to feel successful. Younger children can still benefit from distraction through the use of crib mobiles or other play materials, as well as other comfort measures that will be discussed later.

Diaphragmatic breathing techniques, guided imagery, and progressive muscle relaxation are all aimed at reducing mental and bodily tension and promoting improved coping with
painful or anxiety-producing procedures (Goodyear-Brown, 2010; LeVieux & Lingnell, n.d.). These approaches have all been found to provide clinically significant pain reduction (Kemper, Vohra, & Walls, 2008; Palermo, Eccleston, Lewandowski, Williams, & Morley, 2010). Such techniques are most effective with school-aged children and adolescents, although blowing bubbles or pinwheels to promote deep breathing is a simple strategy to use with preschoolers (Goodyear-Brown, 2010). It is imperative coping strategies such as these are taught prior to the medical procedure so they can be implemented effectively by the child. There are various resources available for learning how to teach diaphragmatic breathing as well as resources for guided imagery and muscle relaxation (Culbert & Kajander, 2007; Goodyear-Brown, 2010). The most effective guided imagery strategies utilize all of a child’s senses and can be therapist directed via scripts or child-directed. With progressive muscle relaxation, skeletal muscles are voluntarily tensed and relaxed in a systematic way (LeVieux & Lingnell, n.d.), but various muscles can be grouped together based on a patient’s age or openness. When first teaching muscle relaxation as a skill in the playroom, I often break it down into only three parts (legs, arms, and shoulders) as a child gains comfort with the concept before becoming more specific and lengthier with his or her practice.

Additional comfort measures might include music, positioning for procedures, and use of heat or cold to mitigate pain. Music has been shown to reduce stress and pain in the medical setting and can be used across all age ranges, including newborns (Novotney, 2013). Music therapists are often part of the multidisciplinary team in larger medical settings and are an invaluable resource in meeting the wide psychosocial demands of these pediatric patients. Other comfort measures include positioning for comfort during procedures by allowing the child to remain in a caregiver’s lap and maximizing skin-to-skin contact for infants (Cohen, 2008).

More specialized nonpharmacological interventions requiring more extensive training include biofeedback, hypnotherapy, and other holistic approaches such as acupuncture and massage. All have been shown to be effective in the reduction of pain as well as other symptom benefits (Gold et al., 2009; Kemper et al., 2008; Palermo et al., 2010). Utilizing the multidisciplinary staff and resources available in the hospital can bring additional benefits to the patient that you alone as the therapist may not be qualified to provide.

Psychoeducation

The importance of children understanding their illness in a developmentally sensitive way is paramount (Goodman, 2007). Research demonstrates pediatric oncology patients “who have a developmentally appropriate understanding of their disease have better psychological outcomes than those who do not” (Beale, Bradlyn, & Kato, 2003, p. 386). A large majority of acting out behaviors seen in younger children with chronic illnesses seems to begin as soon as treatment starts. A 4-year-old does not understand why she is getting poked and prodded every week and taking medicines or shots daily that make her feel abnormal. While her understanding is going to include more basic terms than the explanation provided an adolescent, her illness and the role of medicine in her treatment still need to be explained. Additionally, the therapist can use her reflections during sessions in the playroom to reinforce these concepts and encourage the child’s understanding and efforts in her treatment. Because these types of questions often arise between the child and caregiver, the role of the therapist might also be to equip caregivers with the appropriate words and explanations so they can continue appropriate reinforcement and understanding with the child at home. Research supports threatening events that are better understood are less distressing (Beale et al., 2003; Goodman, 2007).
Bedside Activities

As mentioned previously, a large amount of therapy sessions in the medical setting occur at the bedside. With latency-age children and adolescents, having an expressive therapeutic prompt or activity prepared can be helpful. “Art can be a powerful tool in discovering a child’s concerns” (Goodman, 2007, p. 206). One activity I often use in an initial session is a rapport-building activity using large paper people cut-outs. I bring two cut-outs, one for the therapist to complete and one for the child to complete, along with a variety of markers, pencils, and crayons. By having the therapist participate in the prompt, the child or teen knows there will be a certain amount of self-disclosure by the therapist that can be helpful with older patients or those who are simply shy or perhaps resistant to the idea of meeting with a therapist. I provide simple instructions to allow the prompt to be open to the child’s ideas or interpretations. The therapist should ensure she does not move through the prompt faster than the child, as this often leads to the child’s creation resembling the therapist’s own. The instructions provided are to use words or pictures to put things that “make you happy or that you like” on one side and “things you don’t like or that don’t make you happy” on the other side. I deliberately avoid using any more specific emotional vocabulary in order to maintain a low level of resistance to the activity. The cut-outs allow for the child to spend time creating a face for each side, which can be soothing as well as a good assessment tool for the therapist, as I have often seen some “happy” sides that are far from happy in their expressions. I use my creation to model low-resistance items like chocolate chip cookies for my happy side (or Brussels sprouts for my nonhappy side), in addition to higher level items such as family and friends as positive examples and shots or fighting with friends as negative examples. As with any expressive prompt or activity, one should observe the child’s preferences, struggles, and avoidances. This can be not only a great rapport-building opportunity but also a great assessment tool to identify potential coping strategies and styles as well as levels of insight and self-awareness.

Another therapeutic prompt I like to utilize for bedside sessions with a latency-age or older patient as the patient approaches discharge from the hospital is a “show me your story” prompt. This prompt again is given in a manner that is open and nondirective in order to allow children freedom to participate and to make the task their own. With simple art materials, such as paper and markers or pencils, children can create their version of events leading up to the hospitalization, their experiences while admitted, and an imagined future. This activity allows them to see the effort and work they have done during their admission, and allows the therapist a chance to encourage the effort put forth as well as continue to assess for any distortions or maladaptive thinking related to their illness. For children or teens struggling with adherence, I will often have them create two endings to their story: one depicting good adherence at home and one depicting the events resulting from poor adherence so they might have a clear picture of their role in their treatment.

Facilitating Treatment Adherence

A large part of the role of mental health services in a medical setting is to facilitate treatment adherence. Research estimates 50% to 88% of children and adolescents are nonadherent, but research also shows adherence can be improved with intervention (McGrady & Hommel, 2013). For very young children, the goal is to empower caregivers by teaching appropriate play therapy–based language and skills in order that they might feel better equipped to handle medication refusals or tantrums at home. The skills I am most often consulted to teach in this setting are therapeutic limit-setting and choice-giving strategies. I utilize Landreth’s (2002) ACT method
of limit-setting that involves acknowledging the feeling, communicating the limit, and target-
ing acceptable alternatives. This approach allows caregivers to validate their children's emotions
and help them feel heard and understood (Landreth, 2002; Landreth & Bratton, 2006). Often,
caregivers in the hospital are overwhelmed by the experiences their child is forced to handle and
they minimize their child's emotions with well-intentioned phrases such as “don't be scared” or
“don't cry” in an effort to soothe themselves and their child. They are often relieved when given
a tool enabling them to show caring and understanding while drawing limits on unacceptable
behaviors. For patients in the medical setting, completing all three steps of the ACT method is
essential, especially the final step, to provide choices or alternatives to the child to help return a
sense of control to the child. Be specific with verbal and visual examples for the caregiver, such
as “Jonny, I know you really don’t want to take your medicine, but your medicine is for taking in
the next 5 minutes. You can choose to take it with either juice or milk.”

Another approach utilized in the medical setting involves the use of sticker charts and behav-
ior plans to promote adherence. Play therapists with less behavioral training seem to struggle with
the use of such methods. However, I have found there is often a happy medium where play ther-
apy language and concepts can coincide harmoniously with behavioral strategies such as these.
When I create a behavior plan or reinforcement system for a child, I make sure to include encour-
agement language and scripted phrases for caregivers to use and explain the difference between
evaluative person-praise and encouragement. I often brainstorm with caregivers whether they
want to approach positive reinforcement with a more spontaneous celebration strategy or a more
structured token economy, which can also depend on the child’s motivation and treatment goals.
Sticker or star charts are also useful (Burns, Dunn, Brady, Barber-Strarr, & Blosser, 2013) as an
objective assessment measure to help the therapist gather data and determine if the child's cur-
tent treatment goals are realistic and attainable, as well as plan accordingly for the next set of
goals based on the child’s success rate.

Sibling Interventions

It would be remiss not to briefly touch on the impact on siblings when a brother or sister is hos-
pitalized or diagnosed with a chronic illness. Research demonstrates siblings of children with
chronic illness are two to three times more likely than their peers to experience psychological
adjustment problems (Lobato & Kao, 2002, p. 711). At times, group play therapy with the sib-
ling and medical patient is warranted and can be a powerful intervention, especially when there
are end-of-life concerns being discussed. There are also unique interventions beyond therapy ses-
sions to help promote improved coping and understanding for siblings. At our medical facility, we
conduct sibling days for various populations and involve multiple disciplines such as social work,
child life, pastoral care, and nursing staff. Siblings come together in a group setting for the day to
learn about their brothers’ or sisters’ illnesses and medical experiences. The day involves medical
play opportunities, tours of the applicable clinic, as well as therapeutic activities to help siblings
process their own emotions and reactions to the stressors of having a sibling with a medical ill-
ness. Social workers will often meet simultaneously with caregivers to provide education, support,
and tools for advocating for resources as needed. In addition, several disease-specific groups (i.e.,
ocology, diabetes) run family camps at local facilities, giving families a weekend away to enjoy
the outdoors while having the support of medical staff. These outings are valuable resources for
siblings whose therapy needs may not be identified until much later if they are not regularly
coming to the hospital, or if their caregivers are focused on the medical needs of the ill child.
RESEARCH AND EMPIRICALLY-BASED TREATMENT INTERVENTIONS IN THE MEDICAL SETTING

Research in pediatric medical settings can be difficult due to the broad number of diseases and the impact physical injury or illness can have on standard assessment tools. Research suggests “finding an acceptable outlet for feelings of anxiety, anger, and fear and gaining a sense of mastery over the environment” (Koocher & O’Malley, 1981, p. 10) are critical tasks for this population. A meta-analysis of psychological interventions in chronically ill pediatric patients showed about 80% of participants were positively affected by psychological interventions (Beale, 2006). Further, studies with pediatric oncology patients found patient-centered, interactive, and skill-building interventions seem to be the most efficacious (Beale et al., 2003), and I would argue this to be the case across disease type.

Specific play therapy research has shown short-term intensive child-centered play therapy with children diagnosed with insulin-dependent diabetes mellitus (IDDM) has improved adaptation to their illness even when used as a preventative measure (Murphy-Jones & Landreth, 2002). Research regarding filial therapy interventions with caregivers of chronically ill children shows a decrease in overall parental stress and an increase in acceptance of their children. The study also finds a decrease in behavioral issues and a decrease in reported anxious or depressive symptoms by caregivers who participated (Tew, Landreth, Joiner, & Solt, 2002). Integrative play therapy is a promising direction for future research to investigate the power of combining existing evidence-based approaches with the power of play (Drewes et al., 2011).

CONCLUSION

No matter the type of disease or the duration of the illness or injury, children and their entire families are deeply affected by the events that bring them to a medical setting. Play therapists and mental health professionals in this arena are uniquely positioned to facilitate therapeutic experiences for this population and potentially improve their coping, their adherence, their understanding, and their acceptance. After all, no matter what the obstacle, whether in a medical setting or more traditional setting, at heart, they are all still children trying to be children and we should reach out to them in a language and modality that is their own.

REFERENCES


The school is a unique environment and culture. Its purpose is to educate all children, preparing them for future jobs and to be well-rounded individuals. The American School Counselor Association (2004) describes the role of school counselors as being “to prepare today’s students to become tomorrow’s adults.” Schools not only educate children in core areas such as mathematics, science, reading, and history, but also teach them about the arts, health, and vocational options. They are responsible for feeding students healthy meals; offering speech, special education, as well as occupational and physical therapy services; and, in some instances, ensuring they take their medications. As noted in this description, educating and preparing all children encompasses a great deal, and there are frequently numerous obstacles that inhibit student learning and students’ abilities to become successful adults.

The school is a microcosm of society, and often the core of its community with its unique cultural fabric woven throughout. It serves as the central point for community social engagement; its influence and meaning extend beyond the classroom walls. As such, it is often the location for reunions, voting, and even funerals. Both the strengths and weaknesses of the community are naturally reflected in the school. For example, districts with high crime rates are likely to have more discipline challenges in their schools. On the other hand, districts with high community engagement have more caregiver involvement in their schools, resulting in lower crime rates and discipline problems and creating a safer learning environment for students. Having awareness of these things is vital to understanding the school setting.

In the United States of America, many types of mental health practitioners may work in a school setting. Some schools have school psychologists and/or school-based clinicians (licensed professional counselors or licensed social workers). However, virtually all schools have professional school counselors. Due to the unique culture of the school system, the role each of these professionals plays can be quite different from their roles in other settings, and any of them might be called upon to do play therapy in the school setting. Because professional school counselors are the ones most widely employed by schools, it is their role as play therapists that will be the focus of this chapter.
The school counselor’s primary role is to implement the guidance curriculum. The core areas were established by Gysbers and Henderson (1988) as guidance curriculum, responsive services, individual planning, and system support. The American School Counseling Association (ASCA) established the national model for school counselors in 2004, adopting these components. The national model further delineates direct services as “in-person interactions between student and counselor” within the following areas.

School counseling core curriculum (classroom guidance)

This curriculum consists of structured lessons designed to help students attain the desired competencies and to provide all students with the knowledge, attitudes, and skills appropriate for their developmental levels. The school counseling core curriculum is delivered throughout the school’s overall curriculum and is systematically presented by school counselors in collaboration with other professional educators in K–12 classrooms and group activities.

Individual student planning

School counselors coordinate ongoing systemic activities designed to assist students in establishing personal goals and developing future plans.

Responsive services

Responsive services are activities designed to meet students’ immediate needs and concerns. Responsive services may include counseling in individual or small-group settings or crisis response.

According to ASCA, elementary counselors should allot 75% of their time to provision of the guidance curriculum and responsive services with middle school counselors spending 80% of their time in these functions. These are the areas the implementation of play therapy would fall under as the counselor conducts individual and small-group counseling and classroom guidance. Classroom guidance can be likened to psychoeducational groups in the community setting, teaching structured lessons on social skills, feelings, and so forth. Many studies have highlighted the benefits of fully implemented model guidance programs for K–12 students (Lapan & Gysbers, 1997; Lapan, Gysbers, & Petroski, 2001; Sink & Stroh, 2003). Higher scores on standardized achievement tests for third and fourth graders and a sense of safety and greater satisfaction with the quality of their education for middle school students were a few of the reported benefits. Suggestions for ways to implement play therapy in the direct service component areas will be covered later in this chapter.

WHY USE PLAY THERAPY IN SCHOOLS?

The first reason for bringing play therapy into the elementary and middle school guidance curricula is because it is the most developmentally appropriate approach for working with children (Landreth, 2012; Landreth, Ray & Bratton, 2009; Ray, 2011; Drewes, & Schaefer, 2010). Piaget asserted that children’s cognitive development precedes their verbal skills. Miller (2002) acknowledged this groundbreaking discovery and noted that Piaget’s theory was the first to disprove previously held ideas that representational thought derived from the one’s ability to use words; rather, “thought is both prior to language and broader than language” (p. 47). An example of Piaget’s discovery in action is an infant’s ability to be taught and correctly use sign language.
Many caregivers use sign language with their infants for concepts such as food, drink, and so forth, so their infants have a way to express themselves long before they are able to do so verbally. This allows infants to express their needs and have those needs met by a loving caregiver, decreasing frustration. Piaget (1972) stated, “Language, then, does not seem to be the way to develop intelligence in children” (p. 26). Erikson (1972) asserted that play “may well facilitate in a child an impulse to recapitulate and, as it were, to re-invent his own experience in order to learn where it might lead” (p. 132). This illustrates children’s natural inclinations to make sense of their world through play.

The second reason for utilizing play therapy in the school setting is based on the extremely high need to provide more developmentally appropriate interventions at an early age. The U.S. Department of Health and Human Services (2010) stated: and

Reports on early mental health needs in Head Start indicate that children are showing an increase in disruptive behaviors in the classroom that not only impact the overall learning atmosphere but challenge school staff and contribute to teachers’ level of stress and tension in classrooms.

The behavioral issues can have a negative emotional and even physical impact on students, faculty, and staff. The long-term result of these issues not being successfully addressed is also detrimental. Substance abuse and personality disorders are only two examples of issues that can develop when early interventions are not successfully implemented.

Children exhibiting disruptive behavior are also more at risk for incarceration or even suicide because they frequently display aggressive and violent behaviors toward themselves or others. A report on youth violence by the Surgeon General of the United States of America (2001) emphasized the importance of early intervention, stating, “Youths who become violent before about age 13 generally commit more crimes, and more serious crimes, for a longer time.” The report also stated these children display a pattern of increased violence through their childhood and some even into their adulthood. The report indicates that early interventions are crucial to avoiding chronic, violent careers.

We live in an exciting age in which constant discoveries in the world of neuroscience are providing biological reasons for early intervention. Hirshfeld-Becker and Biederman (2002) studied Australian intervention/prevention programs. They noted the benefits of targeting preschool or early primary aged children: “Younger children are more plastic, both in terms of their behavior and their neurodevelopment.” Recent brain research however, implies this plasticity continues through our lifetime, meaning our brains can be rewired at any age (Siegel & Bryson, 2012). This is an exciting discovery as it offers a reason to intervene and hope for growth at any age. However, the earlier in children’s lives they are able to make changes, the less they may suffer the impact of negative behaviors and choices. Bratton, Ceballos, Sheely-Moore, Meany-Walon, Pronchenko, and Jones (2013) conducted the first controlled outcome study to investigate the effects of Child-Centered Play Therapy (CCPT) on disruptive behaviors in a preschool setting. The results found CCPT was an effective early intervention for reducing disruptive behaviors, thus supporting the use of play therapy to help children in preschool before their behaviors become engrained.

Research clearly indicates early intervention plays an important role in how children perceive themselves and their future success as students, community members, family members, and human beings. For many children, first-time mental health issues are identified upon their entry into school; therefore, it seems both optimal and crucial for interventions to be implemented at this point. Play therapy is the obvious choice for such interventions because it is the most developmentally appropriate method.
Third, play therapy is a developmentally appropriate approach to implementing the ASCA standards (Perryman & Doran, 2010; Ray, Armstrong, Warren, and Balkin, 2005). In this era of high stakes testing and an emphasis on accountability, it is also an effective treatment to utilize when conducting program evaluations in the school setting. Lapan and Stanley (2006) from the Missouri Department of Elementary and Secondary Education have developed a program titled "Partnership for Research Based Evaluation" (PRBE) for counselors to use in identifying a problem, collecting data, and showing how to make changes using a specific technique or intervention. Professional school counselors conduct PRBEs to ascertain the benefits of various areas of responsive services. Ray (2011) states, “Play therapy, as a responsive service, is the developmentally appropriate method of responding to the immediate needs of children who operate more fully in a nonverbal world” (p. 206). Integrating play therapy as a responsive service also offers an excellent intervention that can be easily measured. Suggestions for specific ways to implement play therapy as a responsive service intervention will be addressed later in this chapter.

A fourth reason for using play therapy in schools is familiarity and accessibility. The school counselor is a part of the children's school community and possibly the only mental health professional to whom they have access. An advantage and distinguishing factor of the school setting is the fact the school counselors are a part of the children's daily environment. Counselors are often very familiar with the children's caregivers and siblings as well. The school counselor has the opportunity to see children interacting with their peers, teachers, and other staff in the school environment on a daily basis, both in and out of the classroom. Because the fundamental role of the school counselor is to assist with educating all children, they also typically have established relationships with all students to at least some degree. Counselors also have relationships with the teachers, staff, and administration, all of whom are involved with that student in some manner.

The fifth reason for implementing play therapy in the school setting is its proven effectiveness in improving academic achievement and decreasing disruptive behaviors in schools. Blanco and Ray (2011) conducted the largest controlled group to date, measuring the effect of play therapy on academic achievement. First graders who were identified as academically at risk received 30-minute CCPT sessions for 8 weeks. They found the students’ academic achievement improved significantly. As reported earlier, Bratton et al. (2013) found play therapy was also effective as an early intervention in decreasing disruptive behaviors.

The final reason for utilizing play therapy in the schools is because it is the most appropriate way to meet the needs of diverse children because its focus is not on verbal language. Play is a universal language for children; they use it, rather than words, to make sense of their world. Gil and Drewes (2006) suggest the following principles for becoming a crossculturally competent and responsible play therapist: building sensitivity, obtaining knowledge responsibly, and developing active competence (pp. 7–10). Regardless of children’s cultural identities, they will utilize the toys to resolve issues and recreate their perceptions of their worlds. Therefore, it is vital for professional school counselors working as play therapists to ensure they are culturally competent. How to equip the playroom to ensure it is culturally appropriate will be addressed in a later section.

Understanding the unique culture of the school setting is vital to successfully implementing a play therapy program. This includes awareness of the school’s role with students and in the community, as well as an in-depth understanding of the components of the ASCA national model. In summary, the reasons for implementing play therapy in schools are as follows:

- Play therapy is the most developmentally appropriate method of counseling children.
- There is a critical need for developmentally appropriate, early interventions for children in schools.
- Play therapy is a developmentally appropriate approach for implementing the responsive services component of the ASCA standards.
• The school counselor is familiar to the students as a part of their school community. As such, the students are able to access needed services in the community where the behavioral issues are occurring.
• Play therapy is proven to be an effective way to improve academic achievement and behavioral problems in schools.
• Play therapy is the most culturally appropriate method for working with children.

POTENTIAL ROADBLOCKS TO IMPLEMENTING PLAY THERAPY IN SCHOOLS

There are numerous potential roadblocks to implementing play therapy in the school setting. This section will address five of the most common issues a school counselor attempting to implement play therapy may encounter.

First, lack of time is likely the biggest obstacle negatively affecting the ability to conduct play therapy in schools (Ebrahim, Steen, & Paradise, 2012; Ray et al., 2005). The elementary student-to-counselor ratio recommended by ASCA is one counselor per 250 students. This is obviously a very large number of students for one counselor to be responsible for. It’s safe to assume at least 10% of the student population, or 25 students for whom the counselor is responsible, may need some responsive services at least once during the week. Again, these services include time spent in crisis counseling, individual counseling, or group counseling. In addition, the school counselor is also responsible for teaching the guidance curriculum to all classes (usually weekly or bimonthly) and for individual planning as part of his direct services. Individual planning includes those services such as working with a student on her schedule to help the student achieve her educational goals. The professional school counselor is also responsible for providing a number of indirect services to students, such as collaborating with caregivers, teachers, administrators, colleges, community members, and so forth and providing referrals to other services as needed. From this description of the school counselor’s job, it is easy to see how daunting a task it can be just to find the time necessary to meet the needs of even a minimal number of the students requiring counseling. Finding successful interventions to use for maximum impact is therefore essential.

Second, lack of support from caregivers, teachers, and administrators is another major obstacle for implementing play therapy in the school setting. Caregivers may be concerned their children are missing out on academic time to “play” with the counselor. Unfortunately, such misconceptions are common in schools, as teachers and administrators are rarely educated about play therapy and its benefits. Teachers may see the child as being rewarded for bad behavior by getting to play in the counselor’s office, rather than working in the classroom. Ray, Schumann, and Muro (2004) cited similar difficulties in their study on the lessons they learned implementing play therapy into the school setting. Teachers felt responsible for setting limits on children’s behaviors, even though similar behaviors were appropriate within the bounds of the therapy. Teachers may feel that such allowances in the play sessions could encourage more negative behaviors in the classroom. They may also take responsibility for what they perceive to be the bad behaviors of their students, fearing it reflects on them as teachers. They also generally lacked an understanding of the ethics of the play therapist’s role in regard to making hotline calls as mandatory reporters of child abuse and sharing confidential information. Some teachers also refrained from referring the students whom they considered to be too difficult, in order to protect the therapist. Educating caregivers, faculty, and administrators about the benefits of using play therapy in the school is, therefore, imperative to overcoming this barrier.
Lack of sufficient training is the third factor inhibiting school counselors from implementing play therapy. Wynne (2008) cited counselor training as one of the factors affecting the success of play therapy in the school setting. The American Counseling Association (2014) addresses the professional counselor’s scope of practice in their ethical standards: “Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience” (p. 8). Despite research supporting the many benefits of play therapy, the majority of school counseling training programs do not include it as a part of their curriculum or training. In order to obtain the proper training to utilize play therapy, most mental health professionals have to seek post-master’s training, which can be time consuming and expensive.

The number of play therapy training programs has, however, increased significantly in the past 10 years. Ray et al. (2005) reported that 67% of counselors surveyed had no university-level courses in play therapy, even though 97% of them strongly agreed that play is a child’s natural first language. The Association for Play Therapy (APT) responded to this need for training by creating criteria by which to approve university centers. As of 2014, they list 23 approved university centers for play therapy education, with an additional 180 universities listed as offering at least one graduate play therapy course (Association for Play Therapy, 2014b). These programs include ones in psychology, counseling, and social work. APT-approved centers for play therapy education must offer a minimum of 15 continuing education units every 3 years. Thanks to the advocacy of APT, training for professional school counselors and other mental health practitioners has become more accessible.

Fourth, lack of both space and resources are also frequently mentioned barriers to implementing play therapy in schools (Ebrahim et al., 2012; Ray et al., 2005). These are common challenges in all schools as they continually strive to do more with less. Classrooms are frequently overcrowded, and counselors, speech pathologists, and special education classes compete for space. One school counselor described her first office, which was a renovated janitor’s closet shared with the nurse. The room was just wide enough for a cot to fit at the back wall for sick children to lie on and a desk right by the door. Even in this space, she kept an easel folded behind the door and her tote bag playroom and a plastic tub of sand under the cot. It’s vital that the counselor advocate for confidential space in order to maintain ethical standards. Counselors have shared stories of holding groups in the library or on a stage in the gym, when not in use, in an attempt to find a confidential space. Unfortunately, these stories are common.

The struggle for resources is an equally frustrating problem in schools. Like teachers, counselors often buy many of their own supplies. Professional school counselors typically have a small budget ($500–$800) for the school year. Schools often include testing materials in this budget, even though testing is considered nonguidance by ASCA national standards and, therefore, should be funded separately. Resourceful school counselors also seek resources from parent organizations, community grants, and local organizations such as Lions Club, churches, and others. They also find quality items at discount stores, resale shops, and garage sales.

On the other hand, some school counselors also work at a school in which they have an entire classroom as their counseling office, thus allowing for a private desk area, a play area, and a table and rug area for small groups or classes. The variability of the resources and space depends a great deal upon the advocacy of the professional school counselor who held the position previously.

A final potential roadblock to implementing play therapy in schools is the current wording used to describe the role of the professional school counselor. The ASCA (2005) national model states that while it is appropriate for school counselors to conduct individual and small-group counseling, it is considered inappropriate for them to provide therapy or long-term counseling to address psychological disorders. These terms, however, are not clearly defined by ASCA, and
unfortunately, well-meaning counselors and counselor educators sometimes use this statement to explain why play as a therapeutic technique cannot be utilized in schools. Professional school counselors are the mental health specialists in their schools and are trained using the same theories and techniques as counselors in other settings. Play therapists have an additional set of specialty skills designed to specifically address the developmental needs of students in schools. In order to best help these students and fully implement the ASCA national model, the terminology needs to be clarified to define “therapy,” “psychological disorders,” and especially “long term counseling” in relation to the school setting.

In summary, this section reviewed some of the major roadblocks to implementing play therapy into the school setting. Lack of time, support, training, space, and resources, and the problematic language used to describe the counselor’s role by ASCA were all discussed. With the help of APT and the advocacy of school counselors through research and other means, progress has been made in these areas.

THEORIES BEST SUITED FOR PLAY THERAPY IN SCHOOLS

School counselors’ theoretical perspectives depend a great deal upon the focus of the graduate programs at which they received their training and the focus of any additional training and experiences they have had since that time. Their theoretical frameworks dictate their approaches to addressing the ASCA national standards and the children, faculty, administration, and caregivers they work with. These reflect the counselors’ views of human nature and, thus, the development of both healthy and maladaptive behaviors. Their theoretical perspectives guide the interventions they utilize to help students. For the purposes of this chapter, the following theoretical approaches will be addressed for use in the school setting: Child Centered Play Therapy (CCPT), Cognitive Behavioral Play Therapy, and Adlerian Play Therapy.

CCPT was based on the Person Centered Theory. Carl Rogers (1961) established this theory and the core conditions for therapy as genuineness, empathy, and unconditional positive regard. It is based on the assumption that human beings naturally strive for growth. This nondirective approach was adapted by Virginia Axline for work with children and became known as child-centered play therapy (1947). According to Landreth (2012), “Child-centered play therapy is both a basic philosophy of the innate human capacity of the child to strive toward growth and maturity and an attitude of deep and abiding belief in the child’s ability to be constructively self-directing” (p. 60). CCPT has the strongest research as compared to the other types of play therapy (Landreth et al., 2009). This theory is developmentally based and thus suits the school-aged child as he or she progresses through various stages. The role of the counselor in the environment is to follow the lead of the child, setting limits only as needed to protect the child, the therapist, or the room and toys.

Cognitive-behavioral play therapy (CBPT) was developed by Susan Knell. This theoretical perspective was based on cognitive-behavioral therapy and the work of such theorists as Ellis (1971), Beck (1976), and Bandura (1977). CBPT is directive and goal-oriented and uses structure to teach children, to help them think of new ways to play, to solve their problems, to build relationships, and to think about themselves. In CBPT, the counselor conducts an assessment to determine specific treatment goals and then creates an individually tailored intervention to “increase behavioral competence” (Knell, 1998, p. 30). In CBPT, the counselor focuses on the child’s presenting problem and facilitates problem solving through the use a variety of research-based techniques in order to eliminate the undesired behaviors and replace them with desired ones. Interventions might include the use of games, bibliotherapy, storytelling, role-playing, modeling, desensitization, shaping, and positive reinforcement, as well as confronting any irrational
beliefs that may be contributing to the child’s difficulties (Knell, 1998). CBPT is frequently used in school settings because its direct approach to dealing with an identified problem or behavior appeals to teachers, administrators, and some counselors who were trained in behavioral approaches as a form of classroom management.

A possible challenge to using this approach in the school can be the time it requires to conduct the assessment, develop the treatment goals, and implement the therapeutic intervention; however, it appears to be a relatively time-efficient approach, with the majority of the behavioral interventions taking about 30 days.

Adlerian play therapy is another theoretical approach that appeals to many school counselors. Adlerian therapy was developed by Alfred Adler, who founded the Society for Individual Psychology in 1912 (Schultz & Schultz, 2013). “Adlerians believe that people who come to counseling because they are experiencing difficulties dealing with life’s problems are discouraged” (Kottman, 2003, p. 139). Terry Kottman adapted Adlerian theory for work with children. This type of play therapy takes a holistic approach to working with the child, as it is based on the assumption people are socially embedded. It therefore includes significant others from the child’s social world, such as caregivers and teachers. Adlerian play therapy is a more direct approach to dealing with maladaptive behaviors and offers specific suggestions for caregivers and teachers depending on what the goal of the misbehavior is. This model focuses on the therapist establishing and maintaining an egalitarian relationship with the child; they are viewed as partners in the therapy process. The play therapist explores the child’s lifestyle, helps the child gain insight, and reorients/reeducates the child (Kottman, 2003). In this form of play therapy, the therapist’s role is to be active and directive and to encourage the child. A possible challenge to this approach in the school is the difficulty involved in getting caregivers and teachers engaged in the process and the time it requires in assessing and working with children on a regular basis. However, Adlerian play therapy appears to be a good fit for the social environment of the school setting.

Meany-Walen conducted a study utilizing Adlerian play therapy with early elementary-aged children with disruptive behaviors. The students participated in Adlerian play therapy sessions for 30 minutes, twice a week for 6 weeks and had significant improvement in the disruptive behaviors and in the stress on the student–teacher relationship. These are important benefits.

In this chapter, three theoretical approaches well-suited for working with children in the school setting have been discussed. It is vital for professional school counselors to equip themselves with a theoretical perspective that fits with their own personal beliefs about people and human nature early on in their training and practice. This theory will be the counselor’s guide as she navigates the many issues children bring to the school setting and as she works to help children become academically and personally successful.

PROCEDURAL MODIFICATIONS

Specific procedural modifications must be made in order to use play therapy in the school setting. Three such modifications are the terminology used to describe play therapy, the time spent in play therapy sessions, and the types of toys used. The first of these modifications will be discussed in this section, and the other two will be discussed in the Playroom Setup and Toys and Frequency and Duration of Play Therapy sections.

Because there are various legal and professional constraints on the type of services school counselors can provide and the terms they can use to describe their work, they need to be very familiar with the laws and ethics governing their work in the specific states in which they are employed. The term play therapy is quite general, and play therapists come from a wide variety
of mental health professions. In spite of this, school counselors may be unable to use the word *therapy* to refer to what they do or the word *therapist* to refer to themselves. As mentioned in previous sections, the ASCA National Model (2012) specifically mentions it being inappropriate for school counselors to do "therapy." Further, in some states in the United States of America, there are also legal constraints regarding which types of practitioners can use the terms *therapy* or *therapist.* By definition, school counselors are: counselors who provide individual and group counseling. Given that play-based interventions are clearly the most developmentally appropriate way to work with children, whether one is a teacher, counselor, or therapist, it is both reasonable and professionally appropriate for school counselors to provide play-based counseling. In this way, their work can align with both the general definition of play therapy and the current parameters of their profession.

In writing this section, I became acutely aware of all the stress experienced by school counselors who are trying desperately to meet the ASCA and state comprehensive guidelines and dictates of their ethical code and to offer developmentally appropriate, best-practice interventions to children in their schools. This alone is a daunting task, but the additional need to compensate by being creative with their terminology, time, and toys in order to find support in their school community creates a tremendous burden for any helping professional and caring human being. Moreover, this stress has the potential to convey derogatory messages to students, such as some feelings are bad, there is something wrong with play therapy, and there is a need to hurry up and change. While fantastic strides have been made in the field of play therapy, the need for advocacy on behalf of the use of play therapy in schools to address the needs of children is paramount to the future of the play therapist school counselor and the well-being of the children with whom they work.

### Establishing Play Therapy in Schools

To address some of the issues confronted by school counselors attempting to implement play therapy in school settings, this section will discuss how one might advocate for play therapy. The following guidelines for incorporating play therapy into a school counseling program were adapted from the work of Perryman and Doran (2010):

- Be aware of the unique culture of the school setting.
- Be the advocate for your school counseling program by educating administrators, teachers, caregivers, and community members about play therapy.
- Set up a working playroom, play space, or tote bag playroom.
- Be ethically aware and competent, and educate other stakeholders about the ethical code.
- Evaluate your play therapy program responsive services and report the data to the stakeholders.
- Be a culturally competent play therapist by adapting both language and toys to meet the diverse needs of your student body (p. 84).

As previously mentioned, measuring the success of the play therapy program is vital. Outcome data allows counselors to learn from their mistakes, make needed adaptations to their programs, and to advocate for their program by reporting their findings. Ways to measure the success of a play therapy intervention include both existing school data as well as the use of specific assessments. School-based data might include the children’s grade point averages, absences, and office referrals before and after individual play therapy, a play therapy group intervention, or a set of guidance
lessons has been completed. Specific assessments might include both academic measures as well as things such as self-esteem inventories. Ray (2011) recommended updating teachers and administrators with general progress reports. While this process takes time, it also promotes support as professionals work together and discuss changes in the child’s behaviors. Ray suggests doing this on a monthly basis. Of course these play interventions would need to be short-term (10–12 sessions or less) because responsive services are only one component of the school counselor’s busy job description. Landreth (2012) suggests, “Many behavioral problems and experiences of children can be dealt with effectively in a relatively short period of time,” and the school is an excellent setting for this type of play therapy (p. 370).

Another way to advocate for the play therapy in the school is to create monthly newsletters for caregivers, teachers, and administrators with an overview of the school guidance curriculum, how the counselor’s time is spent implementing that curriculum, and indicating how play therapy provides added benefits for the children being served. Parenting programs can also be implemented to help parents learn more about play therapy, as well as topics such as discipline and how to communicate with children through play. School counselors should also use open house as a time to show off their play space and share wish lists of needed items with caregivers. Ray (2011) also suggested developing a play therapy brochure to promote an understanding of play therapy in the school and community. Rather than developing their own brochures, school counselors could share “Why Play Therapy?” handouts (Association for Play Therapy, 2014c) or show videos highlighting the benefits of play therapy. The school counselor could even prepare a presentation for the school board, caregivers, teachers, and administrators following these suggestions (adapted from Perryman and Doran, 2010) for presentation development:

- Explain that play is the most developmentally appropriate approach for working with children.
- Highlight the advantages to using play therapy or “counseling with toys” in the school setting.
- Describe the function of play therapy in the school improvement plan of the district and specifically for individual schools within the district (when applicable).
- Describe the function of play therapy in addressing the responsive services component of both the state guidance curriculum and the ASCA national standards.
- Conduct a professional presentation using research data regarding your counseling program and its benefits to the district. An example would be selecting a group of students who have poor attendance and conducting a 6-week play therapy group intervention. Their attendance could be compared from the quarter prior to and after the group. Because school districts receive funding based on each student’s attendance, the amount of money the district has earned should be highlighted as a benefit to this intervention. The same could be easily accomplished with behavior referrals and grade point averages to show academic benefits.

This section has reviewed specific strategies for implementing play therapy in the school setting. The school counselor must be a strong advocate and researcher, as well as possess the ability to market the play therapy program to ensure its success.

**Playroom Setup and Toys**

This section explains how to set up a playroom, give an overview of the types of toys needed, and review again the frequency and duration of play therapy sessions in schools. As previously noted,
space and time are a premium in most schools, but the counselor’s creativity knows no bounds when it comes to maximizing both. To begin, this section will discuss the playroom space and location, as well as the toys needed for a playroom and a tote bag playroom.

The playroom should be warm and welcoming and clearly communicate to children that this place is made for them. Landreth (2012) suggested a room 12 feet by 15 feet to provide the space needed for play therapy. He also recommended the room have no windows, to ensure privacy. Tile or vinyl floors are easiest to clean and repair if needed. The walls of the playroom should be painted with an off-white, washable paint. If the school counselor chooses to hang items on the wall, those should be placed at the children’s eye level. Built-in shelves are recommended for organizing the play materials and making these easily accessible. Ideally, the playroom is located away from classrooms and the principal’s office. Locating the room away from classrooms prevents a potentially noisy play therapy session from disrupting the work of other children. Having the office located in a low traffic area within the school prevents students, caregivers, teachers, and principals from seeing who is coming in and out of the playroom, ensuring the confidentiality of the child’s sessions. Having the child questioned as to why he or she is visiting the counselor can detrimental to the counselor–student relationship. Many schools have the counseling office next door to the principal’s office. This can deter children from coming to see the counselor because they already associate the principal’s office with discipline, so the counselor becomes associated with the disciplinary role of the administration by default. While it’s impossible to completely isolate the counselor’s office, counselors should do their best to ensure confidentiality.

Landreth (2012) described the types of toys needed for the playroom as real-life toys, acting out and aggressive toys, and toys for creative expression and emotional release. These toys should be grouped by theme when placed on playroom shelves or placed in plastic bags and containers in the case of a tote bag playroom. Landreth suggested the following list of toys and materials (p. 167–169). Depending on the location of the counselor’s office, noisy musical instruments may also need to be removed to prevent the therapy sessions from disrupting the work of the other students.

- Balls
- Band-Aids
- Barbie doll
- Bendable doll family
- Blunt scissors
- Bop Bag
- Broom, dustpan
- Building blocks (various shapes and sizes)
- Cereal boxes
- Chalkboard, colored chalk, eraser
- Construction paper (several colors)
- Crayons, pencils, paper
- Cymbals
- Dinosaurs, shark
- Dishes
- Dishpan
- Doll clothes, blanket
- Doll furniture (sturdy wood)
- Dollhouse (the type that opens on floor so the child can lean into it)
- Dress-up clothes
Drum
• Egg cartons
• Empty fruit and vegetable cans
• Erasable nontoxic markers
• Flashlight
• Gumby (bendable nondescript figure)
• Hand puppets (doctor, nurse, police officer, mother, father, sister, brother, baby, alligator, wolf)
• Handcuffs
• Hats: firefighter, police officer, tiara, crown
• Lone Ranger–type mask and other masks
• Medical kit
• Medical mask
• Nursing bottle (plastic)
• Pacifier
• Paints, easel, newsprint, brushes
• Pitcher
• Play money and cash register
• Pots, pans, silverware
• Pounding bench and hammer
• Puppet theater
• Purse and jewelry
• Rags or old towels
• Refrigerator (wood)
• Rope
• Rubber snake, alligator
• Sandbox and a large spoon
• School bus
• Soap, brush, comb
• Sponge, towel
• Stove
• Stuffed animals (two or three)
• Telephone (two)
• Tinker toys
• Tissues
• Tongue depressors, popsicle sticks
• Toy camera
• Toy guns, knives
• Toy soldiers and army equipment
• Toy spider and other insects
• Toy watch
• Transparent tape, nontoxic glue
• Truck, car, airplane, tractor, boat, ambulance
• Watercolor paints
• Xylophone
• Zoo animal and farm animal families

Some of these items are aggressive-release toys (e.g., guns, knives, alligator, Bop Bag, and toy soldiers). Because play is a child's language and toys are the words, it stands to reason that a child
would sometimes need to use aggressive play to articulate strong angry or aggressive feelings for which he or she has no adequate words. This premise can be likened to working with adults. It would be unheard of for a counselor working with adults who are feeling hurt or angry to set limits on the words these clients can use in a session to express themselves.

However, when it comes to children, adults may fear that allowing them to play with aggressive toys may increase the likelihood of aggressive acting out outside of the playroom. The vast majority of the time this is not the case. Aggressive play actually allows children to express their feelings in an appropriate and accepting environment, with limits set by the therapist as needed. The ability to express these feelings eliminates the need for the child to express them in inappropriate ways outside the playroom. Using the previous adult example as a reference, adults who use strong language and a loud voice to express their hurt or anger with the accepting therapist are less likely to feel the need to do so with others when they leave their session. This is a prime example of the therapeutic benefit of catharsis. However, due to the heightened fear of school violence in recent years, anything resembling a weapon is not allowed in schools. This includes toy guns, knives, and swords. It is therefore suggested that the previously recommended list of toys be altered for the school playroom. Instead the school counselor may substitute other aggressive toys such as puppets, toy soldiers, blocks that can be kicked or thrown, a Bop Bag, or even a log the children may hit with a rubber mallet. The other thing to remember is that children will be creative if and when they feel the need to express aggression. They may use their index finger as a gun or devise a weapon out of blocks, sticks, clay, or pretty much anything else in the playroom. The important point to remember is that children need an appropriate environment and the tools with which to express their pent-up emotions, such as hurt and anger, just as much as adults do.

In many schools, the counselor will not have the dedicated play therapy space as previously described. In such cases, a tote bag playroom can be prepared with the basic toys needed for use in play therapy. The counselor can then conduct play therapy in small spaces and be mobile if needed, working in the corner of an empty classroom, in the gymnasium, or in the library. The basic list developed by Landreth (2012) is as follows:

- Aggressive hand puppet (alligator, wolf, or dragon)
- Band-Aids
- Bendable doll family
- Blunt scissors
- Costume jewelry
- Cotton rope
- Crayons (eight-count box)
- Doll
- Dollhouse (use box that holds reams of paper, box lid serves as dollhouse, draw lines on inside of lid to mark rooms; box doubles as storage container for toys)
- Dollhouse furniture (at least bedroom, kitchen, and bathroom)
- Gumby (bendable nondescript figure)
- Handcuffs
- Lone Ranger–type mask
- Medical mask
- Nerf ball
- Newsprint
- Nursing bottle (plastic)
- Pipe cleaners
Frequency and Duration of Play Therapy

Due to the pressure on administrators, teachers, and students to raise or maintain state test scores in order to receive state funding, instructional time now takes precedence over all other school activities. In most states, recess time has been cut back from 30-minute periods three times per day to one 15-minute recess period per day. In many schools, PE, music, and art have also been reduced and in some cases eliminated. This has unfortunate consequences for children as they get very little unstructured time to play or socialize or time for their brains to rest. This also negatively affects their natural love of learning and increases anxiety levels. As a result, counseling is needed more than ever. Most traditional counseling sessions are approximately 50 minutes in length. It is highly unlikely the school counselor will be able to implement individual sessions of this length. Fortunately, there is a great deal of research supporting the effectiveness of short-term play therapy sessions. Landreth (2012) recommends 30-minute sessions that occur weekly or biweekly for a total of no more than 12 sessions.

Group counseling sessions are typically 1 to 2 hours in length. The school counselor may have to modify this time as well, while carefully adhering to ethical guidelines. Children should not be rushed through a group session or not allowed to process issues raised in the session as needed. This presents an interesting challenge for school counselors conducting groups as they strive to help the children address issues in a fun and creative way, while trying not to upset teachers or administrators by using up too much classroom instructional time. Awareness of the ASCA national standards, as well as state-specific comprehensive guidance guidelines, can help school counselors advocate for the time needed to fully implement the school counseling curriculum.

In addition, creative school counselors frequently find ways to extend their group sessions. Having groups meet right before or after breakfast or lunch and allowing students to bring their meals with them to the group room is one way to extend the time. If students have to spend part of their group time eating, the counselor can use this as a time to check in with students about their week and introduce a group activity. With older children who are working on friendship issues and social skills, a counselor might bring an electric skillet for breakfast burritos or a waffle maker to incorporate teamwork and breakfast at the same time. While this would not be appropriate for every group, most students find such activities enjoyable, and they have the opportunity to practice their social skills in a fun way. Last, in some schools, caregivers may be able to drop children off early or pick them up after school. Many schools now have after-school programs for activities like art, music, and yoga. School counselors could schedule groups to meet before or after these other school activities.
SPECIFIC TECHNIQUES AND STRATEGIES FOR USING PLAY THERAPY IN SCHOOLS

This section reviews specific play therapy techniques and strategies school counselors might use. For convenience, the techniques have been organized according to each of the theories discussed earlier in this chapter.

Child-Centered Play Therapy

CCPT is less a technique and more a way of being with a child. It’s based on Axline’s eight basic principles (1969), which were revised by Landreth (2012):

1. The therapist is genuinely interested in the child and develops a warm, caring relationship.
2. The therapist experiences unqualified acceptance of the child and does not wish that the child were different in some way.
3. The therapist creates a feeling of safety and permissiveness in the relationship, so the child feels free to explore and express himself completely.
4. The therapist is always sensitive to the child’s feelings and gently reflects those feelings in such a manner that the child develops self-understanding.
5. The therapist believes deeply in the child’s capacity to act responsibly, unwaveringly respects the child’s ability to solve personal problems, and allows the child to do so.
6. The therapist trusts the child’s inner direction, allows the child to lead in all areas of the relationship, and resists any urge to direct the child’s play or conversation.
7. The therapist appreciates the gradual nature of the therapeutic process and does not attempt to hurry the process.
8. The therapist establishes only those therapeutic limits necessary to anchor the session to reality and that help the child accept personal and appropriate relationship responsibilities (p. 80).

Child Parent Relationship Therapy (CPRT) is a technique grounded in CCPT. In CPRT, caregivers are taught how to conduct play sessions with their child using reflective listening and tracking. This allows the caregiver to truly see the world through the eyes of the child, enhancing the caregiver–child relationship (Landreth et al., 2006). This 10-week, small-group intervention for caregivers is perfect for use in schools by a trained play therapist. Offering CPRT can assist caregivers in building stronger relationships with their children, while at the same time educating them regarding other uses of play therapy in schools.

Cognitive-Behavioral Play Therapy

CBPT is often used in schools. One CBPT technique, the coping cat program (Podell, Martin, & Kendall, 2008), consists of 16 sessions focusing on generalized and separation anxiety disorders, both of which are common in schools. It uses fun, playful activities such as drawing and feelings charades to help students learn to cope with anxiety. While this technique takes longer than the 12 sessions, the short-term model recommended earlier, the research on its effectiveness has been positive.

A myriad of CBPT techniques would be appropriate for working with individuals, groups, and classrooms, depending upon the interventions needed. Color-Your-Life (O’Connor, 1983) is an activity in which children express their feelings in nonthreatening and creative ways.
The therapist teaches the children the colors commonly associated with various feelings, such as yellow with happy and blue with sad. Children are then asked to use the colors to create a visual representation of feelings they have had in their lives. This is a simple activity and only requires materials readily available in schools. It could be used to help children address various concerns, such as difficulty recognizing, expressing, or coping with feelings.

**Adlerian Play Therapy**

Adlerian Play Therapy can be easily applied in the school setting. This theory focuses on the crucial Cs (courage, connect, capable, and count) and the notion that there are four main goals of misbehavior (attention, power, revenge, and proof of inadequacy). One tool for utilizing Adlerian concepts in schools is Kottman’s (2010) handout regarding these goals with caregivers and teachers. The goals are listed in columns on the side of the form with the following items listed in rows at the top: child’s feeling, child’s actions (active), child’s actions (passive), adult’s feelings, and child’s reactions. Beneath each of these headings are item examples, helping to identify the child’s goal of misbehavior. The counselor can utilize this with teachers and caregivers by inviting them to identify how they feel when they are with the child and from there, see what the child may actually be feeling and needing when the behaviors occur. This is enormously helpful for building empathy and understanding with the adults in a child’s world.

Adlerian play therapy utilizes techniques such as therapeutic metaphors, early recollections, and creating stories in the sand. Its focus on the egalitarian relationship, encouragement, and tendency to be more directive are aspects school counselors typically appreciate. In metaphorical storytelling, for example, the counselor pays close attention to the toys the child plays with and the stories he or she tells and uses this information to create a story about issues the child is dealing with. The counselor would then use the child’s preferred toys or mode (making a book, drawing, creating music) to tell this story to help the child gain insight and learn new ways of handling similar situations. The counselor would gently process this story with the child, being careful not to personalize too much of the information before the child is ready.

This section reviewed some specific techniques and strategies for utilizing child-centered, cognitive-behavioral, and Adlerian play therapies in the school setting.

**RESEARCH/EVIDENCE BASE**

The need for more research is play therapy has been recognized by the Association for Play Therapy, and in 2013, a research strategy was developed to help boost the credibility of play therapy among other professionals and the general public. This section will review some of the literature, citing the benefits of play therapy.

CCPT has been shown to improve academic achievement, self-esteem, speech and expressive language delays, and adaptive, internalized, and overall behavior in children (Blanco & Ray, 2011; Danger & Landreth, 2005; Post, McAllister, Sheely, & Flowers, 2004; Kot, Landreth, & Giordano, 1998). Traumatized children who received CCPT after an earthquake exhibited significant decreases in overall anxiety, physiological anxiety, worry/oversensitivity, and suicide risk (Shen, 2002). Understanding these benefits can assist school counselors in planning interventions for children in the school setting. A frequently mentioned drawback to the use of CCPT in schools is the time it takes to see results. Recent studies, however, have found positive results with short-term, child-centered play therapy. One example of this was the previously mentioned study by Blanco and Ray (2011), in which CCPT was implemented with first graders who were identified as academically at risk and received 30-minute child-centered play therapy sessions.
for 8 weeks. There was a statistically significant increase on the academic achievement assessment utilized.

CBPT has been successful in addressing issues related to trauma, sexual abuse, domestic violence, emotional/affect regulation, social skill development, anxiety, aggression, and depression (Drewes, 2009).

Ray, Bratton, Rhine, and Jones (2001) conducted a meta-analysis of play therapy outcome research and found play therapy was an effective treatment for helping children deal with their problems. This was groundbreaking research because it spanned a 60-year period and included 94 studies, 36 of which were conducted in school settings. Research has shown positive results for improving young children's academic achievement and spoken language and decreasing ADHD, anxiety, and externalizing behavioral problems (Blanco & Ray, 2011; Blanco, Ray, & Holliman, 2012; Garza & Bratton, 2005; Ray, Schottelkorb, & Tsai, 2007).

CONCLUSION

In spite of some potential logistical challenges, play therapy appears to be an important, developmentally appropriate, and effective intervention in the school setting. To help overcome some of the logistical challenges, it is important for school counselors who are engaged in providing play therapy services to do several things. First, they must ensure they are well trained and are offering high-quality services. Second, they need to consistently collect data demonstrating the effectiveness of their play therapy interventions and disseminate these results to caregivers, teachers, and school administrators. Where possible, publishing this outcome data in both educational and mental health journals, such as the International Journal of Play Therapy, will further support the importance of this work. Last, school counselors need to work with their professional organizations and the many state educational boards to encourage the inclusion of play therapy as part of the school counselor's job description. Easier and more regular access to the healing properties of play therapy can only benefit children and, in the long run, society at large.

REFERENCES


Adhering to legal, ethical, and professional standards should be a pervasive concern and cross-theoretical mandate for all play therapists. Whether adhering to or employing any of the theories and techniques discussed in this book, all play therapists should be well versed in the legal and ethical standards that govern their license and are consistent with state and federal law. While most play therapists are quite familiar with the ethics codes governing their profession, they tend to be less prepared to address many of the legal issues that may arise in the course of their work with children. This chapter will address several of the more common legal situations and issues faced by play therapists, as well as the ethical concerns associated with each.

Readers of this book are dedicated to exploring and using play therapy, based on a belief and recognition that children do not therapeutically communicate in the same way adults do. This does not, however, change the legal and ethical standards applicable to all psychotherapists. In fact, because play therapists commit to working with a largely dependent population with varying levels of psychological capacity, it can be argued they need to be even more committed to addressing legal issues with a balanced concern for their child clients and the requirements of the law. Although the focus of play therapy is consistently on the child and the child's world, it is important to remember play therapy happens in the context of an adult world—a world consistently focused on legal issues.

Also, while traditionally the child is the focus of treatment in play therapy, exclusion of the primary caretakers from the process is both impractical and, in fact, a potential legal issue. In most cases, these caretakers not only have legal responsibility for the child, but also are the adults who spend the majority of time with the child. Play therapy interventions must be systemic and inclusive; this is not only a clinical recommendation, but also arguably a legal and ethical imperative.

Finally, legal and ethical considerations faced by play therapists are not based upon the modality of play therapy nor theoretical approach to play therapy. While play therapists have the legal and ethical responsibility to receive adequate training and supervised experience in play therapy—and are free to operate out of a variety of theoretical and technical approaches—the expectation and requirement to comply with legal and ethical standards remains the same.
The Association for Play Therapy (APT) established Play Therapy Best Practices (2012). Although these are only recommended and not mandatory for APT members, they serve play therapists well in terms of dealing with legal and ethical issues. In addition, play therapists are required to adhere to the ethical guidelines established by mental health organization governing their profession as well as any applicable state and federal laws and statutes. As this brief chapter considers legal issues for play therapists, it is suggested that the play therapy profession base its legal identity on the following statement from the APT Foundation: “The primary responsibility of the play therapist is to conduct therapy that respects the dignity, recognizes the uniqueness and promotes the best interests and welfare of the client” (APT, 2012, p. 2).

COMPETENCE AND CONSENT: WHERE ETHICS AND THE LAW OVERLAP

When working in play therapy with children, it is imperative to remember that although the child may be the focus of treatment, the legal guardian is essentially the client from a legal and ethical perspective (Sweeney, 2001). This is simply because the presumption of the state is that minors are legally incompetent. The age of consent, the point at which children can be considered competent, varies from state to state and will be discussed further later in this chapter.

Generally, children are not considered to have the legal capacity to consent (or refuse) services or the right to obtain and retain privilege in regard to confidential and privileged information. It is the legal guardian, who is the holder of these rights. This can make the legal and ethical aspects of counseling children ambiguous for play therapists and their clients. Henderson and Thompson (2011) commented: "Working with children creates particular challenges for counselors because the rights of minors are more ambiguous than some other points of law and ethics" (p. 118). In combination with ethical standards and law, they also suggested that:

- Many situations have no right solution; the final answer depends on your counseling setting, the philosophy of your practice, the interpretation of the law by your local or state authorities, potential advantages or disadvantages of the solution, and the risk to the counselor and client. (p. 139)

The tenet of informed consent by itself is relatively straightforward. Clients have the right to know what they are getting into when they come in for psychotherapy. It is the process of informed consent that can become complicated, particularly in the treatment of minors.

While there are many elements to the informed consent process, the principle fundamentally involves three primary issues: (1) Therapists must disclose all relevant information about the therapy process; (2) clients must comprehend this information; and (3) clients must agree to voluntarily participate in the therapy process. These elements bring up challenging issues when working with children.

In most states, prior to the legal age as established by law, children are judged to be legally incompetent. They cannot enter into contracts, sign legal papers, or make legal decisions. Adding developmental considerations, therefore, they cannot comprehend the information given, nor can they voluntarily participate in a contractual therapeutic process. Fundamentally, the presumption of the state is that: (a) minors are legally incompetent, (b) minors do not have the capacity to consent to (or refuse) professional services, (c) minors to not have the right to obtain and retain privilege in regard to confidential information, and (d) it is the legal guardian—most often the parent—who is the holder of these rights.
It is also important to remember that only a legal guardian can give consent on behalf of the child. Informed consent, when given by a person without the legal authority to do so, is not informed consent. It is thus important to ensure that the person that is signing—perhaps a non-custodial parent, foster parent, an aunt or uncle, a grandparent, probation officer, stepparent—has the legal authority to do so. Many professionals choose to ask all caregivers to provide legal proof of their ability to consent to the child’s treatment, such as copies of birth certificates, guardianship papers, adoption decrees, the custody agreement portion of the parents’ divorce decree, and so forth. While this may seem excessively legalistic, having such documents can prove invaluable should someone later challenge the decision to place the child in treatment.

There are exceptions to the requirement to obtain what is generally parental consent. These include such circumstances as emergency treatment; an emancipated minor; drug and alcohol treatment; counseling for birth control, pregnancy, or STD; or as otherwise permitted by state law. States vary on the age of consent, and it is crucial that play therapists be familiar with the jurisdictions of their own practices. Specifically, play therapists need to know the age of majority, the laws concerning emancipated minors, the minor consent statutes, and the conditions that may affect the applicability of these consent laws.

In addition to the issue of the competence of minors, specifically as it relates to consent, a different consideration and equally important use of the term competence involves whether play therapists are practicing within the scope of their own expertise. The APT’s Play Therapy Best Practices (2012) specifically states:

Play therapists practice only within the boundaries of their competence. Competence is based on training; supervised experience; state, national, and international professional credentials, and professional experience. Play therapists commit to knowledge acquisition and skill development pertinent to working with a diverse client population. (p. 14)

The very definition of play therapy from the APT (2014)—which defines it as “the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development” (http://a4pt.site-ym.com/?page=WhyPlayTherapy)—focuses on the crucial need for training. It is a clinical, ethical, and legal mandate that play therapists have at least adequate training and supervised experience in the field. Too many play therapists have read an article or book, or have attended a single workshop, and consider themselves adequately prepared. This may not be the case.

Competence is both an ethical and legal concept: “From an ethical perspective, competence is required of practitioners if they are to protect and serve their clients . . . From a legal standpoint, incompetent practitioners are vulnerable to malpractice suits and can be held legally responsible in a court of law” (Corey, Corey, & Callanan, 2011, p. 326). The process of achieving and maintaining competence should be intentional, with the focus that is particularly important for therapists choosing to work with children.

**RECORDKEEPING**

Recordkeeping is as much a legal issue in play therapy as it is a clinical and ethical one. Solid maintenance of records minimizes legal risk. Sweeney (2001) notes that the “play therapist has the responsibility to maintain records that are professionally adequate, appropriately secure, and retained for a prescribed length of time” (p. 71). While few play therapists relish the clerical
aspects of their job, it is a legal and ethical imperative. Every psychotherapist is responsible for the appropriate production and maintenance of records. Corey et al. (2011) assert that the "primary purpose for keeping records is to provide high-quality service for clients and to maintain continuity of service if other professionals are involved" (p. 172). In addition, play therapists should maintain records to ensure that the best services are being provided and that there is evidence that these quality services are provided in keeping with the standards of the play therapy community and their own professional licenses.

All psychotherapy files should include (but are not limited) to: identifying information, dates of service, types of service, fees and billing information, intake information/assessments, informed consent and professional disclosure documentation, treatment plans, progress notes, psychological testing, termination and summary information, and consultation with or referral to other mental health professionals. Also, it is particularly important to include all documentation relating to legal interactions or activities. The acceptable content of these items is beyond the scope of this chapter, and it is recommended that readers consult colleagues and the relevant literature.

Reasonable standards for all play therapists to consider in the production and maintenance of records are: (a) Would the therapist feel comfortable having the parent view the clinical file, which they most often have the legal right to do; (b) would the therapist feel comfortable having the file reviewed 5 years later, in the full light of day, by a jury of their play therapist peers; and (c) most importantly, would the therapist feel comfortable having the file subpoenaed and reviewed by persons in a legal proceeding?

Play therapists are also responsible for the secure maintenance of client records. The first recommendation is that all play therapists and the agencies with which they are affiliated have a written policy regarding how client records are handled. For play therapists who are working in practices to which the Heath Insurance Portability and Accountability Act (HIPAA) requirements apply, there must be written policies regarding records. These policies must be open for client review. Typically, clients sign documentation acknowledging these policies are available for review.

Generally, play therapists should provide for two layers of security for client records. For written records, these should be securely stored in a locked file cabinet behind a locked door (preferably there would be two locked doors—the door to the room that the records are stored in and the locked office). For records that are stored on a computer, the files should be encrypted, and the computer should have a secure password. This password should be changed at regular intervals.

A unique part of play therapists’ records include art or other expressive creations on the part of clients. Original artwork, photos of sandtray creations, genograms created in an expressive format, for example, should be treated with the same respect and confidentiality as any other part of the client records, as should any audio or video recordings of play therapy sessions.

With regard to the appropriate length of time for play therapists to maintain client records, all states and most professional organizations have stated minimums. Play therapists are responsible to be fully aware of these requirements. It is generally recommended that records for minor clients be maintained for the locally required limit beyond the age of majority. This may also vary according to the play therapist's jurisdiction of practice. Generally, it is wiser to maintain records for too long than not long enough.

Play therapists should have a consistent policy for the disposal of confidential client material in a secure manner. This usually involves the destruction of written files through shredding or the erasure of computer records that involves software that precludes later access through exploration or discovery.
An issue related to recordkeeping is the common practice for play therapists (particularly play therapists working under supervision) to video record their sessions both for supervision and professional growth. This creates both a legal and ethical issue that needs to be appropriately handled. Proper authorization from the legal holder of consent needs to be obtained. This can be part of the initial informed consent documentation, but because of the sensitive nature of video recordings, it is suggested an additional separate authorization be secured.

It is also important to realize that any recording is part of the client record, and thus needs to be appropriately handled and secured. Recordings should not be considered a replacement for standard records. Some play therapists use video recordings to make it easier for them to later write up the contents of the session in their clinical charts. This is a rather time-consuming and tedious process, and it is not recommended. Video recordings should generally be destroyed or erased following the termination of therapy, unless there is a clinically or legally compelling reason not to do so.

CHILD ABUSE AND REPORTING

It is common and accepted knowledge that all psychotherapists have a legal obligation to report child abuse to appropriate authorities. While the definition of child abuse may vary by state or jurisdiction, it generally involves injury to a minor (usually defined as a person less than 18 years old) that is not accidental. This includes, but is not limited to: (a) physical abuse, (b) sexual abuse, (c) neglect, and (d) emotional or mental abuse. Within these general categories, there are also such issues as drug-addicted newborns, shaken baby syndrome, involving a child in illegal activities, exposure to domestic violence, inadequate child care, abandonment, failure to thrive, threat of harm, child exploitation or sale, and many other possibilities. The obligation of play therapists to report is unquestionable.

What, when, how, and to whom one must report may vary by jurisdiction. It is the play therapist’s responsibility to be aware of state laws. Not only is mandated reporting a legal obligation, but the failure to report may result in civil and/or criminal liability.

The role of the play therapist is to report suspected abuse, not to investigate the details of the suspected abuse. This should be left to the governmental agency (e.g., Child Protective Services) or government-sanctioned agency. This will be discussed further in the following section.

ON BEING A THERAPIST OR AN INVESTIGATOR

The roles of therapist and investigator should remain separate and distinct. The therapeutic and relational aspects of the child–play therapist experience and the difficult but necessary nature of the investigative process, while related, should not be merged. Children can experience significant anxiety and perhaps some level of retraumatization as a result of the investigative process and, therefore, experience an increased need for continued support in the therapeutic relationship. If the play therapist becomes the primary or even an ancillary part of the investigation, the therapist’s ability to remain in this supportive role becomes tainted, if not impossible.

Lowenstein (2011) shares this perspective, suggesting: “It is recommended that different individuals carry out the function of independent unbiased evaluator of sexual abuse and the carrying out of therapy once it is shown to exist” (p. 294). This recommendation may fall short, however, as it suggests the therapist may be involved in proving that abuse exists in the first place.
Melton, Petrila, Poythress, and Slobogin (1997) discuss some of the difficulties in the opposing roles of therapist and investigator:

- The techniques involved in forensic assessment also may be antitherapeutic. Forensic evaluations typically must be conducted in a relatively short time, are not for the subject's own benefit, often focus on highly emotionally charged events, and commonly involve matters about which there is motivation to lie. As a result, forensic interviews often are confrontational and address traumatic memories faster than would be common in therapeutic assessment and intervention.

- Role confusion is another likely outcome for the mental health professional who undertakes both forensic and therapeutic work. Such a clinician may easily forget the fact that the ultimate client in the forensic evaluation context is not the person being evaluated.

- Because of the exercise of authority that may be involved, forensic practice may alter clinicians' perspectives or reputations in ways that interfere with therapeutic evaluations and interventions with clients without legal-system involvement. Mere association with the justice system may be enough to compromise the clinician's current and potential therapeutic relationships.

- Overcoming the obstacles to sustained relations between the mental health and justice systems requires a level of commitment that may be unrealistic for clinicians for whom forensic work is a secondary task (p. 96).

The roles of therapist and investigator may thus become diffuse and confusing. Melton and Kimbrough-Melton (2006) summarize these concerns:

If a mental health professional becomes concerned with gathering evidence and helping the prosecution to make its case (whether for conviction and incarceration of an incestuous father or a civil adjudication of abuse, placement of the child in foster care, and ultimately termination of parental rights), will the clinician's ability to function as therapist for the child or the family be compromised? Indeed, will the slippage into law enforcement activities compromise that clinician's ability—or even other clinicians' ability—to help other children and families? (p. 37)

It is not unusual for a child therapist to make an initial report, and then be told by the receiver of the report that further information is needed from the child. Play therapists may be given instruction on what information is needed and what action or questions they should use. Play therapists are then free to choose how to proceed. A suggested response to this, however, might be that if Child Protective Services (or another agency) believes there is enough information to warrant suggesting further action or questioning be undertaken by the therapist, that they are responsible for taking this action. The play therapist can then continue in the therapeutic role.

The roles of being therapist and/or investigator are generally not addressed in statute or case law or in the ethical codes of professional mental health organizations. It is essentially up to play therapists if they want to mix the roles to any degree or completely separate them.

Although taking on the roles of both therapist and investigator are not specifically addressed in ethics codes, it could be argued that it falls under the umbrella of taking on a dual or multiple role. The codes of ethics for all major mental health professions prohibit dual or multiple relationships. For example, the APA ethical code for psychologists states: "A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as
It should also be pointed out that while play therapists may not want to serve in an investigative role, they may be served with a subpoena or be called upon to testify regarding material that has been revealed in the play therapy process. Subpoenas and testifying will be discussed in the next section of this chapter. In addition, it has been noted by Snow, Helm, and Martin (2004) that “despite the lack of research supporting the use of play therapy sessions as court testimony, play therapists are asked to testify concerning the psychological damage a child has suffered from abuse” (p. 77). This is in addition to “fact” testimony as to verbal or nonverbal disclosures the child made in the course of treatment.

DEALING WITH SUBPOENAS

It can be an intimidating experience for play therapists to receive and respond to legal subpoenas. Play therapists may react to this intimidation with panic, which can result in ignoring the subpoena or immediately responding with all requested materials. Either of these quick reactions could be an ethical, legal, and/or clinical mistake. Responding to subpoenas may well be complicated, and a measured reaction with the benefit of consultation is the best response.

What is a subpoena? Essentially, it is a legal document or order that requires the play therapist to appear and testify and/or produce documentation of some kind. A subpoena duces tecum (from the Latin, meaning “bring it with you”) is an order requiring the play therapist to bring documents. These documents are normally specified in the subpoena. Subpoenas are usually served by neutral persons who are not a direct party to the legal situation or litigation. Failing to respond to a subpoena could lead to being held in contempt of court. At the same time, simply because the play therapist has been served does not mean that the subpoena is valid or that the therapist must produce all the requested documentation.

There is a difference between a subpoena and a court order. A subpoena fundamentally requires a response, although the play therapist’s response may or may not be what is requested in the subpoena. By contrast, a court order is generally issued by a judge and accordingly compels a disclosure. In such cases, the court determines what oral or written disclosures may or may not be protected.

When served a subpoena, play therapists should neither acknowledge that they know or treated the person noted in the subpoena. The subpoena should be examined to determine its validity and to determine who has issued it. Contacting the client, when appropriate, is generally the most important initial action. Assuming the legal guardian is willing, obtaining his or her authorization to release the information is the easiest and simplest way to respond. However, if the legal guardian does not wish to have the subpoenaed material disclosed, the play therapist is placed in a difficult situation. In either case, the play therapist should not provide any more information than what the subpoena is requesting; for example, a simple summary of the treatment process may be acceptable.

Even if the client provides authorization, the play therapist should ascertain whether release of the information might be clinically damaging. If this is the therapist’s belief, and the client, attorney, or court insists on its release, the therapist should document these concerns in the client file. No matter how aggressively the subpoena is worded or issued, the play therapist should not immediately produce oral or written material. It is important to accept the subpoena and then to consult with knowledgeable experts, including clinical colleagues, attorneys, and legal counsel through professional organizations, as well as the play therapist’s malpractice insurance
to determine the best course of action. Koocher, Norcross, and Hill (2004) suggest the following actions:

- If a subpoena arrives from a client’s attorney and no release form is included, check with your client, not the attorney, before releasing the documents. In a technical sense, a request from a client’s attorney is legally the same as a request from the client; however, it is not unreasonable for the clinician to personally confirm the client’s wishes, especially if the content of the records is sensitive.
- If a signed release form is included, but the clinician believes that the material may be clinically or legally damaging, discuss these issues with the client.
- Psychologists concerned about releasing actual notes should offer to prepare a prompt report or summary, but they ultimately may have to produce the full record. The original record or notes need not be provided. A notarized or authenticated copy of the records will generally suffice.
- On rare occasion, a subpoena generated by an attorney opposing the psychologist’s client or representing another person may arrive at a clinician’s office in the hands of a person seeking immediate access to records. Under such circumstances it is reasonable to inform the person: “I cannot disclose whether or not the person noted in the subpoena is now or ever was my client. If the person were my client, I could not provide any information without a signed release from that individual or a valid court order.” Next, contact your client, explain the situation, and ask for permission to talk with the client’s attorney. Ask the patient’s attorney to work out privilege issues with the opposing attorney or move to quash the subpoena. These steps will ensure that the person to whom you owe prime obligations (i.e., your client) is protected to the full extent allowed by law (p. 571).

TESTIFYING IN COURT

It is important to recognize a crucial antithesis between play therapy and the court process. Play therapy is built upon relationship and collaboration. Because the court process often involves two (or more) opposing parties, it is usually adversarial in nature. In many ways, this places play therapists on unfamiliar and intimidating ground.

Play therapists need to recognize the importance of the concept of credibility in any legal process. Credibility is certainly established by the professional presentation of the play therapist’s training, experience, and credentials. It is also important to recognize that credibility is established by the manner in which play therapists present themselves in terms of professionalism, attitude, and even appearance.

When it comes to court testimony, play therapists will usually testify as either a fact witness or an expert witness. It is important to understand the difference between these roles before entering into the process. Folero and Wrightsman (2009) noted that, while fact witnesses “can only testify about what they have observed or what they know as fact, expert witnesses may express opinions, for they are presumed to possess special knowledge about a topic, knowledge that the average juror does not have” (pp. 31–32).

Fact witnesses testify only about facts they can see, hear, touch, taste, or smell. Bratton and Wallace (2013) note that play therapists serving as fact witnesses are “only permitted to address specific comments or events that occurred in counseling” (p. 17). Fact witnesses generally do not offer opinions outside of their own perception of the facts, which is subject to the objections of both the judge and attorney(s). Imwinkelried (as cited in Bratton & Wallace, 2014) stated:
“The [fact] witness states the primary, sensory data, and the jurors then draw the inferences or conclusions from the underlying data” (p. 17). To be an effective fact witness, play therapists should be prepared and professional. They should be ready to answer questions in the direct examination process, which is directed by the attorney on the side that has called them to witness, and in the cross-examination process.

Expert witnesses have specific and unique knowledge (usually technical or scientific) that allows them to give expert opinions. This specific and unique knowledge stems from education/training and skill gained from experience. Expert witnesses can testify about facts and also can give informed opinions in their area of expertise. To be effective expert witnesses, play therapists should be: (a) experts in the fields of psychology, psychotherapy, human development, and play therapy; (b) engaging and interesting—to both listen to and watch; (c) able to confirm their testimony, based on current research and clinical literature and their current clinical experience; and (d) levelheaded and unruffled during testimony, including during cross-examination.

It is less intimidating to be a fact or expert witness when testifying under direct examination by the attorney who has called the play therapist to serve as a witness. It is in the best interests of this attorney's clients for the attorney to cast the witness in the best possible light. Under cross-examination, however, the play therapist as witness may be considerably challenged. It is the task of both sides to provide zealous representation, thus it is the task of the cross-examining attorney to attack the credibility of the witness. Generally, the attorney who called the play therapist to be a witness will also prepare the therapist for the expected cross-examination.

The cross-examination may include attempts at undermining the witness' credibility and leading questions, which may catch the play therapist off guard after having undergone the process of direct examination. While there are various strategies that might be discussed to guide the play therapists responses to such confrontations, it is suggested they rely primarily on the basic therapeutic skills they have acquired through training and experience, as dealing with confrontation should not be a surprise for experienced psychotherapists.

CUSTODY ISSUES

Play therapists, as experts on the needs and best interests of children, may be called upon to conduct custody evaluations. Similar to therapist-versus-investigator issues previously discussed, the potential for conflict between the role of therapist versus custody evaluator must also be considered. It is contended that these roles are best when kept separate, although play therapists may be called upon to provide fact or expert witness testimony regarding custody recommendations in ongoing therapy cases.

Arguably, play therapists are uniquely qualified to conduct custody evaluations because of their expertise in child and family dynamics. While this may be correct, it is best if the custody evaluator is not providing therapeutic services to any member of the family when custody is being assessed. It can be challenging to maintain an objective and impartial stance when conducting any custody evaluations, and this is even more likely when the evaluator has a previously established therapeutic relationship with one or more of the family members. Further, if a previous counseling relationship does exist, not only can bias be an issue, but also one or both parties can later make an accusation of bias if they are dissatisfied with the custody recommendation and/or result.

While the existence of a therapeutic relationship can bias the evaluation process, the reverse is also true. Although neutrality is the goal for a custody evaluator, bias may emerge toward or against one parent for a variety of reasons, including: (a) personal interactional or relational style
of either parent, (b) accusations or suspicions of child abuse by either parent, (c) accusations of domestic violence toward either parent, (d) beliefs or values that are congruent or incongruent with those of the evaluator, (e) perception of parental involvement or alienation, or (f) the evaluator’s agreement or disagreement regarding parenting style or techniques. These and other biases could easily contaminate the therapeutic relationship the play therapist has with the child and either of the parents.

Custody evaluations can become even more complicated with court-involved parents. Sullivan and Greenberg (2012) summarize several of these potential complications:

Court-involved parents present clinicians with multiple levels of pathology that require systemic approaches to treatment. These parents may come to therapy with vulnerabilities stemming from individual factors such as biology, relational deficits, limited parenting skills, inadequate problem-solving and coping skills, and problems in their co-parenting communication. These individual problems may be further exacerbated by contextual factors in the court system in which the co-parents are imbedded. As the family separates, these individual and contextual factors become intertwined, resulting in the family system being in crisis and chaos. (p. 2)

Custody evaluations also raise risk management concerns for play therapists. Child custody evaluations are frequently the context in which parents file complaints with licensing boards. Glassman (1998) suggested several strategies to reduce risk when conducting custody evaluations:

- **Obtain court appointment.** Court approval immediately signals the evaluator as a credible, objective, and neutral party. An evaluator appointed by the court may receive limited or quasi-judicial immunity against the filing of a malpractice suit.
- **Secure informed consent.** When the evaluator begins a custody assessment, it is essential that participants be provided with a thorough explanation of the evaluation process, fee schedules, limits of confidentiality, and applicable rules governing disclosure of records.
- **Explain the waiver of confidentiality.** Of all the procedural issues involved in custody assessment, the waiver of confidentiality is considered so important that it warrants separate discussion. All evaluation participants, including collateral sources of information, need to be apprised that the role of the custody evaluator differs dramatically from that of a therapist or consultant.
- **Maintain impartiality.** Unintentionally spending more time with one party or failing to apprise counsel of all information contained in the evaluator's file may spark a complaint regarding partiality or bias.
- **Avoid one-party evaluations.** One-party evaluations, unless justified by concerns over imminent danger to the children, are likely to be of limited utility to the court.
- **Avoid ex-parte communications.** Ex-parte communication is the transmission of information—usually of a substantive matter, either orally or in writing—to only one side to a dispute. The neutrality of the evaluator will certainly be challenged should ex-parte communications occur.
- **Provide complete disclosure.** Rules of legal procedure mandate that each side has a right to know what documents, witnesses, and information will be presented at trial. Whenever the evaluator has a legitimate concern about how the disclosure of file contents might harm a party or be misused, both the court and counsel should be advised.
- **Avoid dual relationships.** Changing roles from therapist to custody evaluator will most likely be interpreted as an ethics violation. The custody evaluator should preferably be unknown to the parties prior to appointment.
Preserve a well-documented file. To meet the higher standard for documentation demanded of forensic assessment, the evaluator might consider developing or using standardized procedures for interviewing and data collection, ones that will ensure replicated methodology for both parties (pp. 122–123).

Prior to play therapists conducting custody evaluations, it is important to recognize that laws and guidelines may vary considerably between countries, states, counties, and other jurisdictions. It is advised that therapists consult with other professionals already conducting evaluations and perhaps a family law attorney and family court judge. Play therapists should check if their jurisdiction has specific laws or administrative codes regarding custody evaluations, including (but not limited to):

- What you can and cannot do in a custody evaluation
- What should be included in a custody evaluation
- Specific qualifications, licensure, or training required to conduct a custody evaluation
- What family members can, must, or must not be involved in a custody evaluation
- The issues of child abuse, domestic violence, or other safety concerns
- Privilege and confidentiality in regard to educational, medical, and mental health records, specifically for the parties directly involved with the custody dispute
- The assignment and role of a guardian ad litem, if involved in custody

BEING A LEGAL ADVOCATE

The play therapist may be in a unique position to be a legal advocate for a child in therapy. Doing so may take place within the usual process of child counseling or may push the play therapist beyond the bounds of traditional play therapy.

Because play therapists have unique training and, therefore, a unique view of the child’s world, they can advocate for their clients in a variety of settings. This includes the family system, school, child welfare systems, foster and adoptive situations, residential treatment settings, outpatient and inpatient care, and the legal system. The ability to be a legal advocate may be limited by administrative policies, legal and ethical constraints, and practicality due to potential time and financial constraints.

Helping to prepare a child for a court experience can be thought of as one type of legal advocacy. The play therapist can use a variety of techniques to help a child prepare for this difficult experience, as well as to help a child process the experience after having appeared in court. Related to this, a play therapist may advocate for the child not to participate in the court experience if the therapist determines it not to be in the child’s best interest. This type of legal advocacy, which can be of significant benefit for children, often involves coordination with child welfare, attorneys, and the court system.

One of the most important ways that play therapists may be an advocate as it relates to the legal system is to help children process the experience of abuse disclosure and the subsequent legal process. For example, sexually abused children have already experienced the trauma of their own victimization. The experience of being in court, which often involves testifying and confronting their abuser, can be retraumatizing and recapitulating. Back, Gustafsson, Larsson, and Bertero (2011) conducted a study to assess how sexually abused children experience the legal process. Five major themes emerged from the research: (1) children feeling they were not being believed by the police and the court; (2) the need to make the child sexual abuse visible, often after guilt
and shame had prevented them from earlier revelation; (3) the need for support, especially from their parents, but also from professional therapeutic staff; (4) the need for the offenders to be found guilty and to be sanctioned; and (5) the lack of respect for the child by the police and legal system. The play therapist is in a unique position to address these negative experiences and the emotional aftermath, stemming from both the investigation and adjudication process.

While play therapists may be in a good position to be legal advocates for children in therapy, it can be a delicate process. This stems from the potential view that the play therapist is biased because of the preexisting relationship with the child client. While this perception may by not be fair, therapists who extend their services beyond the typical office experience can be viewed as biased and perhaps as engaging in dual relationships. It becomes important, therefore, for therapists to keep appropriate documentation showing their advocacy stems from professionalism rather than sentiment and to obtain consultation.

LEGAL AND ETHICAL DECISION-MAKING MODEL

All play therapists should have some type of legal and ethical decision-making model by and through which legal issues are evaluated and decisions regarding the best course of action are made. Many models have been suggested over the years. The following is essentially a distillation of lengthier legal and ethical decision-making models, in the form of an alphabetized six-step process. It is argued that this can be applied to the practice of play therapy as well as all other psychotherapeutic legal and ethical situations.

1. **Acknowledge the specific legal and/or ethical challenge.**
   Simply acknowledging a legal situation exists creates the opportunity for the play therapist to explore the issue further, investigate applicable legal codes, and seek the appropriate consultation. It is always possible that the situation will turn out not to actually represent an actual legal or ethical dilemma.

2. **Breakdown relevant legal issues.**
   It is crucial for play therapists to be fully aware of the legal issues, whether related to legal statutes, case law, ethical codes, or administrative standards, relevant to their specific situation, as well as issues relevant to psychotherapy licensure. It is always possible that there could be conflicts between these variables.

3. **Consult with others.**
   It is always best to consult with professionals who are at or above the play therapist’s own level of expertise in the field of play therapy and the wider field of psychotherapy. It is suggested that such professional consultation be done with three professionals, so that some level of consensus can be sought. Often this consultation confirms the action that the play therapist is already considering. It is further suggested that play therapists consult with their primary professional organization (American Psychological Association, American Counseling Association, etc.), most of which have an attorney and/or ethics expert on staff to provide such consultation. It may also be helpful to consult with one’s state licensing board, if such services are available. With legal issues, it is always recommended one seek personal legal counsel.

4. **Decide on and execute the appropriate course of action.**
   Based on the play therapist’s analysis of relevant issues and appropriate consultation, a legal and/or ethical decision must be made. This decision and its execution should be made with confidence, while recognizing that taking no action may be the most reasonable course of action. Regardless, it is important to be clear and purposeful.
5. **Establish written or electronic documentation.**

   The establishment of documentation is crucial. The general principle is that “if it has not been written down, there is no proof that it ever happened.” Whatever the process of documentation is, it needs to be thorough, including the entire decision-making process—relevant codes, policies, and laws considered; persons consulted with (and their level of qualification for being consultants); rationale for making the decision; and so forth.

6. **Follow-up action.**

   Any decision made will have some repercussions, whether positive or negative. These should be evaluated and documented. The play therapist should be prepared for possible backlash and the need to justify the decision made and implemented. Another important reminder is that subsequent recognition of a better course of action does not invalidate the original decision made nor the action taken. This is part of the growth process as a play therapist and professional.

**CONCLUSION**

There are several suggestions that may be helpful when confronting legal and ethical issues for the play therapist. It is helpful and often necessary to consult with other professionals in the field. This consultation often includes conversations with legal professionals. All play therapists should be engaged in ongoing supervision of their practice. This not only assists in the provision of quality clinical services, but also in the recognition of legal and ethical issues that might have gone unrecognized and thus unaddressed. Ongoing, honest, and open dialogue with clients on clinical and legal issues is not just helpful—it is imperative. Clients of any helping professional are more likely to file a complaint or initiate legal action when they feel discounted or ignored. The fact is this: Empathy always works. Finally, any legal issue that is recognized and dealt with, including any action taken by the therapist or the client, should be thoroughly documented in the client record.

All therapists should have ongoing training in the area of legal and ethical practice. It is beyond the scope of this chapter to provide a thorough treatise. Sweeney (2001) suggests that when determining what is good clinical, legal, and ethical practice, there is a “reasonable professional” standard that can be applied. This standard is, essentially: Would a panel of the play therapist’s peers, with similar training and experience, consider the issue at question to be clinically and legally appropriate? If play therapists are willing to subject their practice to this fundamental standard, they should not be concerned. Another way of stating this is: If play therapists are willing to expose their work to the professional and legal community in the full light of day, there should not be a concern.

Interacting with the legal system, while perhaps intimidating and uncomfortable for the play therapist, is not impossible. There are several important things to remember.

- Involvement with the state, the law, courts, and attorneys means walking on different turf and dealing with professionals often unfamiliar with the field of play therapy. Play therapists should respect this turf, recognize that all people involved have their own areas of expertise and perspectives, and grant them consideration even if it seems undue in the moment.
- Recognize that while play therapists are experts in what they do, the legal system involves people who are experts in what they do. Respect given leads to respect earned.
• Learn the legal system and law as much as possible, but do not attempt to practice law. There is the related expectation that the courts and attorneys will not attempt to practice play therapy.
• Whether play therapists like it or not, attorneys and courts make the rules. These need to be abided by. While this is the case, the play therapists are the mental health experts; although they may not make the rules, they have the knowledge and the data the legal system needs to make decisions that are in the best interest of children.
• It is important to recognize that play therapists have different clients than attorneys. The best interests therapists are attempting to promote may not be same as the interests attorneys are trying to promote.
• Know what is being expected by all of the parties involved. The theoretical orientation or “job description” a play therapist has—whether in an agency or in private practice—may not coincide with what is expected of the therapist in the legal system.
• Always respond to legal inquiries, though not immediately, as consultation may be needed. Return emails and phone calls in a timely manner. Ignoring or forgetting is not only disrespectful, it also may be illegal.
• Just as therapists rely on clinical intuition in the counseling room, if something feels wrong in a legal matter, don’t discount this feeling; seek consultation.

There are too few therapists willing to work with children. A smaller percentage of these recognize and employ the therapeutic powers of play. Play therapists really answer a call too few have. This calling should not be interrupted by legal concerns and violations. It is suggested “simply by choosing to touch the lives of children through play therapy speaks positively about a professional’s ethics and values” (Sweeney, 2001, p. 75). Therefore, a basic knowledge of and adherence to legal and ethical principles is not adequate for the play therapist. Rather, aspiration to clinical, legal, and ethical excellence should be the mandate so as to truly reflect the play therapist’s commitment to the welfare of children.

REFERENCES

PART 6

Professional Issues
As a practitioner of play therapy, the assumption is you chose to utilize the powers of play to assist clients’ healing, optimal growth, and development.

You want to ensure that the services you provide are helpful, not harmful. Our clients, however, may have their own opinions about what is helpful and how you should perform as a play therapist. Even the mental health professionals who practice play therapy (counselors, psychologists, social workers, marriage and family therapists, school psychologists, and school counselors) may disagree with each other regarding what is appropriate behavior on the part of the therapist. At times, the ethical guidelines of our professions may be in conflict with the policies and procedures of our employers (schools, agencies, hospitals, etc.), with state and federal laws and regulations, with licensing boards, or with what appears to be in the best interest of the client. The appropriate resolution to an ethical issue might be different depending on your specific professional ethical standards, the location (state or country of your practice), the age of your client, and the specific agency guidelines/policies of your setting.

No handbook exists with the answer to every ethical dilemma that could happen in every setting in every state or country. It is an ongoing challenge for us as play therapists to practice in an ethical fashion regardless of our years of experience. This chapter was not written to serve as a reference with answers to every ethical dilemma; it is designed to increase your awareness of what could be considered an ethical dilemma and to guide you through the process of finding your own appropriate ethical response. It is written with the awareness of the reader’s possible discomfort to the inherent ambiguities of ethical practice.

Play therapy is defined as “the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and resolve and achieve optimal growth and development” (Association for Play Therapy, 1997). The Association for Play Therapy (APT) was formed in 1982 and is now an international organization of more than 6,000 members devoted to the promotion of the value of play, play therapy, and credentialed play therapists. The APT conducts a voluntary registration process that guarantees certain amounts of academic training, practice, and supervision in play therapy. Registered Play Therapists (RPTs) are licensed mental
health professionals who follow the ethical codes of both their particular mental health specialty areas as well as those from the state board that issues that particular license. So even within the specialty area of play therapy, practitioners are regulated by the ethical guidelines of their particular professional organizations and state licensing boards. Although not a licensing board, the APT does provide for its members two invaluable sets of practice guidelines on their website: Play Therapy Best Practices and Paper on Touch: Clinical, Professional, and Ethical Issues.

**UNDERSTANDING DIFFERENCES BETWEEN LAWS AND ETHICS**

Laws are agreed upon rules of society designed to protect the public safety, health, and welfare. Criminal laws address crime or those behaviors causing harm to others and set punishment for violations of those laws. Civil laws address personal interest disputes of individuals, groups, organizations, and the government. Laws are written, approved, and then enforced by the level of government that created the law, whether it is at the federal, state, or local level. Laws may vary between countries, states, or local governments. Laws carrying punishments for violations may include fines or incarceration.

Ethics standards for counselors, psychologists, social workers, and marriage and family therapists, on the other hand, are guidelines for how we should behave as mental health professionals. Consequences for ethical violations may include professional sanctions such as reprimands, loss of license, or mandated supervision.

**LEGAL CONSIDERATIONS**

There are three important federal laws that have affected the mental health professions in the past 50 years: the Family Education Rights and Privacy Act (FERPA), the Health Insurance Portability and Accountability Act (HIPAA), and the Individuals with Disabilities Education Act (IDEA). Each law will be briefly addressed as to its importance to the practice of counseling across settings. Please note these are only brief descriptions, and the reader should pursue additional reading and training for greater understanding.

FERPA was enacted in 1974. It is a set of regulations that applies to those institutions receiving funding from the U.S. Department of Education, such as school districts, preK–12 schools, and postsecondary institutions. FERPA was written specifically for students/parents and guarantees the right to inspect and review their education records, the right to seek to amend education records, and the right to have some control over the disclosure of information from those education records. FERPA requires schools or systems annually send a notice to parents or guardians regarding their right to review their children’s records and to file a complaint if they disagree with anything kept in the record. The system has 45 days to comply or risk losing federal funding. Consent transfers to the student at age 18, but does not specifically limit the rights of students who are 18 and still in high school. Noncustodial parents have the same rights as custodial parents unless there is a court order specifying otherwise; however, stepparents or grandparents who do not have custody are not included under FERPA unless granted by a court order. The Protection of Pupil Rights Amendment (PPRA) gives parents additional rights including requiring informed parental consent before the student is subjected to any examination, testing, or program designed to affect the personal values or behavior of the student. It is also gives parents the right to review instructional programs. No Child Left Behind (NCLB) continued to increase parental rights.
Another federal law relating to mental health practice is the Health Insurance Portability and Accountability Act of 1996. HIPPA primarily protects health insurance coverage for workers and their families when they change or lose their jobs. Title II of HIPAA, known as the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers. The AS provisions also address the security and privacy of health data. The standards were created to improve the efficiency and effectiveness of the nation’s health care system by encouraging the widespread use of electronic data interchange in the U.S. health care system. The privacy rule specifically excludes any individually identifiable health information covered by FERPA. Health records in schools under FERPA are specifically excluded from HIPAA. Agencies and school systems must develop policies and procedures to address the potential conflicts between FERPA and HIPAA (Erford, 2010).

IDEA (http://idea.ed.gov/) was originally enacted by Congress in 1975 to ensure children with disabilities have the opportunity to receive a free appropriate public education, just like other children. The law has been revised many times over the years. The most recent amendments were passed by Congress in December 2004, with final regulations published in August 2006 (Part B for school-aged children) and in September 2011 (Part C, for infants and toddlers). Although the law is very new, it does have a long, detailed, and powerful history. It appears to be focused on education and is of primary interest to school counselors and school psychologists. Other mental health professionals (e.g., those who work in agencies, hospitals, and private practice) need to be aware of the ramifications for their child clients and be able to consult/collaborate with schools to assist children with academic and personal/social success.

In addition to federal laws, each state has enacted binding legislation upon the practice of therapy in the state. Licensing boards (professional counseling, social work, marriage/family therapy, rehabilitation counseling, psychology, etc.) review regulations and may develop policies on how to implement a specific law. State departments of education create laws that are binding on the school employees of their particular state. In addition, individual school systems or mental health agencies create policies and procedures they expect their employees to follow. For example, some states have laws requiring parental consent for a child to receive services from a school counselor. Other states have no such laws, as school counseling is deemed part of the overall educational program and does not require parental consent. Even without a state law mandating parental consent for school counseling, an individual district may create a policy requiring parental consent before a school counselor sees a student. Clearly, it is a challenge for counselors to keep abreast of ethics, federal and state laws and regulations, and school district and agency policies and procedures. At times, school counselors, psychologists, marriage and family therapists, social workers, and clinical mental health counselors may feel they are speaking different languages as they can be governed by different laws and ethics.

**ETHICAL DICHOTOMIES**

As play therapists, we usually want a very clear map of exactly what is expected of us as professionals. The study of ethics may at times be very frustrating because there is much ambiguity inherent in the history and practice of ethics. In the field of ethics, there are three common ethical dichotomies that have opposing viewpoints: ethical absolutism versus ethical relativism, utilitarianism versus deontology, and egoism versus altruism (Remley & Herlihy, 2007). Another ethical dichotomy that frequently occurs is that of principle ethics versus virtue ethics. These ethical dichotomies are discussed in this section in order to provide for you a foundation for understanding the complexity involved in ethical issues.
Ethical Absolutism Versus Ethical Relativism

Ethical absolutism is the doctrine that there is only one eternally true and valid moral code applicable to everyone, in all places, and at all times, whether or not they realize it. Historically, ethical absolutism stems from the Judeo-Christian tradition. Morality is seen as being issued from God's commandments and it not relative to time or circumstance.

Ethical relativism is the view that what is right or wrong is not absolute but variable depending on the person, circumstances, or social situation. This view originated from the works of Protagoras, a leading Greek Sophist of the fifth century BC. Ethical relativism believes what is really right depends solely upon what the individual or society believes to be right, which will vary with time and place. Therefore, there is no objective way of justifying any principle as valid for all people or all societies.

Utilitarianism Versus Deontology

Utilitarianism is an ethical framework focusing on the outcomes or results of actions. Utilitarianism comes from the Greek word τέλος, which means “end.” Acting ethically, according to utilitarianism, means making decisions or taking actions that benefit people by maximizing “good” and minimizing “bad.” The ends can justify the means, and theoretically, it is possible for the right thing to be done for the wrong or bad motive.

Deontology is the ethical position judging the morality of an action based on the action's adherence to a rule or rules. The word comes from the Greek words for duty (ὅντος) and study (λόγος). Deontological ethics have three important features: Duty should be done for duty's sake, human beings should be treated as beings of intrinsic moral value, and a moral principle is a categorical imperative that is universal.

Egoism Versus Altruism

Ethical egoism is the view that a person should pursue his or her own self-interest, even at the expense of others. It does not require moral agents to harm the interests and well-being of others when making moral deliberation. What is in an agent's self-interest may be beneficial, detrimental, or neutral in its effect on others.

Ethical altruism is the philosophical doctrine of living for others rather than for oneself. The French philosopher Auguste Comte coined the word altruisme in 1851, and it entered the English language two years later as altruism. Ethical altruism holds that moral agents have an obligation to serve and help others.

Principle Ethics Versus Virtue Ethics

Principle ethics refers to the question of “What should I do?” Principle ethics is a theory of moral philosophy promoting morals and responsibility and includes rules and consequences. These include respect for autonomy, nonmaleficence, beneficence, justice, fidelity, and veracity.

Autonomy is defined as respecting an individual’s decision-making process and recognizing independence and self-determination. Nonmaleficence is avoiding doing any harm and preventing harmful actions and effects. Beneficence entails doing good and promoting well-being and health. Justice promotes fairness and equity in dealings. Fidelity involves being responsible to clients and honoring agreements. Veracity means being truthful and honest with others.

In contrast to principle ethics, virtue ethics refers to the question of “Who should I be?” Virtue ethics is a theory of moral philosophy that puts emphasis on character rather than rules of consequences. The first systematic description of virtue ethics was written by Aristotle in the
Nicomachean Ethics (Cooper, 2004). According to Aristotle, when people acquire good habits of character, they are better able to regulate their emotions and their reasons. This, in turn, will assist them in making morally correct decisions when faced with difficult choices. In response to the question “Who should I be?” the mental health professions believe we should be persons with integrity, discernment, acceptance of emotion, self-awareness, and interdependence with the community (Pope & Vasquez, 1998). A person with integrity acts consistently in accordance with values, beliefs, and principles he or she purports to uphold. A virtuous person makes choices using discernment with wisdom and judgment. Acceptance of emotion is an important part of a virtuous person’s definition of who he or she should be. Self-awareness involves the ability to see clearly one’s own behaviors, personality, and beliefs in relation to others. Finally virtue ethics emphasizes an ethical person has an interdependence with the community.

Mental health codes of ethics have been developed for a variety of reasons (Herlihy & Corey, 1996; Mappes, Robb, & Engles, 1985; Pope & Vasquez, 1998; VanHoose & Kottler, 1985), including to protect the public; educate members of the profession; ensure accountability; serve as a catalyst for improving practice; protect the profession from government; help control internal disagreement, thus promoting stability in the profession; and protect practitioners in terms of malpractice suits or state licensing complaints (Fischer & Sorenson, 1996).

When a play therapist is charged with the legal or ethical violations regarding behaviors with a client, public confidence in play therapy is undermined. When a play therapist’s harm of a client comes becomes public, the behaviors of all other play therapists are more carefully scrutinized so further abuses do not occur. The public trust in play therapy is critical to the field. Regulatory boards exist to monitor and protect the public and ethical codes, and state and national laws are used to make decisions regarding a therapist’s competence and fitness. Play therapists who harm clients may face disciplinary actions by the state board and may include suspension or revocation of the license to practice.

A code of ethics is vital to the process of educating members of the profession. By having a set of standards, play therapists have a set of principles to follow when issues or dilemmas arise. It is an expectation in all mental health professions that members be accountable for their behaviors. A code of ethics provides the necessary framework for the process of accountability.

Finally, through discussion, review, and revision of the various ethical guidelines, the practice of play therapy can be improved. Ultimately, the goal is to provide the best help possible for clients and to minimize any risk of harm.

**ETHICAL DECISION-MAKING MODELS**

Unfortunately, codes of ethics do not provide a method to solve ethical dilemmas. Instead, mental health professionals rely on ethical decision-making models to help them make informed and appropriate decisions when they face ethical dilemmas. Numerous models have been proposed for mental health professionals (Corey, Corey & Callanan, 2007; Cottone & Claus, 2000). The ethical principles proposed by Kitchener (1984) are presented to help understand the foundations of ethical concepts pertaining to professional practice.

**Kitchener’s Ethical Principles**

An ethical dilemma is a situation that involves conflicting or opposing principles (Urofsky, Engels, & Engebretson, 2008) without an obvious right or wrong answer. When there is a need to arrive at an ethical decision, it is important to recognize individuals are easily influenced by their own personal values and assumptions and often rely on intuition and emotional factors to guide
decisions (Welfel, 2012). Kitchener's (1984) seminal work on ethical decision making indicated personal value judgments and moral intuition are insufficient for assuring ethical choices, and value judgments are not equal among all individuals (see also Cottone & Claus, 2000). Cultural norms, political pressures, and flawed understanding can greatly limit the wisdom of intuition, resulting in unethical decisions (Welfel, 2012).

In order to minimize the potential for harm to clients, mental health professionals must be committed to ethical practice that transcends personal opinions and aligns with ethical codes and accepted standards for best practices (Urofsky et al., 2008; Welfel, 2012). Kitchener's model (1984) supported the need for carefully evaluating ethical issues from a cognitive reasoning approach. When more than one of the principle ethics of autonomy, nonmaleficence, beneficence, justice, and fidelity conflict, the counselor must thoughtfully and carefully "weigh, balance, sift, and winnow competing principles" (Urofsky et al., 2008, p. 68) to arrive at a reliable ethical decision.

Kitchener's ethical concepts are based on the principle ethics briefly mentioned earlier. These principles will be outlined again, this time giving an example of each from a play therapy perspective.

Autonomy is the concept of personal responsibility to make one's own choices and to have freedom to act on one's own behalf. A second aspect of autonomy, according to Kitchener, is to allow others the same choices and freedoms (Kitchener, 1984).

Nonmaleficence is the principle of "do no harm" (Kitchener, 1984, p. 47), either by not intentionally harming a client or by practicing in such manner as to cause harm to the client. We might all agree that an example of intentional harm would be failure to report physical or sexual abuse of a minor child. A more ambiguous type of harm might be a play therapist who utilizes an intervention he or she is not competent to use, and resultant harm is done to the child's emotional well-being.

Beneficence means to promote the health and well-being of a client, not just avoid harming someone. One important aspect of beneficence is that mental health professionals must be competent to practice within their scope of practice. An example of an ethical conflict would be those who claim to do "play therapy" who have never taken a course or workshop, read a book, or received supervision of their work.

Justice and fidelity are the final two concepts in Kitchener's (1984) model. Justice broadly means something is fair, treating clients equally and impartially. An example might be avoiding an unequal sliding scale payment schedule for professional services that would allow certain clients more reductions in rates than other clients.

Fidelity refers to being faithful to do what we say we will, to be who we claim to be, and to be honest and reliable. An example of lacking fidelity would be when a counselor typically runs late, perhaps allowing prior clients to use more than their allotted time, hence cutting into the starting time of the next client.

It is important to understand how an ethical decision-making model can assist the play therapist in critically considering the rationale underlying possible different actions, with the goal of providing the safest and most therapeutic care to the client. However, often Kitchener's principles appear to be in conflict. People are complex, values can be unreliable or biased, and decisions are not always straightforward. Therefore, understanding how to implement an ethical decision-making model and, for beginning play therapists, understanding the need for consultation with their supervisors, is an essential part of professional development. There are numerous ethical decision-making models proposed for mental health professionals to use when faced with an ethical decision (Cottone & Claus, 2001; Cottone & Tarvydas, 2007).
The American Counseling Association (ACA) in 1996 developed a document to guide its members in making difficult ethical decisions (Forester-Miller and Davis, 1996). It is available at http://www.counseling.org for ACA members. The document includes a summary of the Kitchener moral principles and an ethical decision-making model.

The first step is to identify the problem as specifically and objectively as possible, trying to tease apart any innuendos or assumptions. We are encouraged to seek legal counsel if the problem is legal; otherwise, it is important to identify whether the problem is ethical, professional, or clinical in nature. Also, we need to ask if the problem is related to the counselor's actions or inactions, the client's and/or significant others' actions or inactions, or the institution or agency policies.

Next, apply the ACA Code of Ethics (2014) if there is a specifically applicable standard. If there is not an obvious resolution at this point, this indicates an ethical dilemma exists and further steps should be taken.

Determine the nature and dimensions of the dilemma, including identifying the Kitchener principles that apply and which one would assume priority; reviewing current professional literature; consulting with colleagues and supervisors; and consulting state or national professional associations. After gathering this information, it is time to generate potential courses of action, consider the possible consequences of all options, and determine a course of action. Creative brainstorming and consultation lead to winnowing of the potential actions with best possible outcomes (Forester-Miller & Davis, 1996).

The last step is to evaluate the selected course of action. One consideration is whether the course selected presents any additional ethical dilemmas. Three tests can be applied: (1) for justice, would you treat others in this same manner; (2) for publicity, would you want this action reported in the media; and (3) for universality, would you recommend this action to another counselor in the same situation (Forester-Miller & Davis, 1996)? Finally, implement the course of action. This is not always an easy step to take. Following action, it is then important to assess the effect and consequences of the action taken (Forester-Miller & Davis, 1996).

The authors remind the reader that different professionals may arrive at different decisions and complete different actions because there is not usually just one correct answer to any given dilemma. The important thing is to be able to provide a thoughtful and professional rationale for the decision if asked about it (Forester-Miller and Davis, 1996).

Welfel's Model for Ethical Decision Making

Welfel (2012) noted professional ethics encompass four main dimensions: (1) having sufficient knowledge, skill, and judgment to use efficacious interventions; (2) respecting dignity and freedom of the client; (3) using the power inherent in the counselor's role responsibly; and (4) acting in ways to promote public confidence in the mental health professions. Considering these four dimensions can enable play therapists to wisely use an ethical decision-making model to solve ethical dilemmas.

The first step of Welfel's model is becoming sensitive to the moral dimensions of practice (2012). Client acuity, managed care or third-party payer concerns, and large caseloads can contribute to a therapist's lack of sensitivity and recognition of potential ethical issues in clinical practice. Formal education in one's training, especially in development of principles and philosophy that align with those of the mental health professions, and assistance in integrating professional values into personal moral belief systems are essential in developing one's ethical sensitivity and personal ethical identity (Handelsman, Gottlieb, & Knapp, 2005). Welfel (2012)
posited that being ethically sensitive goes beyond knowing and following the rules; instead, it is a core aspect of the play therapist’s work and life. Character traits such as personal virtue, altruism, and commitment to social justice are also significant aspects of ethical sensitivity (Jordan & Meara, 1990).

Mental health professionals must have successfully completed all required coursework on ethics in their master’s or PhD program in order to graduate and become licensed. In addition, state licensing boards require a specific number of continuing education hours, some of which will be in ethics, to renew licenses. This education will help enhance ethical sensitivity in the play therapist. Personal attributes such as maturity, thoughtfulness, self-reflection, good self-awareness, and a trusting relationship with the clinical supervisor can also foster ethical discernment and decision-making.

Welfel’s second step is to identify the relevant facts, sociocultural context, and stakeholders (2012). This includes fact finding, assessment of the client, and identification of stakeholders (i.e., others potentially impacted by the counselor’s actions, such as parents or guardians of a minor). The caution in this step is the recognition that insufficient knowledge of the facts may be misleading and result in erroneous decisions. An important aspect of this and all subsequent steps is the documentation that must occur at each step. In regard to documentation, the play therapist should include options identified and considered, outcomes of each step, any and all consultations with supervisors and colleagues, and any other information considered essential as part of the process notes for the client’s file (Welfel, 2012).

The third step is to define the central issues in the dilemma and the available options. This involves a broad classification of the type of ethical dilemma involved and how the context of the client’s situation will affect the particular decision. This requires play therapists to separate their own cultural and personal values and assumptions so as to not be unduly influenced by personal history. In addition, it is important to continue brainstorming numerous possible actions as started in step two, without judgment or elimination, while actively looking for reasonable alternatives. An important consideration is the balance of the therapist’s own personal moral values and environmental pressure with the potential emotional difficulty a specific alternative might entail (Welfel, 2012).

The fourth step is to refer to professional ethical standards and relevant laws and regulations, and consider how the standards apply to the particular issue (Welfel, 2012). It is possible a conflict may be apparent, such as protection of client confidentiality versus revealing the risk of suicidal intent to the proper authorities.

The fifth step is to search out the relevant ethics literature. Consulting the relevant professional literature and the ACA professional Code of Ethics (2014) enables the mental health professional to explore what others have said about similar dilemmas. Other experts’ opinions and ideas may illustrate unconsidered points, especially in regard to a multicultural perspective (Handelsman et al., 2005; Welfel, 2012).

The sixth step is to apply fundamental ethical principles and theories to the situation (Welfel, 2012) in an attempt to bring about some sense of order within the particular dilemma. Autonomy, nonmaleficence, beneficence, justice, and fidelity often are in opposition to each other. The play therapist should attempt to abide by all five principles, but it is often not possible. Therefore, the ultimate goal is the prevention of harm to the client by implementing the action resulting in the least amount of harm (Welfel, 2012). Complicating the potential conflict between principles is that certain principles may be more significant than others. According to Kitchener (1984), many have suggested nonmaleficence is a stronger obligation than beneficence. Also, autonomy does not imply “unlimited freedom” (Kitchener, 1984, p. 46) with infringement upon
the autonomy or rights of other people. For example, in the case of threatened suicide, the principle of nonmaleficence would trump the principle of autonomy, and a client's right to privacy would be ethically breached in light of the higher value of not allowing the client to come to harm. In addition, the idea of autonomy originates from Western thinking. Many family- and community-based cultures do not promote individual autonomy, but rather group identity.

The seventh step is to consult with colleagues about the dilemma (Welfel, 2012). Ethical dilemmas are potentially overwhelming for the mental health professional, and there may be a tendency to become isolated in the face of the distressful situation. Obtaining feedback and advice from colleagues can provide alternative considerations, reduction of moral or emotional isolation, new information, and even comfort. Rather than utilizing consultation as a means to simply guard against malpractice, Welfel (2012) endorses consultation with other colleagues at every step along the way of decision making. Also, if a trainee or a licensed mental health counselor under supervision is providing the services, the supervisor must be consulted as soon as possible. In addition, many professional organizations provide free ethics consultation by phone during standard business hours for members.

The eighth step is to deliberate independently and decide which alternative is the most ethical and how to implement the decision (Welfel, 2012). Personal reflection plus examination of any competing ethical principles are essential aspects of this step. Ethical choices may coincide with costs to the play therapist, such as increased work hours, disapproval from clients or others, or even risk to one's income or job.

The ninth step is to inform the appropriate people of the result, its rationale, and implement the decision. Documentation of the decision with accompanying rationale is a critical part of this step (Welfel, 2012).

The final step is to reflect upon the actions taken (Welfel, 2012). Welfel maintained that reflection and evaluation of the decision-making process and the accompanied actions provide insight for the future. Evaluation can inform future decisions in possible similar ethical situations. Observation of the outcomes, consultation with supervisors, and debriefing and processing the mental health professional's emotional reaction to the experience can be beneficial to both parties.

PERSONAL ETHICAL READINESS AND FITNESS

Many of the ethical decision-making models suggest awareness is the first step in making ethical decisions. The following 10 statements are offered as a way for mental health professionals to assess their own levels of ethical readiness and fitness (Reynolds & Tejada, 2011; Reynolds & Sadler-Gerhardt, 2015). Read each one and consider whether it is true or false for you.

1. I understand the need for ethical codes and guidelines. The primary reason ethical codes and guidelines are needed is to protect the public from the misuses of power. Clients come to us in a vulnerable or needy state, and we have power over them. Ethical codes are also instructive for members of the profession and their clients about acceptable behaviors of mental health professionals. Ethical codes and guidelines provide standards professionals are expected to follow and can be held accountable for practicing. When mental health professionals come to consensus about what is good practice and this practice is codified into ethical standards, the level of care provided is raised for all clients. Finally, when there are major violations, the government usually gets involved to provide oversight. Most mental health practitioners would prefer self-regulation over governmental regulation.
2. I have read the ethical codes and guidelines of my profession. This is the most fundamental responsibility for a mental health practitioner. Otherwise, there is no way to know if what you are doing is right or wrong. Ignorance of the ethics does not afford any protection to the violator. You will find that each time you read the ethical codes, your understanding of them deepens.

3. I keep the latest copies of the ethical and legal codes and practice guidelines of my profession readily available in case I need to refer to them in a hurry. With most organizations going “green,” this means there are no longer paper copies distributed. Most ethical codes are updated on a regular basis, and state licensing boards often make several changes a year. You may want to download the latest copies once a year and keep them in a binder. You may find the time you have an ethical crisis is usually the time your computer is exceptionally slow, not able to get Internet, or unavailable. Your preference may be to leaf through paper pages rather than trying to scroll back and forth between 40 pages of online codes or between two separate documents of legal guidelines and ethical codes.

4. I have a trusted colleague or peer I can consult with when needed regarding ethical issues. It is important to have an ethics buddy who has agreed to be there to consult any time, day or night. You should have developed a high level of trust with this person, and you should be able to count on this person to set you straight if need be. Both parties document the consultations given and received (Gottlieb, 2006).

5. I can recognize at least one ethical issue per day on the job. It is normal to have at least one ethical issue per day on the job. If you cannot discern any, you may need to update your training with an ethical class or workshop. You may not be tuning in to what is occurring right in front of you.

6. I have a limited scope of practice and follow the guidelines of my profession. A school counselor does not provide family counseling. The school counselor may consult with the family regarding the success of their child in school, but if you have not been trained in a systemic perspective, you should limit what you do with families. If you attend one weekend workshop on hypnosis, it does not qualify you to advertise that as areas of expertise. If you have never taken a class in play therapy or counseling children, you will be operating outside your scope of practice to say you are qualified to work with children or do play therapy. Operating outside of one’s scope of practice means risking a malpractice suit.

7. I belong to professional organization(s) and their listserv(s), and I keep my license(s) /certificate(s) up to date with the appropriate Continuing Education Units (CEU)’s. If you are ever called to court to testify, one of the first questions from the attorneys will be: To what professional organizations do you belong? Professional organizations and their listservs exist to keep practitioners updated regarding legal and ethical changes. Professional conferences and workshops are held and CEU’s are granted in areas of best practices, empirically validated treatments, ethics, cultural diversity, supervision, and so forth. Although some mental health practitioners choose to not join professional organizations because of expense, it is even more financially risky to not be a member. Many professional organizations provide free ethical consultation to members, a benefit that outweighs the cost of membership. Some states have entities that monitor completion of the appropriate CEUs. Other states require licensees to attest they have completed the appropriate CEUs, but only a small percentage are randomly selected to provide the actual documentation to the licensing board.

8. I have a high tolerance for ambiguity and appreciate the complexity of ethical dilemmas. If you need an immediate answer for a problem, if you rush to judgment, or if you are
more comfortable with either/or thinking, it will be difficult for you to take differing perspectives and see issues from others’ points of view. In order to fully be engaged in the ethical decision-making process, it is critical to have an open mind, a tolerance for ambiguity, and an appreciation of the complexity of ethical dilemmas. As a play therapist, you need to be able to view a dilemma not only from the perspective of the child, but also the perspectives of the caregivers, the institution, and so forth.

9. I engage in self-care and assess my professional fitness so I am able to make quality ethical decisions or get help if impaired. Much of our time and energy is spent dedicated to the caring of others, but our ability to share our talents rests with our ability to take care of ourselves. Just as the flight attendants tell us to put on our own oxygen masks before assisting our traveling companions, we must be able to prioritize our own well-being. We need to become aware of the signs of exhaustion, burn out, and overload, and we need to monitor ourselves in order to be the best for our clients.

10. I know how to use and apply at least one ethical decision-making model. Understanding your particular professional code of ethics is only a first step, as often times there is a conflict between standards. Knowing and using an ethical dilemma model will assist your search for an ethical resolution.

COMMON ETHICS TERMINOLOGY IN WORKING WITH CHILDREN

The following terms are frequently used in therapeutic work with children. This is by no means an exhaustive list of every term contained in ethical codes. It is offered with the knowledge these are the most frequently asked topics for therapists beginning to work with child clients. For more information, check out the relevant ethical standards listed at the end of this article.

- **Confidentiality** refers to the client’s expectation that information shared with a therapist remains private and confidential. It is the cornerstone (Erford, 2010) of the mental health professions (Erford, 2010). Clients have the right to waive confidentiality and share information with a third party. Confidentiality belongs to the client, not to the counselor. When working with children, parents may have the legal right to know what is being discussed. Therefore, the play therapist has to balance the child’s expectation of privacy with the parent’s right to know. Those who work with children on a regular basis address confidentiality on a proactive basis by discussing it with both parents and children before counseling begins.

There are exceptions to confidentiality, including harm to self others or abuse. Group, couples, or marriage and family therapy counseling have specific interpretations of confidentiality. Other limits to confidentiality according to the codes of ethics include subordinates, treatment teams, consultation, third-party payers, contagious or life-threatening diseases, and court-ordered disclosures.

- **Privileged communication** is the legal term used to describe the privacy of the communication between the counselor and client. Privileged communication exists by statute and applies only to testifying in a court of law.

- **Mandated reporting** involves the clear directive to mental health practitioners that they must report suspected abuse or neglect of children under 18 years of age within 24 to 72 hours of having “reason to suspect.” While there is no liability involved with reporting (without malice) that does not turn out to be verified, there are serious penalties for failure.
to report. Consult with your state laws regarding mandated reporting. Different mental health professions may have their own guidelines about how this reporting is done.

- **Informed consent** is a legal procedure to ensure a patient, client, or research participant is aware of all the potential risks and costs involved in a treatment or procedure. The elements of informed consent include informing the client of the nature of the treatment, possible alternative treatments, and the potential risks and benefits of the treatment. In order for informed consent to be considered valid, the client must be competent and the consent should be given voluntarily.

- **Duty to warn** refers to the decision by the counselor to break confidentiality in order to warn foreseeable and identifiable victims of potential violence.

- **Professional competence** requires ongoing professional growth and education to maintain licensure. Mental health professionals are required to stay up to date on their training and credentials and to only provide services for which they have been appropriately trained and approved. Mental health professionals do not misrepresent their qualifications.

- **Scope of practice** is a term used by national and state licensing boards for professions that define the procedures, actions, and processes that are permitted for the licensed individual. The scope of practice is limited to those practices in which the party demonstrates specific education, experience, and competency. Scope of practice is of particular interest to RPTs and Registered Play Therapist Supervisors (RPT-S) who have voluntarily submitted to the registration process by seeking training and supervision in play therapy.

- **Professional disclosure statement** informs clients about the mental health professional’s background and the limitations of the professional relationship. The state may dictate what must be included in your statement of disclosure, such as contact information; qualifications, including licenses; certifications, training, and experience; professional associations; services offered; theoretical approach; fee structure (broken appointments, collecting debt, cancellation policy); confidentiality and its exceptions; insurance procedures; emergency policies; the professional code of ethics you adhere to; and how to file a complaint against you.

- **Permission** refers to the parent or legal guardian’s agreement for their child to receive mental health services. Play therapists are aware custodial and noncustodial guardians may have different rights and responsibilities under the law for the welfare of their children, including, but not limited to, granting permission for treatment, obtaining information from records, and involvement in treatment planning. When dealing with parents/guardians of children who are involved in legal conflicts, play therapists comply with state and federal laws and court orders when providing play therapy for these children.

- **Dual relationships** occur when a therapist and client or client’s family members have relationships outside of the therapeutic sessions. Play therapists are encouraged to guard against personal, social, organizational, political, or religious relationships with the client and family. Play therapists should take precautions through informed consent, consultation, self-monitoring, and supervision when involved in unavoidable dual or multiple relationships. Consult your specific professional ethical codes for further clarification.

- **Touch** refers to physical contact between the child and the therapist, which can range from beneficial, to neutral, to harmful. Although ethical codes generally forbid touch, or at the least require documentation in case notes and explanations to guardians, some proponents of play therapy recognize touch can promote growth and healing. The APT's (2012) *Paper on Touch: Clinical, Professional, and Ethical Issues* explores the use of touch and provides recommendations for its use.
SEEKING CONSULTATION

When involved in ethical issues, it is always advisable to seek consultation from one or more experienced therapists. In order to benefit fully from consultation, you should organize your thoughts and provide all of the accurate information about the dilemma. By leaving out important facts or not revealing some of your own behavior, you do not give the consultant a fair chance to provide useful recommendations. In addition, when you consult with a colleague or peer, he or she becomes liable because his or her license is on the line.

PROVIDING CONSULTATION

As a RPT-S, you will be asked to consult on ethical dilemmas regarding working with children and play therapy. You may have already been approached by a supervisee or peer after work, on your way to the restroom, or while waiting for your tea to warm in the microwave. The surprise element of these random requests can actually set you and the consultee up for a negative interaction. To be able to respond in the most ethical fashion to a request for an ethical consultation, you must be able to set boundaries to protect yourself, as well as to provide the best service possible. Gottleib (2006) developed a series of questions to ask yourself if approached for ethical consultation:

- Am I qualified?
- Can I be objective with my colleague?
- Do I have time available?
- Have I ruled out potential conflicts of interest?
- Am I willing to assume responsibility for my consultation?
- Should I refuse?

We are extremely busy professionals with work and personal lives. We can make choices about how we allot our time. In the interest of self-care, we may at times choose to defer from serving as a consultant after having asked and answered the above questions.

Gottleib (2006) also created a template for peer consultation that includes a number of suggestions:

- **Allow sufficient time.** For the most, part ethical dilemmas are complicated and require time to sufficiently discuss and consider possible options. It is difficult to give adequate consideration to issues without time to interact, refer to resources, and so forth.
- **Use a secure venue.** Remember, the issues being discussed involve confidential client information that needs to be protected. The restroom, lunchroom, or local coffee shop is not a secure and private location for discussion of specific ethical issues.
- **Get all of the relevant facts.** You will need to ask your consultee for the client file to be able to view all relevant information. It is the obligation of the consultee to provide you with all of the relevant facts, but often memories fail when under stress.
- **Rule out other issues.** What are some of the other issues that may be competing for your attention with this particular client or consultee? It may be necessary to put those aside until the ethical issue is handled.
- **List all issues that may demand attention.** It is possible when dealing with complex issues to overlook minor details. Making a list ensures all the information is factored into the decision-making process.
• Define and prioritize the issues. In times of stress, it is very useful to define the actual issues being addressed and to list them in order of what needs to be dealt with immediately and what can be safely delayed.

• List all reasonable courses of action. There may be more than one course of action. Listing all reasonable courses can begin the process of deciding which one is best for this particular ethical issue, setting, therapist, and client.

• Determine whether other opinions were sought. Is this a critical issue about which the consultee believed it was important to get several different opinions, or is the consultee just shopping around for an answer close to his or her own opinion?

• Many issues have no obvious solutions. Unfortunately, there are issues that have no easy or immediate solutions. This is where an ethical decision-making model can be of assistance.

• Establish a plan. After discussion, put together a written plan about how the ethical issue will be addressed with specific steps. This ensures both the consultee and consultant know what was ultimately decided.

• Encourage deliberation. You may have the answer to the problem, but you are also helping the consultee to develop internal deliberation skills as well. Often the best answers come from bouncing ideas back and forth.

• Seek feedback. Schedule a meeting to find out what the consultee decided to do. Ask what was helpful or unhelpful about your consultation. Feedback can assist you in your development as a consultant.

Finally, documentation is critical to the ethical consultation process. Both the consultee and consultant should record the issues discussed, as well as the process by which solutions were gained. Details should include relevant ethical codes and legal statutes, as well as agency or school policies. When ethical principles collide, what was the balancing principle used to make the final decision?

INTEGRATING ETHICS INTO EVERYDAY PRACTICE

This chapter is by no means a comprehensive exploration of ethics in play therapy; it is merely an overview of basic ethics to serve as a springboard for deeper exploration on the part of the play therapist. Becoming ethically competent is a lifetime process, but it can become second nature with practice. Understanding how therapists utilize ethical decision-making models provides valuable assistance as we strive to become more ethical and competent play therapists who are dedicated to providing excellent care for children and their families.

REFERENCES


**WEB RESOURCES**

http://www.a4pt.org
http://www.aamft.org/imis15/content/legal_ethics/code_of_ethics.aspx
http://www.counseling.org
http://schoolcounselor.org
http://www.hhs.gov/ocr/privacy
http://www.socialworkers.org/pubs/code/code.asp
http://www.nbcc.org
http://hhs.gov/ocr/hipaa/
http://idea.ed.gov/
http://nichoy.org/laws/idea

**Pthomegroup**

Ethics in Play Therapy
In life we have rules, boundaries, and limits. In order to succeed, we need to navigate through these opportunities. At certain times these structures are restrictive and constrictive, and sometimes they are inviting and expanding. Our ability to understand, respond to, embrace, or reject rules, boundaries, or limits guides our relationships, our professional ventures, and our personal interests. To those ends, understanding and defining rules, limits, and boundaries is critical, as they define our human existence.

Rules exist in all civilized societies. More often than not, they are created, designed, implemented, and enforced by the reigning powers. As we know, there are universal and regional rules, and there are good and bad ones as well. Rules set the tone for civilizations and human interactions. Boundaries are structures we establish for our own world. We define them on a personal basis. They allow us to function and enhance relationships (e.g., who we can touch, how we drive, or what we can eat). Boundaries become more personal and are less implemented by governments. Professional organizations establish rules of credentialing, ethics, and competency. Therapists set boundaries in the office: what touch can be, which toy can be used, or when a session ends. Limit-setting is what therapists establish with their clients. Boundaries are more interpersonal or relationship driven, whereas limit-setting is more directed to client behavior (e.g., one cannot throw sand, paint walls, or destroy toys). These distinctions are critical to understand in our task of defining the role of limit-setting in play therapy.

BOUNDARIES

In therapy from early days, discussions about structure, countertransference, and relationships began the therapeutic journey of modern 21st century therapists to define and describe what we now call boundaries, structure, or limit-setting.

Freud writes about boundaries and the safety of clients (Freud, 1915). Carl Jung speaks about the implied inherent limits and structure in marriage and spiritual development (Jacoby, 1999; Staub de Laszlo, 1938). Carl Rogers comments on fees and relationships vis-à-vis boundaries.
(Rogers, 1939, 1957). Frederick Perls acknowledges structure as it is related to the fluidity of the self and relationship to its development (Perls, 1969; Perls, Hefferline, & Goodman, 1951). All of these forefathers were strong proponents of understanding the rationale behind establishing boundaries and structure.

**BOUNDARIES AND LIMIT SETTING WITH CHILDREN**

As child analysis emerged and was subsequently modified to a form of child psychotherapy, a plethora of theoretical approaches emerged and the topic of boundaries was revisited. Because children are underdeveloped, primitive, and impulsive, the discussion of boundaries became more relevant than with adult therapy (Novick & Kelly-Novick, 2009), and limit-setting became a focus.

Ginot’s model (Ginot & Dell 1976) was very specific when he described boundaries and limits in the playroom. In stating a limit, he offered a four-step procedure. First, he suggested helping children express their feelings or wishes underlying the misbehavior (e.g., “You’re angry at me because you can’t take the toy home”). Next, clearly and firmly state the limit: “Hitting is not allowed.” Third, identify an acceptable alternative to the inappropriate behavior: “You can pound this clay to get your anger out.” Finally, enforce the limit as needed: “We have to end the play now because you still want to hit.” This procedure avoids the extremes of being too harsh or too soft in teaching children responsible behavior. Limit-setting provides children with the opportunity to learn the process of regulating their feelings and actions and allows for the therapeutic work to occur. All child therapists use limits in play therapy. Generally, the limits pertain to physical aggression against the therapist or the equipment, socially unacceptable behavior, safety and health, playroom routines, and physical affection.

Carl Moustakas (1959) expanded on relationship boundaries and limits:

Limits exist in every relationship. The human organism is free to grow and develop within the limits of its own potentialities, talents, and structure. In psychotherapy, there must be an integration of freedom and order if the individuals involved are to actualize their potentialities. The limit is one aspect of an alive experience, the aspect that identifies, characterizes, and distinguishes the dimensions of a therapeutic relationship. The limit is the form or structure of an immediate relationship. It refers not only to a unique form but also to the possibility for life, growth and direction rather than merely to a limitation. . . . In a therapeutic relationship, limits provide the boundary or structure in which growth can occur. (pp. 8–9)

Ray Bixler (1979) also contributed to the discussion on limits:

Restriction of behavior is one of the few universal elements in therapy. Limits have a role in all treatment methods, whether the client is an adult or child, withdrawn or aggressive. The value of limits in therapy has been minimized in the current directive-nondirective arguments. The therapist may find that the more precise his limits and the more quickly they are invoked, the easier it is for him to use them therapeutically, especially with very aggressive children. It may be that the use of limits on behavior in therapy is equally as important as acceptance of the attitudes which provoke behavior. (p. 277)
Limit-setting serves many purposes in the therapeutic relationship. At the most fundamental level, it ensures that both the therapist and child are physically safe. For the child client, limit-setting promotes emotional safety and provides a structure in which to learn affect regulation, frustration tolerance, and increased self-control.

THE PLAYROOM

How a child is introduced to the playroom is very defining. Child-centered play therapists say, “This is a playroom. It is a safe place. You may play with the toys” (Landreth, 2005, pp. 180–181). A cognitive-behavioral play therapist might invite the child into the playroom to draw, talk, or play puppets in order to resolve the anxiety she is experiencing (Knell, 1993). A child analyst would escort the child into the playroom without direction, comments, or explanation. This, in turn, would allow the child to explore, ignore, or avoid the therapist or toys (Glenn, 1978). A therapist’s theoretical orientation immediately expresses the limits in entering and using the playroom. More inexperienced therapists have a tendency to establish these limits at the onset. For example, “You are allowed to play with the toys, but you cannot throw sand or break the toys.” Inviting children to experience the playroom and toys is preferred. That will inevitably lead to the testing of limits, such as the spilling of the sand. A good response is usually, “Sand is for the sandbox.”

As previously stated, the importance of setting limits is for the child to feel safe, to help learn self-control, and to promote greater frustration tolerance, especially in the playroom. If a child is allowed to break toys, throw sand, or leave the room at any time, the ability to learn or to be encouraged to self-regulate could be problematic. A worried child could run out of the office and continue to respond in similar fashion when anxious. If the therapist or caregivers do not establish limits (e.g., “If you are feeling you need Mommy today and you need to leave the room, you can go for 3 minutes, and then return”), the child doesn’t have the opportunity to manage his or her responses differently. By setting limits, we are acknowledging feelings, communicating them to children and caregivers, and redirecting them (Moustakas, 1994).

LIMIT-SETTING STRATEGIES

With approximately 15 different theoretical approaches to play therapy, one could utilize numerous limit-setting strategies to help therapists and their clients in the task of resolving problems. Depending on one’s training, experience, and understanding, one could be very assertive and directive from the initial intake: “I do not allow children to spill sand on the floor. If you do this, the session will end.” In the child-centered approach one might comment: “You’re angry with me because I couldn’t help you with the game” or “Spitting is not allowed. You can spit in the sink. We have to end playing because you want to spit.” In the interpreting/reflecting technique, the aggressive destructive behavior is expressed: “You’re mad at Mom,” “You want to hurt Billy like he hurt you,” or “Maybe you want to die like Daddy did.” Being able to understand these different approaches, from a cognitive-behavioral perspective of setting specific limits (Knell, 1993, pp. 14–15), to a child-centered process of tracking behavior (Landreth, 2005, pp. 260–265) or an Ericksonian system of interpreting and reflecting (Erikson, 1950, pp. 255–258), will help clinicians appreciate how boundaries are established and can be used in a therapeutic setting.
SETTING LIMITS IN PLAY THERAPY

Too often, setting limits is presented as negative, using words such as don’t, no, or be careful. However, the act of setting limits is positive. One needs to be clear about what happened and be positive, reflective, articulate, and passionate in expressing oneself; for example, “I know you are sad about your dog’s death, but you cannot stab the couch with the scissors. The scissors can be used for cutting paper or clay, or you can stab the sand ... sad hurts!”

As to the question of when limits should be set, the strategy/approach is debatable. There are three distinct times therapists have opportunities to address this issue: at the intake, during sessions, and after a session. Each period provides an opportunity to explain limit-setting violations. In the initial session, one can introduce limit-setting to the child. The playroom, toys, and our demeanor are the external unspoken limits that our presence defines. I am an older male, and I find my “grandfatherly” presence speaks volumes to children to redirect or say no. Whether a child is playing or entering or leaving the office, therapists need to have a conceptual theoretical framework from which to work. Countertransference issues also need to be taken into consideration. A child removing something from the desk at 9:00 a.m. might get a different response than when the therapist experiences the same behavior at 7:00 p.m. How one responds in both of these situations might be quite different, and it might be quite effective if this topic of limit-setting has been conceptualized before the opportunity arises.

We are more emotionally and behaviorally prepared to deal with the during and after if we have addressed the before. For example, a child sits on the therapist’s lap or gives a hug. The rule can be explained, but it is easier to do so in the moment if the limit has been previously set. This interaction in the moment is as critical as the introducing of limits before they occur. Do we ignore the touching, redirect it, interpret it, or confront it? One’s theoretical inclination, especially when it comes to touch, will define our responses. I believe acknowledging touch and redirecting it is essential. In addition, it is important to inform the caregivers at the end of the session. An example of this would be to say, “Suzie was playing and wanted to sit on my lap. I told Suzie if she needed a ‘hold,’ to please get the blanket so we could practice holding.” When working with children, there are many situations that often require one form or another of limit-setting. The remainder of the chapter will address a range of issues that commonly occur in the practice of play therapy.

Resistant Children

Sometimes at the beginning of therapy, children refuse to come into the playroom. In the event this occurs, caregiver support is essential to address this issue. In the beginning, ask the caregiver to bring the child in, or sit in the waiting room with both of them and do simple introductions, always sitting while talking. During this time, try to engage the child and then encourage both to come to the playroom. If the child still refuses to come to the playroom and one can’t continue the intake in the waiting room, ask the caregiver to bring the child into the playroom (even if the child is screaming and yelling), or reschedule the appointment. Sometimes the resistance of not coming into the playroom is dependent on the stage in therapy. The resistance at a later stage could be the child’s intense feelings about a trauma, a painful encounter, the material of a divorce, or saying goodbye. Sitting in the waiting room with children, reading a book with them, drawing, or just sitting and singing can aid in the transition into the playroom. While sitting, thinking out loud (e.g., “I wonder if you are feeling sad about the tornado and how it destroyed...”)
your house” or “saying goodbye is tough”) gets a child’s attention. After sitting awhile, inviting the child into the playroom to finish the session is a good way to proceed. If the child does not come, inviting the caregiver into the playroom to talk about the week can encourage the child to follow into the playroom. If it doesn’t, the child can remain in the waiting room, as it is a safe environment for the child while one meets with the adult. One must also prepare for the next session: “Next week, Suzie, we’re all going to be in my playroom, to color, play in the sand, or throw balls. See you next week. Thanks for coming.”

Aggressive Behavior

Aggressive behavior can be both verbal and physical. A play therapist should be reflective when verbal aggressive behavior is displayed. Examples of reflective responses are: “You sound angry.” “You want me to argue with you.” “You have a lot to say.” “You seem to be upset.” “In here, it is safe to say what you want to say.” “I wonder who else in your family uses those words.” “What would your friends say?” There is a myriad of reflective or interpretive responses. With verbal aggression, remaining in children’s presence while they are screaming, yelling, or cursing helps. At the peak of the child’s passion, listen. Listening and being supportive of the feeling is critical. Sharing these episodes with the caregivers at the end of the session helps continue the work. The follow-up is to teach the child the hand muffler exercise: “Say all you want, but cover your mouth with your hands or pillow so no one can hear and you won’t get into trouble. Let’s practice.”

With physical aggression with the therapist or property, such as dumping large quantities of sand, painting on walls, or leaving the office, one might direct: “The toys (and I) are not for breaking. If you feel like you want to break something, you can pound the clay, or rip up paper in the wastebasket.” “If you continue to break that toy, the session will end.” “If you want to continue to hit, you can hit the couch; I am not for hitting.” If those interventions, interpretations, or reflections do not diminish the behavior, one should kindly say “stop it” or walk to the waiting room and seek assistance from the caregiver. Sometimes a caregiver has to restrain a child. Some have been removed from the office. It is important to discuss or play out these behaviors during a subsequent session, perhaps with a puppet show or directive dollhouse play.

Self-Destructive Behavior

Self-destructive behavior (e.g., hurting oneself with a toy) is similar to aggressive physical behavior. Interpreting or reflecting is useful. A child should not be allowed to choke himself, scratch to bleeding, or hit his or her head against the wall. If after a distraction (e.g., “Let’s go to the sandbox or pound clay”) this behavior increases or sustains itself, getting the caregiver and encouraging the caregiver to hold, play in the sandbox, or color can often calm the child. A very critical component of these behaviors is the follow-up. The session that follows is a time to observe, comment, lead, or direct which activity the child chooses, and then try to recreate the same behavior from the previous session. Depending on the age and the relationship, one might say “Whew, you were pretty upset last time. Do you want to talk about it?” “What would happen at home if you had acted like that?” The therapist can direct a child to draw, clay play, or sand play with the same material again, or wait to see what toy the child picks. “You are using the sword this week. You are stabbing the couch, and you are stabbing the dog puppet. I wonder if you’re still upset from last week.”
Intrusive Behavior

Asking about your family, bringing gifts, and wanting to sit in your lap (to be discussed in the Touch section) are also significant limit-setting challenges. Strategies include reflection, interpretation, or redirection. Try being reflective: “You are looking at my pictures. You are wondering about the pictures.” Try being interpretive: “You are wondering if I like you.” “I wonder if you wish your family looked like my family.” “You are going to miss me at the end of therapy.” Directing the child to draw pictures of his or her family or playing in the dollhouse and setting up situations could be helpful: “What does Saturday morning look like in your house?” “Draw me a picture of your brother.” “Where is your Mom in the dollhouse?” Redirecting the child from the therapist to his or her intimate relationships is critical.

Touch

Touch is a very sensitive topic for which there is no consensus in the field. It is a subject that demands well-defined, proactive “before” clarification. Male therapists need to be even more restrained than their female counterparts. Touch should not be encouraged, whether it is holding hands, high-fives, sitting in laps, or walking the child to a bathroom. This is a very agonizing topic. Many therapists are emotional and physical people, but we need to substitute traditional touch with creative touch. The blanket has been quite helpful in replacing actual touch. When a child wants or needs a hold, say “Let me hold you with my blanket.” Proceed by wrapping the child in the blanket. Sitting in silence or singing softly continues the soft moment. At the end of the session always let the caregiver know what transpired. When one is caught off guard and a child slips into one’s lap, holds a hand, or gives a hug, informing the caregiver of the event is essential. Timing is critical as to when one informs a child of the policy: “I know you like me and want to sit in my lap; next time, let’s hold with the blanket or with the wise old frog puppet, Mr. Froggy.” Some therapists suggest this rejection might hurt the child’s feelings. Perhaps rejection in a kind and loving way can be part of the therapeutic work (Brody, 1993).

Bathroom Behaviors

Often children come into the playroom and request to go to the bathroom. If the child is enuretic or encopretic and this is the presenting problem, it’s important the child be seen by a medical doctor to determine if there is a physical basis for the condition. Often times this is a behavioral or developmental issue. Sometimes a psychological component becomes prominent and plays out in sessions. Initially, allow the child to go to the bathroom. Alert the caregiver that the child should use the restroom before the session and that during the session, we do not typically allow the child to use the bathroom. This could create a very messy situation in which the child would soil or wet him- or herself. As the work unfolds, limits will need to be set.

This is very controversial. Why wouldn’t you allow a child to go to the bathroom? Sometimes needing to go to the bathroom is the therapy. This anxiety, discomfort, or impulse needs to be addressed, discussed, and played out. By allowing the child to run to the bathroom, maybe we are not allowing the child to be anxious or uncomfortable. “You seem to have really needed to go to the bathroom, I wonder if this happens at home.” “Going to the bathroom sometimes can be scary.” It is critical to encourage clay play, sandplay, or finger-painting, or anything else that has an “anal” tone to it. This will involve messy, sloppy, smearing play. Play with the child with these mediums. Talk about what they are creating, smearing, or spraying. But again, set limits:
“The clay is for the clay board, and not for the carpet.” “Water is for the sink and not the chairs in my office.” The basic limit-setting in the beginning is important to review. This type of play does not necessarily mean there is sexual abuse, neglect, or an attachment difficulty. It might simply be an extension of the dynamics in the family, the anxiety of a child, or not having been potty trained in a timely fashion. The words we use also need to be simple (bathroom, pee, poop), one-word recognition.

The second category is the child who all of a sudden needs to go to the bathroom. Again, it is controversial. Remind the child of the rules. Allow him or her to go once and, subsequently, set the limit of going to the bathroom before or after the session. If a child has soils him- or herself in the office, explain to the caregiver, “Scott wanted to go to the bathroom. The last two times I allowed it. I told him he would not be able to go this time; it seems that he is testing” (or is anxious or uncomfortable with the topic). Inform the caregivers to make sure the next time their child comes in to first go to the bathroom. During the next session, set up something in the dollhouse with the toilet being very prominent. This encourages the child to do the toilet work. A puppet show in which characters talk about Mr. Frog running to the bathroom and taking care of “business” is helpful. Drawing and seeing what the child does with bathroom talk can be therapeutically useful. Water play is also illuminating.

**Shy Children**

We don’t often think about limit-setting with a shy kid. There are things we need to do in order to encourage the shy, anxious, or selectively mute child to engage. Sitting in silence with children who do not want to engage is powerful. Observe their choice of toys or the free association of choosing toys. Put crayons and paper next to them and draw pictures. Puppet shows with a shy or quiet puppet, such as a turtle, create opportunities to address the child’s presentation in a nonthreatening manner. The puppets often talk to the child or with each other. This usually helps to engage the child. The goal is not to talk per se, but rather to interact. To encourage speaking, to diagnose whether the child is really shy, selectively mute, or being manipulative and oppositional, use a technique called “the window.” Open the window shades and look out. The child is just sitting. Begin counting colored cars. Often the child becomes intrigued, and will try to see what you are doing. Invite the child to sit next to you to count. This is a subtle way of challenging the boundaries of the child’s silence.

**Passive-Aggressive Children**

Passive-aggressive children are the ones who, when you turn your back, break a toy “accidentally on purpose”, bounce the ball to land on your desk, or shoot the dart gun and hit you. The first time this happens, point it out very explicitly: “The ball bounced on my desk.” It might progress to: “I wonder if you are angry with me” or “Does this ever happen at home?” Interpret or reflect on the behavior. With the passive-aggressive child, it is difficult to identify behavior that is oppositional, aggressive, or destructive. Join with a child and enter a dart shooting contest or throw balls at the walls. As the child is shooting the dart gun and it “accidentally” hits you, you can take the opportunity to connect behavior with the presenting problem or stressors that are going on in the child’s life: “I wonder if you are angry with your mom and you’re just taking it out on me [my desk]?” Children have lots of feelings about issues involving their parents, especially divorce. Sometimes the passive aggression being directed toward the therapist is a reflection of anger at
parents that can’t otherwise be expressed. Redirection to dollhouse play to explore home issues can be an effective strategy for more directly acting out a conflict at home.

**Compliant Children**

How many times do you have a child that comes in, lets you go first, lets you pick out the game, doesn’t mind losing, and is always well behaved? Or, as soon as the child meets you, all of the behaviors that are presenting problems disappear or improve after 1 week of therapy? We are magicians! With the compliant child, one needs to be a little more assertive and confrontational. If this child acts like this in the intake session, predict his or her behavior and alert the caregiver that you are neither a magician nor do you possess clairvoyant powers, and the behavior will return. The dictum “when your child starts behaving, that’s when the therapy begins” is helpful to remember. You will have to figure out what behaviors brought the child/family into therapy. When a child says “you go first,” for example, you might say, “How do you choose who goes first?” The child, being compliant, will say, “You can go first.” Respond, “You decide who goes first” and then wait it out. When the child loses a game, and one could say: “Most kids get upset when they lose. You seem to always be okay with losing. I know at home you aren’t and at school you aren’t. Why are you okay with it here?” Or, if playing a game and the child is playing nicely, you might say: “Why are you able to do this in here, and not outside with other kids?” Go out to the waiting room to get the caregiver and bring him into the playroom and say, “You won’t believe this. Suzie was playing basketball with me, lost five times, and yet was happy and okay! Yet at home, it is not okay. Why is Suzie being so nice to me and not to you?” This may set up tension between the parent and the child, and often it gets the child to speak up or act out, which will help shift the status quo relationship.

**Gift-Giving**

The receiving of presents is also a sensitive issue. Cookies at holiday time, gifts at the end of treatment, or giving pictures during treatment must be considered. For the child analyst, gift-giving is a serious transference issue worthy of notice (Kay, 1978). For the gestalt therapist, this can be incorporated into a puppet show about giving, taking, and sharing (Caroll, 2009). The message behind the puppet show is to act out the above topics and recognize there are situations, e.g. bringing the therapist a gift, which could be problematic or not recommended or simply to help with how to say “thank you” and “you’re welcome.” Sometimes asking the kids to tell the puppets what to say can help them express their thoughts and feelings. For some therapists, the policy is to thank the child and explain that the agency’s practice is to put the gift in the communal room to share with others. Acknowledging the gift and being attentive to its meaning in the child’s play is crucial. When the opportunity arises, interpreting or exploring its meaning is helpful. A gift given can be solicitous in the session, as can inviting you to go first in the board game or to be first to choose a color, and being helpful in cleaning up. Commenting on how kind the child was being and suggesting, “You really like me. I wonder if you wish your dad and you could play like we do?” can be a powerful intervention. The initial gift and continued kindness might be the child’s way of telling you how he was feeling about his relationship with his dad. Be aware of gift-giving by an angry or hurt child. Perhaps the gift is a way of saying “I don’t want to be upset with you.” You might say something like, “You’ve been so upset with me, and you bring in a nice gift. How does your upset feel?”

**Pthomegroup**
Ending a Session

Children often don't want to put away toys or leave. If a child does not want to clean up, wait until the caregivers come into the office at the end and ask them to help the child, or suggest a consequence for not following the rules. Maybe we can help the child put things away. The therapist should not talk during this time because the child needs to finish the task. One should not allow children to leave a mess for the therapist to clean up. The message of being responsible for one's own mess is one we need to model.

Another issue that comes up at the end of session is the caregiver or child adding, “Oh by the way,” and presenting a very significant piece of material that should have been introduced earlier in the session. If it is not something that is dangerous to the child or to the family, one can respond, “This is very important. Let’s talk about it at the beginning of next session.” This is done while walking toward the door and down the hall.

CONCLUSION

As discussed and illustrated, the topics of limit-setting and defining boundaries are complicated and sensitive. Being aware of internal and external capabilities and limitations of a child is a critical part of our work. How therapists define themselves, stock their playrooms, introduce play therapy to the child and family, or interact when there is tension are crucial aspects of our work. Also, how therapists involve themselves in the activities of the child in the playroom shows how the therapist limits and encourages children's testing behaviors. The better we conceptualize our ideas and behaviors regarding our theoretical inclinations and prepare for inevitable behaviors, the more efficient and successful we will be in this ongoing journey of setting limits.

REFERENCES

Play Therapists, regardless of their level of expertise, need clinical supervision. Clinical supervision provides opportunities for both personal and professional growth. It is a unique professional relationship that supports the play therapy supervisee as well as the supervisee’s child clients, their families, and the larger community. The responsibilities of both the play therapy supervisor and the supervisee in the supervisory relationship are considerable. Supervision, like play therapy, is a complex relationship grounded in trust and respect. Supervision is more than what one does; it is a reflective process, a manner of being (Carroll, 1996). Also like play therapy, the benefit of the relationship is growth, and sometimes even change and healing.

AN INTRODUCTION TO SUPERVISION

In the world of the helping professions there are several types of supervision. Generally there are two types of supervision a play therapist may encounter. Administrative supervision refers to a relationship with a senior member of the profession or agency in which the focus is on nonclinical tasks. For instance, in administrative supervision, the supervisee may discuss clerical aspects of their work such as recordkeeping, data entry, and number of clients on her caseload. The focus of administrative supervision is the work the supervisee does, not the nature or quality of the clinical work or the nuances of play therapy. Because the focus of this kind of supervision is on administrative and business-related tasks not specific to play therapy, it is reasonable to assume the administrative supervisor would not need to have more than the most basic familiarity with play therapy.

This chapter will focus on clinical supervision because this form of supervision has a significant impact on play therapists’ professional development and their clinical practice. Clinical

---

1 I would like to express my gratitude to Jacob Hedges, graduate student at SUNY Oswego Mental Health Counseling, for his assistance in preparing this chapter.
supervision, which for simplicity will be referred to in this chapter as supervision, is defined by Bernard and Goodyear (2014) as:

An intervention provided by a more senior member of a profession to a more junior colleague or colleagues who typically (but not always) are members of that same profession. This relationship is evaluative and hierarchical, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s); monitoring the quality of professional services offered to the clients she, he, or they see; and serving as a gatekeeper for the particular profession the supervisee seeks to enter. (p. 9)

Several key components of this definition are worth deconstructing and highlighting. Perhaps most importantly, a senior member of a particular profession, the supervisor, conducts supervision. For our purposes, this means play therapy supervision should be conducted by a professional trained in play therapy who has more clinical experience than the supervisee. Supervisors and supervisees may be matched on compatible primary professional identities (i.e., social work, psychology). However, when play therapy is the focus of supervision, this secondary professional identification (play therapist) or specialty (play therapy) is the more salient variable on which supervisor and supervisee should be matched. In this chapter, the type of supervision discussed is that which occurs between a senior play therapist and a junior play therapist, unless otherwise noted.

The definition offered by Bernard and Goodyear (2014) also indicates that the supervisor’s role in the relationship includes a number of significant responsibilities to the supervisee, the supervisee’s clients, and, ultimately, the greater community. Considered broadly, supervision impacts the supervisee, the lives of the clients, and the community as a whole. Therefore, being a supervisor is a significant responsibility. The roles of the play therapy supervisor will be discussed later in this chapter.

THE FOUNDATION OF SUPERVISION

According to Bernard and Goodyear (2014), there are several potential theoretical approaches to providing supervision. They discussed psychodynamic, person-centered, cognitive-behavioral, systematic, and narrative approaches. Each kind of supervision has particular foci and goals. Although it is beyond the scope of this chapter, it behooves supervisors to have an understanding of these theoretical approaches to supervision because they provide a framework for the supervision intervention.

HOW IS SUPERVISION CONDUCTED?

Supervision may be provided through several media. Supervision can be conducted face to face, via phone, or through the use of visual conferencing like Skype or Facetime. Each of these venues has its advantages and limitations.

Consent

Play therapy supervision always requires one to obtain permission from the child client’s parent or guardian. Consent is required because, in the context of supervision, the play therapist
will: (a) talk to someone else about the session; (b) share things, such as a child's drawings or images of sandtrays; (c) make an audio or video recording; and (d) transport the recording (if the supervision doesn’t occur on site). Beyond obtaining permission to share the content of play therapy sessions, the consent form should also indicate the specific time parameters over which supervision will occur and a clear explanation of how session materials and records will be handled postsupervision (i.e., how and where they will be stored, as well as how and when they will be destroyed).

Some parents are understandably reluctant to give consent, as their experiences with mental health professionals may not have always been positive. Others may be wary because of their shame or guilt regarding to the reason the child is participating in play therapy (Mullen & Rickli, 2011). When parents have such concerns, it can be a great learning opportunity for a play therapy supervisee. New play therapists and play therapy students often tend to be more concerned about consulting with parents than with conducting the play therapy itself. The play therapy supervisor can use role-play and self-disclosure during supervision to help prepare supervisees for the conversation with the child's parent (see Mullen & Rickli, 2011, for case studies and activities designed for the specific challenges of dealing with parents of children in play therapy). Last, it is important to show the child respect at all times during the play therapy relationship. If the parent does indeed grant permission for the child to be observed while in play therapy sessions, it behooves the play therapist to ask for the child's permission as well.

**Face-to-Face Supervision**

Face-to-face supervision is conducted individually or in a group format. In this form of supervision, the full range of communicative resources are available to the supervisor and supervisee. Verbal, nonverbal, and paraverbal communication can all be considered and processed. This has a number of benefits. The access to the multiple streams of communication aids in the exchange and ultimately the understanding of the material being presented as well as an understanding of the supervisory relationship between supervisor and supervisee.

While the concepts of verbal and nonverbal communication are probably quite familiar to most readers, the concept of paraverbal communication may not be. Paraverbal communication includes body language, cadence of speech, vocal or percussive sounds, and other nonverbal communications. According to Heimlich (1980), this sort of communication can be advantageous in modifying maladaptive behavior and assisting children in grasping cognitive concepts, such as time and speed. Children's paraverbal communication in the playroom often carries a lot of content. Many play therapists worry they are missing a lot of this sort of content or are concerned about how to use it with children in session when they do see it. Knowing this, supervisors can use the supervisee's paraverbal communication in supervision to teach the supervisee about how children communicate without necessarily using their words. Seizing the opportunities to respond to paraverbal communication in supervision allows supervisees to experience firsthand what their clients may experience in play therapy sessions. This is a powerful authentic learning experience and an opportunity for empathy.

Of course there are some drawbacks to face-to-face communication, many of which are logistical. Having a play therapy supervisor within reasonable traveling distance can be a challenge (this is frequently a hurdle in attaining professional credentialing for play therapy supervisees who live in remote areas in the United States of America and or in other countries where qualified supervisors are not easily accessible) (J. Downs, personal communication, February 24, 2014). Finding workable times for supervision can also be difficult for the supervisee, who may need to factor in travel to and from supervision.
Phone Supervision

Phone supervision provides a way around the logistical limitations of face-to-face supervision, in that the geographic distance between supervisee and supervisor is no longer an obstacle. Travel time is eliminated and the costs are not prohibitive. Because phone supervision can be conducted from anywhere the supervisor and supervisee have phone service, it also means convenient meeting times are more readily arranged. Supervision sessions can even be managed even if supervisor or supervisee are at home in their workout clothes or even their pajamas!

Phone supervision has some significant limitations, most of which are related to the loss of some of the relational and communication benefits of face-to-face supervision. The inability of the supervisee and supervisor to see one another can lead to five potential problems. First, the supervisor and supervisee are limited to their verbal communication. So some paraverbal communication, such as sighs and prolonged silences, can also be realized; however, the rich communication that takes place when the supervisee and supervisor can see each other is lost. Second, some of the responsibilities connected to the supervisory relationship may be compromised. During phone supervision, both supervisor and/or supervisee have the opportunity to engage in multitasking. Distractions such as driving, doing laundry, or preparing clinical notes during supervision are not respectful to the relationship and are certainly not good use of the supervision time. Fourth, both the supervisee and supervisor should come to supervision sessions prepared with any necessary notes or other ancillaries that aid in the supervision process, as well as a means of taking notes when necessary. The preparedness of each can be somewhat more difficult to gauge when neither can see the other. Last, in phone supervision, there is less opportunity to use those in vivo teachable moments about communication mentioned in the discussion of face-to-face supervision. As one can imagine, phone supervision makes it very difficult for the supervisor to act out a play scenario for the supervisee to practice responding to, and it is equally difficult for supervisees to try to show supervisors something the child played in session, such as the child using dolls in the dollhouse.

Video Conferencing

Technology has greatly enhanced the opportunities available for receiving and providing play therapy supervision, allowing for many of the benefits of both phone and face-to-face supervision while minimizing the limitations. When video conferencing is used for communication between supervisor and supervisee, the full range of verbal, nonverbal, and paraverbal communication is available to both the parties, enhancing communication and understanding. The ability to virtually role-play and demonstrate play therapy itself is very important in play therapy supervision. When using video conferencing, supervisee and supervisor can communicate about the clinical nuances of play therapy by showing rather than merely telling. This is exactly how children communicate through play. In addition, because there is a visual component, accountability of both parties is easily assessed. Though the advantages may intuitively seem considerable, very few studies have examined the use of visual conferencing technology in supervision (Perry, 2012).

CLINICAL REVIEW

Another consideration in the way supervision is conducted has to do with the way supervisors and supervisees review clinical cases and the knowledge and skills of the supervisee. Case review in supervision can be conducted by self-report, recorded sessions, and direct observation. Each has advantages and limitations.
Self-Report

Supervision sessions that rely on the supervisee describing what happened in play therapy are considered self-report. Supervisees may also use their clinical notes to share their perspectives on what is happening in the play therapy sessions and the child's behavior, thought, and feelings with the supervisor. Self-report-based supervision has its advantages. According to Noelle (2002), self-report may provide the supervisor with valuable insights into the supervisee's thoughts and emotions, adding to the richness of the supervision session. However, there are significant limitations to self-report-based supervision.

When the only means of reporting on the play therapy experience come from supervisees self-reports, there are risks they will distort or withhold information. This is exacerbated when the supervisee does not experience the supervisory relationship as safe. Ladany, Hill, Corbett, and Nutt (1996) argue there is an imbalance of power in the supervisor-supervisee relationship, just as there is in the counseling relationship. Because of this, supervisees may feel pressure to present themselves in a more positive light, fearing failure or inadequacy. The authors report supervisees may also “withhold information as a means to gain some control in the supervision relationship” (1996, p. 11). Creating a supervisory relationship in which the supervisee feels safe, comfortable, and respected is essential to the provision of high-quality supervision, and this is discussed later in the chapter. For now, it is important to recognize how the lack of a safe supervision setting would amplify the problems with self-report.

Recorded Sessions

Video-recorded sessions provide the supervisor with the benefit of being able to see and hear what is happening in the play therapy session. The supervisor can provide feedback on what the play therapist is doing, how the child is presenting, and what is happening between the play therapist and the child. There is rich clinical and relational data for the supervisor's feedback. Many of these benefits are similar to direct observation supervision that will be discussed later in the chapter.

Video-recorded sessions do have some drawbacks. Because it would be disruptive to the flow of the child's play, it is inadvisable for the supervisee to move the camera around the playroom during the session. Because the camera remains in a fixed position, some of the important pieces of the clinical play therapy puzzle may not be captured in the recording. This can occur if the child moves about the room, has his or her back to the camera, or is doing something very detailed, such as drawing a picture. It is likely that some of the child's facial expressions and body language will be missed. Even the best camera may not have the kind of high-quality audio recording capabilities needed to capture the child's verbalizations well enough for them to be understood when the recording is played back. Perhaps most importantly, regardless of how the supervisor views the play therapy session, the overall intimate experience of being in the room with the child during the session can never be fully assessed.

The greatest limitation of video recording may be the overwhelming amount of information it provides, as this may intimidate the supervisee (Rubenstein and Hammond, 1982). Not only are all of the client's verbalizations, nonverbal communications, and body language on display, but so are those of the supervisee. Hill et al. (1994) have found that therapists and therapists-in-training have reported a lowered mood after viewing their sessions, probably because they tended to be self-critical when given the opportunity to second guess themselves. A video recording puts everything out in the open, and both newer play therapists and seasoned professionals may be uncomfortable with the result as they second guess their every word and gesture.
Direct Observation

Direct observation provides the supervisor with the most objective perspective on what occurred in the supervisee's session. In direct observation, supervisors view the supervisee and the child client during play therapy sessions through a one-way mirror or through the use of video-streaming technology. One significant advantage, particularly when compared to self-report supervision, is that the supervisor has the opportunity to view the child and the session through his or her own lens. As discussed earlier, self-report is limited to only the perspective of the supervisee. Direct observation allows the supervisor to make conclusions about the child, the child's play, the supervisee's skills, and the relationship between the child and play therapist (supervisee). It is easy to see how direct observation can make for a much richer supervision session, but it also has some significant limitations.

Many of the limitations are logistical in nature. Having the space and setup required to do this type of supervision is not likely in schools and agencies in which there may also be budgetary constraints. Coordination of schedules is also a potentially limiting factor because the supervisor, supervisee, and client must all be in the same place at the same time.

Live Supervision

This form of supervision is similar to direct observation, except it includes an embedded teaching component. In live supervision, the supervisor can either directly or through the use of technology provide the supervisee with immediate feedback so he or she can implement the feedback in the ongoing session. Because of the technology required, this form of supervision is most often conducted as a component of university-based training programs. The logistical limitations are significant and similar to those of direct observation sessions. It also seems there would be greater potential for the growth-promoting dynamics of supervision to be compromised in cases where the supervisee becomes dependent on the supervisor. In addition, this form of supervision seems to require a particularly safe supervisory relationship because the supervisee will be hyperaware of the supervisor's presence and may interpret any suggestions made by the supervisor as criticism.

FORMATS OF SUPERVISION

Supervision can be conducted individually in a one-to-one format or in some variation of a group format in which either the supervisor is consulting with several supervisees or the group format is used to provide peer-to-peer supervision. In individual and group supervision, the supervisor has a level of expertise the supervisees do not have. In peer supervision all members of the group have approximately the same level of expertise and come together to promote each other's professional and personal growth by providing alternate perspectives and input on their play therapy cases.

Individual Supervision

Individual supervision is the most commonly used supervision format because it allows for close evaluation and can meet the supervisee's unique needs (Newman, Nebbergall, & Salmon, 2013). Individual supervision occurs between supervisor and supervisee on a one-to-one basis, and like counseling and play therapy, the relationship is crucial to its success. The supervisee is in an emotionally and professionally vulnerable position, and it is the supervisor's responsibility to create enough safety in the relationship to enable the supervisee to be open and responsive to feedback. The supervisor can use self-disclosure and expressive communication techniques to minimize supervisee defensiveness and encourage growth. While common and highly effective, individual supervision is the most time-intensive format.
Peer Supervision

Zins and Murphy (1996) define peer supervision as “a small group of professionals with a common area of interest who meet periodically to learn together, to share their expertise, and to support one another in their ongoing professional development” (p. 176). By definition, peer supervision does not include a designated supervisor; rather, members provide each other with supervision. Bernard and Goodyear (2014) note a pro and a con to this format. On the positive side, the availability of multiple perspectives means supervisees may receive input that might be overlooked by a formal supervisor. On the other hand, they also argue these benefits are most pronounced when peer supervision is structured and overseen by a supervisor who can help the group make sense of all the varied input and information. With or without a designated primary supervisor, there are many benefits to peer supervision, including increased enthusiasm and motivation, expanded range of skills and expertise, increased involvement in professional organizations, and an increased knowledge base (Newman, et al., 2013). Peer supervision is particularly helpful when other supervisory support measures are not readily available or affordable.

In peer group supervision, each member is usually given the opportunity to present a case and receive feedback from the group. Most often, the presentations will focus on the clinical aspects of the case, but they might also focus on related matters, such as dealing with a difficult parent or preparing to testify in family court. Nonclinical presentations support professional development in addition to the improvement of clinical skills.

One way to structure peer (and group) supervision is by having each member of the group take on a job or responsibility. This ensures all members remain highly engaged in the supervision as they fulfill their independent responsibilities. Periodically changing the roles or tasks allows for many alternative perspectives and helps demonstrate the complexity of the play therapy process. Of course, one member will have taken on the role of presenting a case. At least one other member should be a given the task of teasing out of the presentation all the things the presenting supervisee is doing well. In laying out this role, it is important to remind members of the value of focusing on both the therapist’s clinical and relationship skills. It may also help to remind members that sometimes the thing being done well is something the presenting supervisee is not doing. For example, the presenting supervisee may be doing a good job of resisting his or her impulse to try to force the child to talk in the session.

Another potential task for a play therapy group supervision member is to draw a representation of what he or she thinks or feels is happening in the relationship between the presenting supervisee and the child client. This job is assigned to bring out play therapy supervisee’s playful and expressive side while still having he or she respectfully attend to the presentation. This same task can be augmented by having a supervisee create a sand tray as a representation or choose sand play miniatures to represent the case in order to get at the expressive rather than the intellectual aspects of the session or case. Incorporating narrative elements into supervision can also be very powerful in all forms of play therapy supervision. Just as narrative approaches allow clients to distance themselves from problems, it can do the same for supervisees in supervision. Externalizing the problem through narrative means is a powerful way for supervisees to feel a sense of power and control in their role as play therapists while simultaneously illuminating a perspective that was formally limited to only internal means of analysis. Supervisees may be prompted to write a letter to the child who is the focus of the presentation. Alternatively, they might be prompted to write a letter to the supervisee making the presentation, or to a parent or teacher who has a prominent role in the case conceptualization. Even writing a letter to a toy in the playroom that seems to have salience for the child is an option. In this style of letter writing, the focus is on giving the inanimate object human qualities. Once the object has these qualities, it can offer a perspective of what is happening in the playroom. This particular example frees the letter-writer, as well as
the supervisee who is the focus of the feedback, a sense of distance, making the feedback easier to hear, synthesize, and integrate. Last, writing a letter to the child’s presenting problem (such as grief or a diagnosis like PTSD) can be a powerful experience for all involved and can aid in a broader, more comprehensive and sensitive case conceptualization.

Because there is no designated leader in peer supervision, the group must attend to certain issues. First, most of the aforementioned examples of ways in which peer (or group) play therapy supervision can be structured would require a leader to be chosen or to emerge in order for these processes to be effective. Second, in the absence of a single, responsible leader, successful peer supervision also requires supervisees hold each other to ethical and professional codes of conduct. They must come prepared and provide honest feedback. This last part can be difficult because peers are sometimes reluctant to give critical feedback or are not finessed in the delivery of feedback in general. Last, members should be aware of the possibility they will not take peer feedback as seriously as they would if it were coming from a single, more seasoned play therapist.

**Group Supervision**

Group supervision shares some commonalities with both individual and peer group supervision, while offering three significant benefits: (1) It is more cost effective than individual supervision; (2) like peer group play therapy supervision, supervisees can provide each other with feedback and support in achieving their goals; and (3) unlike peer supervision, there is at least one seasoned play therapist in the group to lend his or her expertise. The format discussed in the peer supervision section also works well in group supervision. The play therapy supervisor may consider thoughtfully assigning various roles to each member of the group. For example, a supervisee who struggles with reflecting feelings can be assigned to listen to another member’s case presentation and then write down all the feelings the child might have been having during the activity or session being described. The assignment could be expanded by having the same member then come up with a synonym for each of those feeling words, essentially building the affective vocabulary of the entire team. Group play therapy is also a nice format for authentic learning experiences. Supervisees can be engaged in supervisor-led role-plays to deal with challenges in the session or even in the supervision process itself.

**WHO SHOULD BE INVOLVED IN PLAY THERAPY SUPERVISION?**

**The Supervisee**

Because play therapy is a specialty in a variety of helping professions such as social work, counseling, or psychology, some aspects of supervision can be more complicated. For instance, the play therapist and play therapist supervisor may come from differing professional backgrounds. Although these professionals are both grounded in helping, they have fundamental differences in their perspectives and even, to a degree, in how they conceptualize the role of the helping professional. However, when choosing a supervisor, expertise in play therapy seems to be the most salient issue from the perspective of the supervisees. A study conducted by Vandergast, Culbreth, and Flowers (2010) revealed that play therapy supervisees preferred supervisors who identified professionally as play therapists and who also held the Registered Play Therapist-Supervisor credential from the Association for Play Therapy. In addition, the authors noted participants expressed an openness to various supervision mediums and formats, whether they be long distance through electronic means, face-to-face, or peer and group supervision. Qualified play therapy supervisors may be scarce, but it appears supervisees are willing to bridge the gap to receive quality supervision.
In addition, many supervisees entering into the field of play therapy may feel like they are starting at square one. Like most beginning supervisees, they may be at times unsure, yet at other times confident. According to Ronnestad and Skovholt (1993), this dichotomy creates tension in the supervisory relationship. Supervisees may experience a high level of anxiety in the early stages of their training. Ronnestad and Skovholt argue, “The supervisor at this early level should provide much encouragement and support, much feedback, and generally high levels of structure” (p. 403). Ray (2004) takes this a step further and advocates for structure in the supervisory relationship with play therapy supervisees. While early career play therapists are clearly anxious about their competency, people who have been mental health professionals for many years and are now beginning the arduous task of becoming a skilled and credentialed play therapist may also feel like neophytes. These supervisees can be particularly challenging as the dichotomy between their sense of general professional competence, on the one hand, and insecurity about their skills as a play therapist, on the other hand, is all the more real. These challenges are best addressed in supervision between supervisee and supervisor.

There are several ways supervisors can prepare for these common challenges, as well as ways supervisees can make sure these relevant professional issues are addressed. Assessing the developmental stage and needs of supervisees will give the supervisor a framework for where to begin supervision. The supervision needs of beginning play therapists are very different from the supervision needs of seasoned play therapists. Beginning play therapists are more likely to focus on the mistakes they made and to ask questions related to those perceived mistakes. Intermediate and advanced play therapy supervisees seem to appreciate more focus on case conceptualization and unique challenges. They are more likely to view supervision as a professional growth endeavor.

The Supervisor

What does it take to be a play therapy supervisor? According to the Association for Play Therapy (2014), RPT-Ss are licensed or certified mental health professionals. They possess a master's degree in a medical or mental health profession, have a minimum of 150 clock hours of instruction in play therapy, and have completed 4 hours of didactic training in the theory and practice of supervision. They have completed at least 5 years and 5,000 supervised hours of post-master's clinical work and a minimum of 1,000 hours of play therapy. They have been supervised in their clinical work and have documented a minimum of 50 hours of play therapy–specific supervision. Again, let’s deconstruct this definition and highlight some of the most important aspects.

Across all of the mental health professions there is a dearth of RPT-Ss. According to the APT (2013), as of this writing, there are only 1,126 medical or mental health professionals who possess the RPT-S credential in the United States of America. However, the good news is, the number of professionals with the RPT-S credential has increased greatly since 1992 (C. Guerrero, personal communication, September 4, 2014).

Variety of Roles

There are a variety of roles the supervisor can take on in the course of providing supervision. Where a particular supervisee is in his or her development as a mental health professional and as a play therapist will play a part in determining those role(s) and how they will change over the course of the supervision. Either prior to beginning or at the outset of supervision, the supervisor will be in the role of assessor as he or she evaluates the supervisee’s current needs and skill levels. Just like an initial assessment is the foundation of clinical decision making, so this evaluation forms the foundation of the supervisory relationship.

It makes good sense for the supervisor to have an initial meeting with the supervisee to define the parameters of the supervisory relationship, including the expectations of the supervisor, the
expectations the supervisee can have of the supervisor and the process of supervision, and any
potential ethical considerations. This initial meeting is also where the supervisor begins creating
the sense of safety the supervisee will need to make optimal use of the sessions. By initiating a
conversation about what the supervisee wants out of supervision, the supervisor demonstrates
respect and mutuality while simultaneously modeling good listening skills. One way to do this
is by creating a list of the possible roles the supervisor might take on, such as teacher and men-
tor, both of which are supportive, as well as those of evaluator and gatekeeper, both of which
illuminate the power differentials embedded in the relationship. To foster and document these
discussions, the supervisor can use a form on which the various supervisory roles are listed. Super-
vises can then indicate which of these roles they think would be most useful in fostering their
professional growth. This can be done at the beginning of the supervision and then repeated at
regular intervals to assess growth.

HOW DO SUPERVISORS LEARN TO SUPERVISE?

Fall, Drew, Chute, and More (2007) surveyed RPT-Ss regarding their own perspectives on super-
vision. They found that a lack of training in and possible misunderstanding of clinical supervision,
as well as the lack of perceived need to be supervised in one's role as a supervisor, were all areas
of concern. Fall et al. (2007) concluded, “we suspect that many individuals may not have been
exposed to the type of supervision that is aimed at growth of the supervisee, support of that
individual, and assistance with clients” (p. 141). Simply stated, supervisors were not trained to
do supervision, did not have a solid knowledge base of what clinical supervision entails, nor did
they acknowledge a need for their own supervision. Many supervisors learn supervision from their
personal experience in supervision. In this way, it’s like learning parenting—you learn some of
what to do and some of what not to do as a parent from your experience of being a child. Mostly,
though, you just follow in your parents’ footsteps. Allen (2007) also notes the lack of knowledge-
able play therapy supervisors and goes on to state that supervisors unfamiliar with play therapy
who supervise play therapists may be prone to limiting the supervisee's work due to this lack of
knowledge.

Play therapy supervision, like other forms of approach-specific supervision, has room for
growth and development. Over the past decade, a trend has emerged in helping professional
organizations offer supervisor credentials. APT members have had the opportunity to earn the
RPT-S credential for many years and, as recently as March of 2014, the parameters of that
credential were revised to increase the stringency of the initial credentialing process and to
require supervisors to obtain ongoing continuing education specific to clinical supervision.

SUPERVISION OF SUPERVISION

Virtually all mental health professionals and play therapists have been observed and supervised
in the course of their training. Supervision helps one grow professionally and serves an impor-
tant gatekeeping role by ensuring those not suited to the profession are counseled out of it.
Play therapy supervisors can hold themselves and fellow play therapy supervisors to the same
supervisors to be observed doing play therapy supervision. This training, for example, matches
seasoned play therapy supervisors to supervisors in training to provide them with feedback about
their play therapy-specific supervision. Offering supervisors opportunities to be supervised in
their roles as supervisors, to get additional training specific to supervision, and to receive mentoring as play therapy supervisors elevates the entire field. The supervision of play therapists, just like play therapy itself, requires a specialized knowledge base and skills, including child development, attachment theory, child pathology, family systems, parent–child relational dynamics, foster care system, child protective services, legal rights of children, family court, adoption, residential placements, pediatric psychopharmacology, educational system, occupational therapy, physical therapy, and speech therapy services and consultation.

Now that the stage has been set, let’s discuss how play therapy supervision may differ from typical forms of clinical supervision—even clinical supervision that is focused on child counseling and not specific to play therapy.

**PLAYFUL SUPERVISION**

Landreth (2012) argues that play therapists should be playful. Although play therapy and supervision are serious endeavors, there is room in supervision and the supervisory relationship to incorporate play and playfulness. Mullen, Luke, and Drewes (2007) argue that play therapy supervision should include playful and experiential components as a means of integrating skills and philosophies, modeling play therapy skills, and building one’s professional identity. Play is a form of communication regardless of age. Play therapy supervisors, perhaps more than anyone else, should appreciate this. Lahad (2000) argues that children are the best learners, especially children who are having fun while being challenged in a safe, constructive environment. Knowing this, supervisors structure the supervisory sessions so as to incorporate play therapy skills and interventions in order to fully take advantage the very skills they are supervising. Drewes and Mullen (2008) list numerous examples of playful supervision techniques to bring out playfulness in supervisees.

**CONCLUSION**

Play therapy supervision is a dynamic and specialized component of the training and preparation of play therapists. Play therapy supervisees and supervisors have responsibilities in the supervisory relationship that contribute to the professionalism of play therapists and the quality of services that play therapy clients and their families deserve. What makes play therapy a holistic and culturally sensitive approach is that play is universal. Play therapy supervision can borrow from the fields of play therapy and supervision to develop and provide play therapy supervision that elevates the field while simultaneously enriching the lives of supervisors, supervisees, children clients, and their families.

**REFERENCES**


PART

7

Contemporary Issues
Pthomegroup
Play therapy's long tradition, high index of acceptance among practitioners, and developmental appeal have firmly embedded it in the repertoires of many clinicians who work with children. With a history spanning more than 100 years, play therapy remains a popular and easily disseminated form of child psychotherapy, particularly in comparison to some evidence-based treatments that have labored to earn the endorsement of therapists in common clinical settings. Play therapy’s evidentiary base includes two meta-analyses conducted by different research teams (i.e., Bratton, Ray, Rhine, & Jones, 2005; LeBlanc & Ritchie, 2001) and decades of small-scale research studies that demonstrate promising treatment effects for many common childhood problems. Yet, there is little recognition of play therapy as an empirically supported treatment and even less agreement about the strength of its research base.

This chapter is written to examine the complexities of contemporary play therapy, including what it is, why it has been difficult to define, and how these issues pose challenges to play therapy researchers. We will also examine play therapy’s evidentiary base and address the key points that have sparked debate about play therapy’s empirical foundation, before concluding with issues we believe to be important to play therapy’s growth in the 21st century era of evidence-based treatments. With this chapter, we hope to shed light on an often misunderstood but widely practiced field that has sparked both controversy and ardent advocacy.

PLAY THERAPY’S RESEARCH AND QUESTIONS OF EFFICACY: THE BROAD NET

Play therapy is, perhaps, the most widely used, theoretically diverse method of child psychotherapy practiced today. From its original psychoanalytic and humanistic origins, play therapy has

---

1The authors wish to thank Lindsey Watson and Alex Watkins for their assistance in preparing this manuscript.
evolved to include dozens of different theoretical orientations and treatment methodologies. Play therapy’s broad scope encompasses a staggering range of presenting issues, diagnostic disorders, and target populations. Yet, what constitutes a play therapy remains a matter of ambiguity (i.e., definitions vary or are contradictory), and there is little consensus as to how to deliver play therapy treatments or why they provide therapeutic benefit.

What Is Play Therapy?

Definitions of play therapy deviate in both range and content. Some definitions are so specific they exclude play therapies grounded in different theoretical orientations. Others are so inclusive they incorporate all therapies that include play. In its definition, the Association for Play Therapy (APT) endorses a relatively broad approach but also emphasizes the centrality of play. Play therapy is described as “the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development” (APT, 2014). Thus, play therapy practitioners of diverse theoretical bends share similarities (i.e., relationship aspects of treatment and the use of the therapeutic powers of play) in a manner that is thought to transcend the differences associated with different theoretical orientations. In practice, the degree to which play therapies resemble each other may range widely. In fact, different denominations of play therapy practice appear within the same theoretical school of thought, such that play therapy practices vary both within and between theoretical orientation groups. Furthermore, the term play therapy has been used to refer to treatments delivered to children, but also to both caregiver–child dyadic and parent-training interventions (e.g., treatments in which caregivers are the direct recipients of training to use play techniques at home with their children). Schaefer (1993, p. 1), recognizing the challenge of defining play therapy, aptly reminded, “Play, like love, happiness, and other psychological constructs, is easier to recognize than to define.”

Another central distinction made in many play therapy definitions is whether the child leads the play, the therapist directs the interventions, or both. Axline (1974, p. 9) described that play therapy may “be directive in form … or it may be non-directive” and Schaefer (2001) advocates for an integrated, prescriptive approach in which both methods are used. Practitioners who practice a single form of play therapy are likely to use a humanistic, child-directed approach, such as child-centered play therapy (Landreth, 1991). In fact, a disproportionate number of play therapy studies have examined this or a related approach, which makes it challenging to draw conclusions regarding the research base for all types of play therapy.

With such broad—or sometimes contradictory— notions of what constitutes a play therapy, it is particularly important to identify the unifying or specific therapeutic factors at the nucleus of play therapy’s diverse forms and definitions. Little research has been conducted to identify play therapy’s therapeutic factors. Apart from the positive therapeutic relationship essential to all forms of psychotherapy, the therapeutic use of play as the primary medium of discourse would seem a logical, and perhaps the only, common characteristic unique to play therapy (Kool & Lawver, 2010). But, from among the many types of play in which children may engage, what type or types have therapeutic value? Traditionally, symbolic, expressive, and dramatic play have been widely used in play therapy settings. However, several additional categories of play exist, including physical play, manipulative play (e.g., dropping a toy to see if parent picks it up, moving puzzle pieces), familiarization play (e.g., preparing for medical procedures), games (e.g., video, computer, card, board, sports), and surrogate play (e.g., when ill or incapacitated children watch play behaviors undertaken on their behalf). Play therapists must determine which types of play hold curative value, and if multiple types of play are postulated to provide therapeutic benefit, a model of change must account for how such diverse forms derive their positive outcome
Play Therapy Research: Issues for 21st Century Progress 565

(e.g., video games would seemingly emphasize the therapeutic relationship less centrally than other forms of play; and sports play, given the need to adhere to rules and meet the demands of the activity, might not involve as much self-expression and processing of experiences as other forms of play). Nonetheless, more empirical work is needed to understand not only whether, but also which, why, how, and with whom particular types of play may be more therapeutic than others.

Key Ingredients and Change Mechanisms

"The goal is to understand what invisible but powerful forces resulting from the therapist-client play interactions are successful in helping the client overcome and heal psychosocial difficulties," Schaefer and Drewes (2009, p. 4–5) pointed out. Play therapy process research is needed to clarify what it is about play that achieves positive outcomes, including mechanisms of change (i.e., how and why outcomes are produced) and specific factors (i.e., ingredients) or combinations of factors that produce change. Fortunately, empirical work specifying why and how play holds therapeutic benefit is beginning to emerge (see Russ & Niec, 2011; Stagnitti & Jellie, 2004; and Stagnitti, O’Connor, & Sheppard, 2012; for further discussion of this topic), and though not empirical in nature, a few authors have hypothesized play therapy’s key ingredients (e.g., Mulherin, 2001; O’Connor, 2002; Schaefer 1993; Schaefer & Drewes, 2014). In Schaefer’s proposal, the therapeutic powers of play are the means through which therapeutic gain ensues. These powers, or change mechanisms, achieve optimal therapeutic benefit when paired with the causative agents underlying the child’s difficulties (Drewes, 2011; Schaefer & Drewes, 2009). The authors postulate that the specific therapeutic powers of play are most beneficial when they target specific presenting issues and involve the blending of different models and treatments. Table 30.1 summarizes Schaefer and other authors’ efforts to articulate the factors and processes through which play therapy change occurs.

Identification of key ingredients of change is a critical first step in understanding more about play therapy’s process, and offers an important foundation from which the postulated curative factors associated with the play methodologies can be examined. However, identifying change factors is particularly complex in play therapy contexts because most play therapies are imbedded within an overarching theoretical orientation. This fusion makes it unclear whether therapeutic benefit is derived from the change agents postulated within the theory, the specific play techniques utilized, or the interaction between the standard methods and the play. As Phillips (2010) pointed out, the play therapy interventions are confounded with the theoretical base. Therefore, change models must also be articulated for each type of play-based treatment (e.g., child-centered, Adlerian, or cognitive behavioral). For example, the humanistic therapist must decipher whether the relationship, the play, or some combination of both produces the therapeutic change (Baggerly & Bratton, 2010). Similarly, the CBT play therapist treating a traumatized child must discern whether it is the exposure-based emotional processing of the traumatic event, the play, the caregiver collateral sessions, or a combination that produces the therapeutic gain. Another interesting issue to detangle is that the means of achieving therapeutic gain postulated in the overarching theory (e.g., CBT, humanistic, or psychodynamic) often involves nonplay methods, so play therapists must articulate how and why the play adds additional benefit.

An interesting process issue is whether play therapy is merely a vehicle facilitating change, or whether it is the play itself that holds unique curative value. In some therapies, play serves as an ambient platform from which the therapeutic key ingredients or communication take place. For example, in child–parent psychotherapy (Lieberman & Van Horn, 2008), the dyadic interaction occurs largely through play, but play is not perceived as a key ingredient of change. These issues prompt play therapists to decipher whether: (a) play itself constitutes a theoretical base for many child therapies, (b) play therapy is a unified and conceptually distinct treatment held
Table 30.1 Proposed Key Ingredients in play therapy

<table>
<thead>
<tr>
<th>Author</th>
<th>Term Describing Process Variables</th>
<th>Key Ingredients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schaefer and Drewes (2009, 2014)</td>
<td>Therapeutic powers</td>
<td>- Self-expression</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Access to the unconscious</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Direct and indirect teaching</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Abreactions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Stress inoculation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Counterconditioning of negative affect</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Catharsis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Positive affect</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Sublimation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Attachment and relationship enhancement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Moral judgment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Empathy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Power/control</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Competence and self-control</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Sense of self</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Accelerated development</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Creative problem solving</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Fantasy compensation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Reality testing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Behavioral rehearsal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Rapport building</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Diagnostic opportunities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Breaking down defense mechanisms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Facilitating articulation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Therapeutic release</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Anticipatory preparation</td>
</tr>
<tr>
<td>O’Connor (2002)</td>
<td>Processes of change</td>
<td>- Cognitive Domain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Schema transformation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Symbolic exchange</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Insight</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Skill development</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Affective Domain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Abreaction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Emotional experiencing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Affective education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Emotional regulation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Interpersonal Domain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Support and validation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Corrective relationship</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Supportive scaffolding</td>
</tr>
</tbody>
</table>
by shared tenets of a universal play therapy theory, or (c) play therapy is an offshoot stemming from the parent theoretical orientation (e.g., humanistic, psychodynamic, or cognitive behavioral). Jent, Niec, and Baker (2011) recommend that play therapists align more closely with both evidence-based principles and the theoretical origins of the play therapy types the therapists use. However, play therapists have traditionally maintained that the unifying elements of play transcend play therapy's different theoretical manifestations. In any event, these complex identity and process issues establish the context in which we now examine 21st century play therapy outcome research.

THE STATE OF PLAY THERAPY RESEARCH: IN THE EYE OF THE BEHOLDER?

Rarely has a single body of literature been interpreted with such contrasting opinions. In the literature, play therapy has been described as having a sound research base, and it has also been portrayed as supported by no or limited evidence. Ray and Bratton (2010, p. 3) concluded “play therapy research dates back more than 45 years, providing empirical support for even the harshest of critics.” Others have similarly noted, “there is a great deal of [play therapy] research available” (Kool and Lawver, 2010, p. 23), play therapy is statistically viable (Bratton, Ray, Rhine, & Jones, 2005), and play therapy is an effective means of mental health intervention for children (Homeyer & Morrison, 2008). Baggerly (2009) reviewed 16 relatively rigorous, recent studies (8 play therapy studies and 8 filial therapy) and determined there is sufficient research to meet the promising or probably efficacious standard. Psychodynamic group play therapy (Bonner, Walker, & Berliner, 1999) and trauma-focused play therapy (Gil, 1998) were identified in a child physical and sexual abuse task force report (Saunders, Berliner, & Hanson, 2003) as a “supported and acceptable treatment” and a “promising and acceptable treatment,” respectively. However, the Centers for Disease Control (2008) concluded play therapy has not been proven to be effective. Wethington et al. (2008) reviewed seven interventions for childhood trauma and concluded evidence was insufficient to determine the effectiveness of play therapy and the other five non-CBT treatments. Urquiza (2010) surmised that empirical research on play therapy has consistently lagged behind its practice and needs more examination of its strategies—not merely more research—to earn the credibility it seeks. Phillips (2010, p. 13) summarized the state of play therapy (PT) research by stating, “The sobering answer is that a body of credible scientific evidence for most of PT still does not exist.” To date, play therapy has not been determined to rise to the level of an evidence-based treatment by any organization, task force, or clearinghouse designed for the purpose of evaluating the merits of various treatments’ empirical bases.

With such seemingly discrepant reviews of the play therapy literature, whom is a play therapist to believe? All of them, we suggest. Each view provides part of a more holistic perspective. In the following pages, we will describe the existing data in an effort to assemble an accurate, comprehensive, and balanced view of the state of play therapy research.

IS THERE EVIDENCE TO SUPPORT THE USE OF PLAY THERAPY?

In order to examine play therapy's evidentiary base, this review will first focus on studies that both describe interventions clearly labeled as play therapy and fit the current definition provided by APT as described earlier. Caregiver–child therapies widely considered by play therapists to be play therapies that use parent training to promote the child's play will be considered as
a distinct—albeit overlapping—category of treatment. Therapies that fit a more expansive definition of play therapy or those that meet the definition but are not clearly described as play therapies by the authors are also described separately. While it is beyond the scope of this chapter to present research evidence from all child treatments that include a play component, some of these treatments will be considered to address the fact that play therapy’s empirical foundation is strengthened significantly if these treatments are included in groupings of play therapies.

Meta-Analytic Research on Play Therapy

The most widely cited aspect of play therapy’s research involves its meta-analytic research. In meta-analytic reviews, the effects of a type of treatment are analyzed by combining the results of multiple individual studies, thus helping to overcome the limitations of small sample sizes. Study outcomes are converted to effect sizes (ES), which are the average amount of change in standard deviation units achieved by individuals in a treated group versus the change achieved by members of a control/comparison group. According to Cohen (1977), $d = 0.2$ represents a small ES, $d = 0.5$ represents a medium ES, and $d = 0.8$ represents a large ES. LeBlanc and Ritchie (2001) conducted the first meta-analysis to focus exclusively on play therapy studies, with dissertation abstracts dated from 1945 and including more than 40 studies over several decades. They reported a moderate treatment ES of 0.66 for 42 controlled studies. In addition, they reported a strong relationship between treatment effect and both (a) the inclusion of parents, and (b) treatment duration. A second meta-analysis was conducted by Bratton et al. (2005) and reported a large treatment ES of 0.80 for 93 play therapy studies. A few other meta-analyses and systemic reviews of child psychotherapy have reported favorable outcomes for play therapy, but included very few play therapy studies and made only minimal note of its effects (Allin, Walthen, & MacMillan, 2005; Casey & Berman, 1985; Eyberg, Nelson, & Boggs, 2008; Hetzel-Riggin, Brausch, & Montgomery, 2007; Wethington et al., 2008). Overall, these meta-analytic findings suggest play therapy is effective to a similar degree as most other forms of child psychotherapy (Casey & Berman, 1985, ES = 0.71; Weisz, Weiss, Han, Granger, & Morton, 1995, ES = 0.54).

Bratton and colleagues’ (2005) review is the largest and most current meta-analysis, and it will therefore be summarized in the most detail. This meta-analysis included studies that used a controlled research design (i.e., differentiated from a randomized controlled design), sufficient data for computing ES, and clear identification of a play therapy intervention. In the final analysis, 93 studies were assessed with an overall ES of 0.80, indicating a large treatment effect. Importantly, Bratton et al. (2005) examined several specific treatment characteristics, participant characteristics, and study characteristics that might impact treatment outcomes. In regard to treatment characteristics, both humanistic/nondirective play therapy interventions and nonhumanistic/directive approaches were shown to be effective. Nonhumanistic/directive approaches yielded a larger ES, but the authors encouraged the reader to interpret this finding with consideration to the larger number of studies coded as humanistic/nondirective versus nonhumanistic/directive, a lack of specificity in the description of interventions used in many of the studies, and a lack of consistency in treatment protocols, even within the same theoretical school of thought. Indices of the quality of the individual studies comprising the meta-analysis were not included, and the authors noted the limitations associated with including studies of questionable quality. Also of note, the ES of play therapy provided by a paraprofessional (parent, teacher, or peer mentor trained and supervised by a professional) was significantly higher than the ES when provided by a mental health professional. Again, the authors advise cautious interpretation of this significant difference (i.e., caregiver participants provided outcome ratings, possible differences between treatments with and without caregiver participants, and possible differences related to
the population likely to receive treatment directly from a mental health professional). Most studies in this meta-analysis were conducted in a school setting or outpatient clinic, but play therapy conducted in critical-incident or residential settings produced a significantly larger ES, though the low number of studies in these settings limits the conclusions that can be drawn regarding the finding of superiority.

Analyses of participant characteristics indicated neither age, gender, nor type of problem (e.g., internalizing, externalizing, or a combination) were significant factors in predicting treatment outcomes, although approximately one-third of the studies could not be coded in these categories, and studies targeted diverse conditions such as mental retardation, pervasive developmental disorder, and childhood schizophrenia. Ethnicity was not reported due to lack of specificity in the individual studies. The authors reported several of the individual studies lacked appropriate instrumentation to measure outcomes, which the authors identified as a limitation of the meta-analysis. Finally, the source of the outcome measures (i.e., parents, teachers, trained observers, participant performance, or participant report) was analyzed and results did not show significant differences among or between sources.

In addition to treatment and participant characteristics, study characteristics (i.e., publication status, study design, and source of participants) were examined. A unique quality of this meta-analysis was the effort to address publication bias (a tendency for studies reporting statistically significant findings to be published over those reporting nonsignificant results) by including 50 unpublished studies. As expected, results indicated a significantly larger treatment effect for published compared to unpublished studies. Source of participants (i.e., those seeking clinical services versus those recruited for research) and study design (i.e., play therapy versus control, play therapy versus alternate treatment, or play therapy versus alternate treatment versus control) did not appear to affect treatment outcome.

Bratton et al. (2005) offered a much needed organization of research activities in an expansive field, quantifying the value of play therapy and its relative stature among the repertoire of child therapy interventions and taking the extra step to combat publication bias. Their work provided an important base from which subsequent research interest sprang and added support for the practice of play therapy. However, the methodological limitations of the existing research available to Bratton and colleagues mean the results must be interpreted with caution. As the authors articulated, a meta-analysis is only as strong as the individual studies that are included and submitted to the statistical procedures. It is difficult to draw conclusions from the meta-analytic findings without a coding system for study quality (Phillips, 2010). Baggerly and Bratton (2010) addressed this omission and acknowledged concerns related to study quality. They explained that many of the criteria considered in assessing study quality today (e.g., use of treatment protocols and measuring adherence to protocol) were not standard procedure in research until the later 1990s. Their inclusion of early play therapy studies required many studies to be omitted from the final analysis, and although only some studies (i.e., those using a pre–post comparison-control group design and with sufficient detail to code most study characteristics) were included, there was often a lack of clear description of methods and procedures in the original studies (Bratton et al., 2005). Thus, results from the meta-analysis fall short of providing the firm support play advocates wish to find for their work, and the meta-analysis cannot be said to provide robust support for play therapy’s efficacy. However, the meta-analysis can be accurately described as providing preliminary support, or some—albeit limited—support for play therapy’s use. Nevertheless, the meta-analysis was a monumental step that built upon LeBlanc and Ritchie’s earlier meta-analysis toward demonstrating play therapy’s research support. Many positive outgrowths emerged from both studies, including play therapy’s enhanced credibility and more widespread discussion of play therapy research.
Play Therapy Research in the 21st Century and Individual Studies of Play Therapy

Though necessary to acknowledge the limitations of existing play therapy research, it is equally important to acknowledge the field's growth in the realm of scientifically rigorous methods. Over the past few decades, psychological treatment research standards have progressed to require experimental or quasi-experimental studies that provide more than a large ES to determine a particular treatment's empirical foundation. Experimental indicates the study met the most stringent criteria for research design, including random assignment of subjects, comparison to a control group or another treatment group, clear methodology and treatment descriptions, and attention to internal and external validity threats. Quasi-experimental indicates the study used comparison or control groups with clear methodology and attention to internal and external validity threats but not random assignment (Rubin, 2008).

There are many views of evidence-based treatment (EBT) criteria, but randomized-controlled trials, careful delineation of the client sample, specification of treatment, and replication of results by an independent investigator or team are among the commonly used criteria (Kazdin, 2011). Southam-Gerow and Prinstein (2014) recently provided criteria for evidence-based treatments, based on well-known standards developed by Chambless et al. (1998), Silverman and Hinshaw (2008), and Nathan and Gorman (2007). These criteria are outlined in Table 30.2.

According to these EBT criteria, most play therapy studies published since 2000 fall into the level 4 category, experimental, due to an overall lack of essential study characteristics required to meet evidence-based criteria, including comparison groups, randomized assignment, adequate sample size, reliable and valid measures with blind administration and scoring, treatment manuals implemented with fidelity checks, appropriate training and supervision of therapists, specific inclusion/exclusion criteria for participants, and appropriate statistical analyses among some studies. A select subset of play therapies, however, fall into the level 2, probably efficacious, category and some filial therapies also place in the level 2 category, as we will discuss later.

The use of randomized controlled trials (RCTs) and the aforementioned criteria have not gone uncriticized. However, as Urquiza (2010) aptly described, achieving these research standards is the clearest path toward wider acceptance and play therapy credibility. During the past few years, play therapy researchers have responded to the need for more rigorous empirical evidence to advance play therapy to higher placement in EBT criteria categories. One example is an RCT designed to examine child-centered play therapy (CCPT) for preschool children with clinical levels of disruptive behaviors (Bratton et al., 2013). This RCT met all five methods criteria outlined by Southam-Gerow and Prinstein (2014). Group design: Children were randomly assigned to CCPT (i.e., the experimental treatment) or reading mentoring (i.e., the active control). Independent variable defined: CCPT therapists were required to attend CCPT training and to follow the specific CCPT protocol (Ray, 2011). Treatment fidelity was ensured by recording all sessions, providing weekly supervision, reviewing all sessions with the CCPT skill checklist (Ray, 2011), and random fidelity checks. Population clarified: The authors gave a clear description of the participants, who were being treated for a specific issue (i.e., disruptive behaviors). Participation in the study was limited to youth who scored in the clinical or borderline range on a well-established measure of disruptive behaviors, the teacher's report form (TRF) (Achenbach & Rescorla, 2001). Outcomes assessed: The TRF was used to assess the outcome of disruptive behavior. This measure has well-established reliability and validity (Achenbach & Rescorla, 2001). Analysis adequacy: The sample size (N = 54) was sufficient to find a statistical difference between the experimental and control groups over time according to an a priori power analysis. Data analyses were appropriate and reported results included both statistical significance level and ES.
Table 30.2 Criteria for Evidence-Based Treatments

Methods Criteria

M.1 Group design: Study involved a randomized controlled design
M.2 Independent variable defined: Treatment manuals or logical equivalent were used for the treatment
M.3 Population clarified: Conducted with a population, treated for specified problems, for whom inclusion criteria have been clearly delineated
M.4 Outcomes assessed: Reliable and valid outcome assessment measures gauging the problems targeted were used
M.5 Analysis adequacy: Appropriate data analyses were used and sample size was sufficient to detect expected effects

Level 1: Well-Established Treatments

Evidence criteria
Efficacy demonstrated for the treatment by showing the treatment to be either:

1.1.a Statistically significantly superior to pill or psychological placebo or to another active treatment

OR

1.1.b Equivalent (or not significantly different) to an already well-established treatment in experiments

AND

1.1.c In at least two independent research settings and by two independent investigatory teams demonstrating efficacy

AND

All five of the methods criteria

Level 2: Probably Efficacious Treatments

Evidence criteria

2.1 There must be at least two good experiments showing the treatment is superior (statistically significantly so) to a wait-list control group

OR

2.2 One (or more) experiments meeting the well-established treatment level except for criterion 1.1.c. (i.e., level 2 treatments will not involve independent investigatory teams)

AND

2.3 All five of the methods criteria

Level 3: Possibly Efficacious Treatments

Evidence criteria

3.1 At least one good randomized controlled trial showing the treatment to be superior to a wait list or no-treatment control group

AND

3.2 All five of the methods criteria

OR

3.3 Two or more clinical studies showing the treatment to be efficacious, with two or more meeting the last four (of five) methods criteria, but none being randomized controlled trials

(Continued Overleaf)
Table 30.2 (Continued)

<table>
<thead>
<tr>
<th>Level 4: Experimental Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence criteria</td>
</tr>
<tr>
<td>4.1 Not yet tested in a randomized controlled trial</td>
</tr>
<tr>
<td>OR</td>
</tr>
<tr>
<td>4.2 Tested in one or more clinical studies but not sufficient to meet level 3 criteria</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 5: Treatments of Questionable Efficacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Tested in good group-design experiments and found to be inferior to other treatment group and/or wait-list control group (i.e., only evidence available from experimental studies suggests the treatment produces no beneficial effect)</td>
</tr>
</tbody>
</table>


There are more experimental and quasi-experimental studies of CCPT for disruptive behavior (Fall, Navelski, & Welch, 2002; Garza & Bratton, 2005; Ray, Blanco, Sullivan, & Holliman, 2009; Schumann, 2010), but due to methodological limitations, none of these studies meets all five methods criteria. Primary limitations include small sample sizes and nonspecific descriptions of the treatment protocols and targeted populations. Therefore, CCPT meets classification criteria for a level 2 treatment for disruptive behavior. One experiment has met all five methods criteria, but it cannot be considered a level 1 treatment until another study of equal methodological caliber is conducted by a different research team. Another recent treatment study, conducted by some of the same authors and using almost identical study design as Bratton et al. (2013), provided evidence for Adlerian play therapy as another level 2 treatment for disruptive behavior (Meany-Walen, Bratton, & Kottman, 2014). While the remainder of play therapy interventions published since the year 2000 remain at level 4, there has been a growing number of 21st-century experimental and quasi-experimental research studies indicating positive treatment effects for several presenting problems, including internalizing problems (Packman & Bratton, 2003), ADHD (Ray, Schottelkorb, & Tsai, 2007), trauma (Schottelkorb, Doumas, & Garcia, 2012; Tyndall-Lind, Landreth, & Giordano, 2001; Shen, 2002), academic problems (Blanco & Ray, 2011), delayed language skills (Danger & Landreth, 2005), teacher–child relationship problems (Ray, 2007; Ray, Henson, Schottelkorb, Brown, & Muro, 2008), and adaptation to medical problems (Bloch & Toker, 2008; Jones & Landreth, 2002; Li & Lopez, 2007; Tsai et al., 2013). The empirical evidence for medical play therapy is particularly notable for its methodological strengths and promising results.

Our review of 22 additional play therapy studies identified as quasi-experimental or experimental since 2000 showed a significantly positive treatment effect, although it is important to recognize the potential confound of publication bias. “Not once was play therapy deemed unnecessary, counter-productive, or a failure,” noted LaMotte (2011, p. 71) from a review of play therapy for trauma. Nonetheless, research support for play therapy is mounting and research methods have been strengthening over the past two decades. Play therapy researchers have improved in all five of the methods criteria presented by Southam-Gerow and Prinstein (2014). This emerging body of support warrants more credibility for these forms of play therapy than is commonly acknowledged in the literature beyond play therapy journals. In fact, several widely accepted, non-play therapy treatments in the mainstream child psychotherapy literature rise only to level 2 criteria, which leads many play therapists to wonder whether play therapy research is simply overlooked. In summary, play therapy has an emerging research base, but it does not yet have a strong
evidentiary base. Methodological limitations continue to hamper play therapy from meeting criteria to become designated as an empirically based treatment. To illustrate how methodological issues impact perceptions of play therapy research, we will examine several studies in terms of their level of research methodology rigor and we will discuss both strengths and limitations of these studies. Before doing so, however, we recognize that relatively few play therapists are researchers, and the contributions of those who have endeavored to conduct research are both acknowledged and valued.

**Group Design**

RCTs have become much more common in play therapy research. This review of 21st century peer-reviewed and published nonfilial play therapy studies identified 18 experimental studies (Blanco & Ray, 2011; Bratton et al., 2013; Carpentier, Silovsky, & Chaffin, 2006; Danger & Landreth, 2005; Fall et al., 2002; Garza & Bratton, 2005; Jones & Landreth, 2002; Li et al., 2008; Meany-Walen et al., 2014; Packman & Bratton, 2003; Paone, Packman, Maddux, & Rothman, 2008; Ray, 2007; Ray et al., 2007, 2008; Schottelkorb et al., 2012; Shen, 2002; Tsai et al., 2013; Wang Flahive, & Ray, 2007). While randomization is often difficult when designing an intervention-based research design, play therapy researchers have clearly responded to the need for RCTs.

**Independent Variable Defined**

Play therapy research has made progress in identifying and describing treatment protocol. Similar to Bratton et al. (2013) and Meany-Whalen et al. (2014), some studies clearly identified and described the treatment protocol (Blanco & Ray, 2011; Garza & Bratton, 2005; Li et al., 2008; Ray, et al., 2007, 2008, 2009; Tsai et al., 2013). Specification of treatment components and assurance of treatment fidelity included important elements, such as structured trainings for therapists, frequent supervision, videotaped sessions, and checklists to ensure treatment fidelity. However, research termed “play therapy” but conducted without a precise description and/or structure is sometimes a methodological barrier, even if other aspects of the research are sound. For example, Shen’s (2002) important study of group play therapy would have provided stronger evidence if a more clear description of the intervention had been provided, and Schottelkorb et al. (2012)'s pioneer RCT comparing CCPT to a trauma-based treatment would have been strengthened if the comparison treatment, TF-CBT (Cohen, Mannarino, & Deblinger, 2006), had maintained its integrity and fidelity (i.e., the manualized form of TF-CBT was modified such that the time frame was abbreviated, sessions were increased to twice a week, and parents did not receive the indicated collateral sessions). These methodological issues do not necessarily mean the play therapies were ineffective, and in many cases, positive effects for play therapy were found. Methodological issues and/or limitations of the studies, however, change the scope and confidence of the conclusions that can be drawn. These factors influence perceptions of both play therapy's research and its efficacy.

**Population Clarified**

Play therapy research has also improved in terms of identifying specific inclusion and exclusion criteria. Some recent studies clearly identify a particular diagnosis or presenting problem (Bratton et al., 2013; Garza & Bratton, 2005; Meany-Walen et al., 2014; Schumann, 2010; Tsai et al., 2013), but others provide nonspecific presenting problems. For example, if the studies of Fall et al. (2002) and Wang et al. (2007) are repeated, it would be helpful to narrow the broad populations of children (i.e., any child in special education and referred by teachers as
experiencing behavioral difficulties, respectively) to those with a specific problem, concern, or diagnosis. Some studies use nonclinical samples or general samples (i.e., refugees or school children). Such broad inclusion criteria do not clearly identify the populations who might benefit from the treatment being investigated, and, if used on a nonclinical population, may not be generalizable to a population of children in clinical settings. Omitting aspects of the population description is a limitation in many play therapy research studies, but the vast majority of contemporary play therapy studies provide thorough reports of other participant characteristics such as age, gender, and ethnicity.

Outcomes Assessed
Many recent play therapy studies utilize well-established assessment measures with sound reliability and validity. Furthermore, there has been increased use of assessors who are blind to the participants’ assignment to the treatment or the comparison group. Most recent studies have used assessment instruments measuring the specific presenting problem related to the research question, but the frequent absence of a clarified presenting problem, as previously discussed, muddles this issue.

Analysis Adequacy
Across the identified 21st-century studies, sample sizes ranged from 19 to 291, with a mean of 57. When the one study with 291 participants was eliminated as an outlier, the mean was still an impressive 47 participants (range = 19–93). Although adequate sample size continues to be a barrier to acquiring higher-level EBT status, this mean and range is a clear improvement from the first several decades of play therapy research plagued by small sample sizes. However, only a select few recent studies provided an a priori power analysis, which is an important preliminary analysis to identify how many participants are necessary to identify a statistically significant effect. While this appears to be more common in recent studies, play therapy research would benefit from the provision of detailed descriptions of statistical analyses, including alpha levels and effect sizes.

Overall, play therapy research has made substantial methodological advances in the 21st century and is making steady progress toward a strong evidence base. The research from our review ranged from several studies with significant limitations to studies demonstrating scientific rigor, and additional support for play therapy is continuing to accumulate. With careful consideration to the methods criteria previously outlined, future play therapy research will likely continue to advance toward improving play therapy’s level of empirical support.

Expanded Definition Play Therapies: Are They Efficacious?
Many treatments that are not necessarily conceptualized or defined as play therapy include play, play-therapy techniques, or rely upon play as the primary vehicle to implement therapeutic interventions. Several evidence-based or strongly supported dyadic or parent training approaches fit this condition, and these will be discussed separately, in the next section of this chapter. In addition to these treatments, many other play-based, empirically supported child therapies exist that may not be identified as play therapies. Schaefer (2008) identified numerous child treatments—many with controlled or randomized controlled studies to support their use—including virtual reality play (Reid, 2004), guided fantasy (Krakow & Zadra, 2006), structured parental counseling-child psychotherapy (Cohen & Mannarino, 1996), pivotal response training (Stahmer, 1995), and the early start Denver model (Rogers & Lewis, 1989). Other well-researched CBT or complex trauma treatments incorporating play also exist (c.f. Asarnow, Scott, & Mintz, 2002; Briere & Lanktree, 2008), yet these are not widely or clearly considered play therapies. Interestingly, play is considered an essential ingredient—or at least a
prominent vehicle—for change in these treatments, though the authors may not identify the treatments as play therapies or themselves as play therapists. This raises important questions about how therapies are included or excluded from the pool of treatments considered play therapies. Should the criteria for play therapy involve interventions, including play to achieve change, author affiliation, or both? Moreover, if the scope of interventions perceived as play therapies is broadened to include all treatments with a significant play component, several evidence-based and strongly supported therapies would then be contributors to the play therapy’s evidentiary support. Greater inclusion of treatments would broaden play therapy’s already wide scope but may murk the conceptual base a bit further. Overall, the benefits of expanding play therapy’s empirical support with greater inclusion of related play-based treatments are compelling, and warrant further consideration.

Play Therapy Integrated With Parent Training Approaches: Are Dyadic Play Therapies Efficacious?

Several rigorous studies support the use of parent training/relationship enhancement approaches that integrate the therapeutic powers of play, though these treatments are not widely considered to be play therapies (e.g., parent–child interaction therapy [PCIT; Eyberg et al., 2001], child–parent psychotherapy [CPP; Lieberman & Van Horn, 2008], and the incredible years [IY; Gadner, 2006]). A review and meta-analysis of PCIT treatment studies concluded PCIT meets criteria for a “well-established treatment” (Thomas & Zimmer-Gembeck, 2007). Another example is CPP, an intervention investigated in RCTs with positive results (e.g., Lieberman, Ghosh, & Van Horn, 2006; Toth, Rogosch, Manly, & Cicchetti, 2006). Also, several RCTs support the IY protocol (Gadner, 2006). These treatments have been identified as EBTs by multiple professional and governmental agencies. Research support for dyadic treatments with long-standing play therapy traditions has also emerged. Filial Therapy, originally introduced by B. Guerney (1964) and L. Guerney (2000) is an integrative approach in which therapists train and supervise caregivers who then conduct child-led play sessions with their own children (Van Fleet, 2011). Landreth and Bratton (2006) later developed a filial treatment from the Guerney’s work, called child–parent relationship therapy (CPRT). In Bratton et al.’s (2005) meta-analysis, filial therapy studies (and particularly studies involving parent-led filial therapy) demonstrated a significantly larger treatment effect than therapist-led play therapy. These results should be interpreted cautiously, though early research evidence for filial play therapy is promising. Empirical support for filial play therapy was present prior to and has continued to grow since Bratton et al.’s (2005) meta-analysis, most notably for CPRT (Landreth & Bratton, 2006). CPRT research provides a good example of increased methodological rigor in play therapies; specifically, many of these studies investigated clearly defined populations and target behaviors, used randomized controlled trials, had adequate sample sizes, and adhered to a manualized protocol. Bratton and Landreth (2010) provided a review of recent research on CPRT, including 13 experimental and 19 quasi-experimental studies published from 1995 to 2010, concluding CPRT currently meets the criteria for a “promising” or “probably efficacious treatment.” Statistically significant positive results were found on the vast majority of all study outcome measures. Impressively, 28 out of the 32 studies were conducted by investigators who were directly trained and supervised in the CPRT protocol by the authors of the CPRT manual. The issues and populations addressed in these studies included sexually abused children, children with an incarcerated parent, children diagnosed with learning differences, pervasive developmental disorders, chronic illness, and both internalizing and externalizing behavior problems. Another caregiver–child dyadic play therapy, Theraplay®2 (Jernberg, 1979; Munns,

---

2Theraplay is a registered service mark of The Theraplay Institute, Evanston, IL.
2000) is an attachment-based approach described as an “engaging, playful, relationship-focused treatment method that is interactive, physical, and fun” (Booth & Jernberg, 2010, p. xxi). Contemporary Theraplay has a growing evidentiary base, including at least one controlled trial with randomization (Siu, 2009), and several other studies with some aspects of experimental design (Weir, Lee, Canosa, Rodrigues, McWilliams, & Parker, 2013; Wettig, Coleman, & Geider, 2011). In addition to these relationship-enhancement therapies, there is also an RTC to support the use of caregiver–child dyadic play therapies focused on specific issues, such as darkness phobia (see also Santacruz, Mendez, & Sanchez-Meca, 2006). In summary, several play-based or play-inclusive dyadic treatment programs have been studied and a mounting evidentiary base is accumulating for the use of these parent–child dyadic play therapy treatments.

WHERE IS PLAY THERAPY AND HOW CAN PLAY THERAPY CONTINUE TO ADVANCE?

Within the play therapy field there have been promising strides in strengthening both play therapy’s research base and practitioners’ acceptance of the need for highly powered RCTs in order to meet EBT criteria. At times, these strides have neither been popular nor well understood. Nevertheless, there is now a more firmly developed research base, a wave of emerging rigorous research, and, perhaps most importantly, greater consensus to move toward the use of mainstream research practices. Numerous authors now agree that highly powered RCTs, as well as process-focused research is needed (Baggerly, 2010; Baggerly & Bratton, 2010; Drewes, 2011; Schaefer & Drewes, 2009).

Fortunately for play therapists, there is support for several types of play therapy. We summarize the research in this way: There is more support than most outside the play therapy field are aware and less than most within the field seek. Several play therapies, however, remain unstudied. To continue the momentum toward the development of a strong play therapy research base, we offer the following suggestions in line with the trend toward 21st-century research principles: (a) further efforts to develop a cohesive and conceptually rigorous play therapy model by refining play therapy’s definition, and identifying common elements, key ingredients, change mechanisms, and methodologies; (b) publicize play therapy’s existing research and bolster efforts to publish findings in a wide range of journals, not merely in play-specific journals; (c) continue and expand research activities focused on generating highly powered RCTs consistent with the APT’s research strategy (APT, 2006); (d) interpret research findings and the state of play therapy’s literature accurately, avoiding overinterpretation and overgeneralization of findings; and (e) welcome and value critical feedback as part of the evolution of scientific discovery.

CONCLUSION

Play therapy’s popularity and its 50 years of research have not quieted doubts about play therapy’s credibility and empirical base. At the same time, neither criticisms of play therapy research nor the emergence of evidence-based, nonplay alternative therapies for children have dissuaded play therapists from using play therapies. Lack of specificity in the definition of play therapy, lack of clarity regarding play therapy’s ingredients, and methodological shortcomings have hindered efforts to establish play therapy as an EBT. Play therapy’s heterogeneity and the dearth of empirical work to identify common elements and key ingredients pose ongoing challenges for researchers who need to define it in order to study it, as well as for therapists, who must decipher how research findings from some but not all forms of play therapy pertain to their own practice. Yet, 21st-century play therapists have progressively recognized the need to strengthen
play therapy’s empirical base by increasing the number and quality of experimental studies. The recent focus on enhancing scientific rigor in play therapy research has resulted in several studies that strengthen the field’s evidentiary base and foster recognition of play therapy as an effective treatment option. There is research to support several—but not all—uses of play therapy. When dyadic treatments are included, the research merits increased confidence. If treatments that include play as a platform or vehicle are included as play therapies, there is sound support for the collective use of play therapy methods across a range of treatments. In summary, play therapy research has made substantial methodological advances in the past decade, and there is reason to feel optimistic about play therapy’s empirical future.

REFERENCES


CHAPTER

31

Neuroscience and Play Therapy: The Neurobiologically-Informed Play Therapist

EDWARD F. HUDSPETH AND KIMBERLY MATTHEWS

Play, the frivolous, unimportant, behavior with no apparent purpose has earned new respect as biologists, neuroscientists, psychologists, and others see that play is indeed serious business and is perhaps equally important as other basic drives of sleep, rest, and food. In the scientific community, if not in social institutions, play and the people who study it are no longer seen as strange and immature.

——J. L. Frost, 1998, p. 2

What happens when you do an Internet search using the two simple words play and neurobiology? The outcome is an overwhelming number of studies, yet this is a realistic demonstration of how and where play and neurobiology intersect. The outcome of this search is fruitful. However, it is somewhat off target when looking to understand the relevance of neurobiology to the practice of play therapy. If you were to do a search using the words play therapy and neurobiology, you would find a very limited number of studies, in part, because the term play therapy has not been operationalized in neuroscience research to the extent the terms play and play behaviors have.

It is a daunting task to describe the influences of neuroscience on play therapy, because all aspects of play therapy have a neurobiological and subsequent biological basis. Consider the Association for Play Therapy’s (APT) definition of play therapy, “the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development” (APT, 2001, p. 20). From the definition, several concepts emerge and can be explained through neuroscience research, including optimal growth
and development, interpersonal process, and therapeutic powers of play. These three concepts are put in this sequence to make the following descriptions and explanations flow smoothly. These concepts can also be thought of as points on a timeline. For instance, by the time a child or adolescent comes to play therapy, optimal growth and development have often already been affected; therefore, they are part of the child’s past. Interpersonal process is likely in a state of current disruption and is a part of the child’s present functioning. The child’s future is represented by the therapeutic powers of play, because these are what will be used by the play therapist to restore functioning.

THE NEUROSCIENCE OF OPTIMAL GROWTH AND DEVELOPMENT

In the following section, optimal growth and development will be described from a neurobiological perspective, namely the optimal growth and development of the brain and subsequent neurobiological foundations of emotions.

Evolution of the Human Brain

Prior to discussing how complex brain systems interact to form our emotions, cognitions, and behavior, it may be useful to provide a brief overview on the evolution of the human brain and basic functions of its parts. The oldest portion of the brain, often referred to as the reptilian brain, contains the brain stem and cerebellum (Siegel, 2009). The reptilian brain is the control center for basic survival systems because it regulates elements such as heart rate, metabolism, and breathing and connects the upper brain to the spinal cord. The cerebellum is responsible for balance and coordination (Kalat, 2007). In addition, clusters of neurons in the reptilian brain activate the fight-flight-freeze response when an organism is threatened (Siegel, 2009). The limbic system, unique to mammals, sits above the reptilian brain.

The main structures of the limbic system include the amygdala, hippocampus, thalamus, and hypothalamus (Franks, 2006) (see Figure 31.1). Siegel (2009) posits that the limbic system is vital for at least five functions, including (1) motivational states, (2) meaning making, (3) affect generation, (4) memory differentiation, and (5) attachment relationships. The limbic system is the seat of humans’ abilities to experience emotions, make value judgments, and form relational bonds. However, current advancements in neuroscience warn that in order to understand emotion, cognition, and behavior, it is necessary to recognize these as the complex interplay of neurologic systems, neural circuitry, and feedback loops rather than to focus on dedicated regions of the brain (Goldsmith, Pollak, & Davidson, 2008). The body, reptilian brain, and limbic system are often referred to as the subcortical regions, because they lie below the cortical brain regions, which were last to develop in the process of evolution.

The cerebrum makes up 85% of the brain’s weight (Franks, 2006) and is divided into cortical regions associated with, but not solely responsible for, distinct processes. The cerebral cortex is the outer surface of the cerebrum and is organized into four lobes and two hemispheres (Kalat, 2007). The frontal lobe is “involved in planning action and control of movement; the parietal lobe with sensation and forming body image; the occipital lobe with vision; the temporal lobe with hearing and through its deeper structures it is involved with aspects of emotional learning and memory” (Franks, 2006, p. 45).

The neocortex is the outer layer of the cerebral cortex and contains 75% of the brains neurons (Franks, 2006). According to Franks (2006) “the massive expansion of the human neocortex
in the frontal lobes is considered critical to full consciousness, thinking, planning, and linguistic communication” (p. 45). The prefrontal cortex is located behind our forehead and undergoes important developmental changes into late adolescence. This region contributes to our most advanced cognitive functions including motivation, memory, learning, abstraction, and goal-directed behavior (Kalat, 2007).

The cingulate cortex is involved in emotional and cognitive processes. This region is necessary for the somatization of emotions (i.e., feeling emotions as sensations in our bodies), the integration of emotions with the forebrain, and the attention devoted to feeling diverse states of arousal (Franks, 2006). Likewise, the insula is also a “somatosensing region behind emotional feeling” (Franks, 2006, p. 47). The insula functions as a relay station between the body/brainstem and ventromedial prefrontal lobes and the anterior cingulate. While the brain can be categorized via its specific regions, it is also often conceptualized via two hemispheres.

Lateralization is the term for the functional specialization of the right and left sides of the brain. Typically, the right hemisphere is perceptual, intuitive, and literal, while the left hemisphere leans toward concrete and analytical interpretations of experience (Franks, 2006). Therefore, the right hemisphere complements the left by being open fully to environmental stimuli the left side will utilize to create meaningful interpretations (Franks, 2006). That being said, the brain has a remarkable capacity to adapt in the face of damage. For instance, when a child experiences a traumatic injury to one hemisphere of the brain, the opposite hemisphere possesses the ability to rewire itself and compensate for the lost function (Franks, 2006). This may also occur with adults; however, the adult brain is less adaptive than a child’s brain (Kalat, 2007).

The previous section presented a rudimentary summary of the basic brain regions, some of which will be discussed again later in the chapter, and the following section presents some information on the normal development of the human brain.
Human Brain Development and the Importance of Relationships

The human brain continues to develop across the lifespan; however, accelerated development occurs during the first years of life. At birth, the average human brain weighs 350 g, and within the first year it nearly triples in weight to an average of 1,000 g (Kalat, 2007). While we have a great deal to learn about brain development, most researchers agree it is a complex interaction between genetics and environmental experiences (Franks, 2006; Goldsmith et al., 2008; Siegel, 2006; 2009).

Development is unique to each individual, in large part due to neuroplasticity. Infants are born with roughly 100 billion neurons, far more than needed (Siegel, 2006). Throughout development, environmental experiences activate genes that direct the firing of location-specific neurons, which if powerful enough, to lead to the creation of new connections (synapses). Synaptogenesis, the formation of new synapses, is a lifelong process in the brain, as is the discarding of unused neurons (i.e., pruning; Franks, 2006; Kalat, 2007). Myelination is the process of developing a protective sheath over neurons that allows neural signals to move at a faster rate (Kalat, 2007). "Myelin forms first in the spinal cord and then in the hindbrain, midbrain, and forebrain. Unlike the rapid proliferation and migration of neurons, myelination continues gradually for decades" (Kalat, 2007, pp. 124–125).

Individual personality development is influenced by clusters of neurons firing over time, causing what is known as "states of mind" (Siegel, 2006, p. 254). These states are typically activated as a need satisfaction response (i.e., a cluster of neurons working together, as needed, to accomplish a task) and at times conflict with goal-directed behaviors or one's self-concept. Siegel (2006) demarcated late adolescence as the time when an individual typically learns to integrate and resolve states that cause conflicts within the organism.

The mirror neuron system is also a vital contributor of brain development (Levy, 2009). Mirror neurons activate via observing others actions. Levy notes, the "mirror neurons fire in the regions of the observer's brain that would have produced the same actions had the observer actually performed them herself or himself" (p. 54). The mirror neuron system contributes to the development of empathy and the individual's subjective sense of self.

At birth the brainstem is fully developed, which is necessary for the infant’s survival (Kalat, 2007). The limbic system and cortical structures continue to develop across the lifespan; however, the fastest rate of development occurs within the first three years of life. During the first year, the size of the cerebellum near triples, allowing the infant to develop motor skills quickly (Knickmeyer et al., 2008). By three months, the infant's recognition ability increases dramatically, because of the growth of the hippocampus, an area associated with recognition memory. During the second year, the synapses and connections in the language areas of brain increase dramatically, quadrupling a child's vocabulary. The third year is marked by increased synaptic density in the prefrontal cortex and the continued formation and consolidation of the neural connections to other areas of the brain. With more connections available, the child's cognitive processes become more complex.

Siegel (2009) defines the middle prefrontal cortex (MPC) as a part of the brain consisting of the anterior orbital area, the medial prefrontal cortex, and the anterior cingulate. Moreover, he believes research demonstrates the MPC is central in developing nine processes: (1) body regulation, (2) attuned communication, (3) emotional balance, (4) response flexibility, (5) empathy, (6) insight, (7) fear extinction, (8) intuition, and (9) morality. He suggests the MPC integrates the systems of the subcortical and cortical structures. Moreover, he contends that if children form a secure attachment with a caregiver during their early years, then the circuits of the MPC integrate toward positive mental health, because the infant learns how to self-regulate via "self-reflective observation" (p. 251).
Beyond relationships, play is also a critical aspect of early childhood brain development. Levy (2009) noted that the activity of play induces and integrates multiple brain regions including “motor, visual, auditory, and other sensory regions” (p. 51) and is therefore a conduit for brain growth. He expanded on this, saying, “[play] entails coordination of sensory inputs, motor responses, and reflective thought, as well as emotional engagement and awareness” (p. 52). The holistic nature of play promotes the integration of the cortical and subcortical processes, providing an environment for sustained emotional change (Panksepp, 2003) and increased empathic abilities (Siegel, 2006).

While describing brain development, it is necessary to briefly mention neurotransmitters. Human existence and functioning can be described as a complex system of electrical impulses, neurochemicals, and neuromodulators. The three elements are inseparable, likely of equal importance, and necessary for survival. For the purposes of this chapter, neurotransmitters are of utmost importance, specifically those involved in the regulation of emotion and disruptive behaviors. As a means to understanding commonalities rather than individual disorder differences, Hudspeth (2013) described disruptive behavioral symptoms common across diagnoses from the perspective of neurotransmitter system involvement. He states:

I will categorize disruptive behaviors based on neurotransmitters and brain regions. These behaviors include those related to (a) dopamine [DA] and aggression, irritability, hyperactivity, and problems with attention and motivation, (b) norepinephrine [NE] and negative emotions and withdrawal, and (c) serotonin [5HT] and impulsivity. A fourth category, gamma-aminobutyric acid [GABA], is not usually responsible for disruptive behaviors, but may be involved in regulating these behaviors. (p. 7)

These neurotransmitters are heavily involved in emotional development; emotional regulation; executive, cognitive control; and behavioral control. Without proper functioning of these neurotransmitter systems, an individual is dysregulated and dysfunctional. Later in the chapter, these neurotransmitters will be discussed in terms of how they are influenced by medications.

**Emotional Development**

Franks (2006) suggests it is best to conceptualize the emotional brain rather than specific regions within the brain dedicated to emotions. Whether we are discussing the processes that generate emotions or the processes that allow an individual to feel emotions, different regions of the brain are activated (Berridge & Kringelbach, 2013). Together, this has moved research from focusing on dedicated emotional regions, such as the limbic system, toward trying to understand the complex interplay of cortical and subcortical systems. In addition, the environment plays a role in the emotional stimuli we experience, how we feel and interpret emotional stimuli, and how that felt experience is fed back into higher cortical structures and/or stored as memories (Goldsmith et al., 2008). Keeping the above in mind, while reading the next sections discussing specific brain regions, it becomes clear there is a great deal more to learn about emotions and the brain.

During childhood development, when the brain is most plastic, exposure to emotional experiences in turn influences behavior and has an impact on the developing brain’s neural networks as children process the experience via feedback loops (Goldsmith et al., 2008). These emotional experiences also include how they interact with their caregivers by conveying their felt emotions and interpreting the emotions of others. The plasticity of the brain during childhood is beneficial because it allows children to adapt quickly and acquire early emotional regulation skills; however, under negative emotional experiences, the plastic brain is vulnerable to establishing long-term disorganized neural connections (Goldsmith et al., 2008).
Brain regions found to be associated with emotions include the amygdala, insula, anterior cingulate cortex, orbitofrontal cortex (Berridge & Kringelbach, 2013; Deak, 2011), dorsolateral cortex (Levy, 2009), nucleus accumbens, and ventral pallidum (Berridge & Kringelbach, 2013). Because of their strong connection to emotional experience, each of these will be discussed briefly; however, keep in mind that other brain regions are involved in how emotions are stored in memories via feedback loops and how they are retrieved via interaction with environment triggering learned reactions.

The amygdala plays a role in storing, coding, detecting (Deak, 2011), and generating emotions (Levy, 2009). Franks (2006) notes the amygdala is capable of inhibiting the strength of the felt emotion via its direct pathways to sensory cortical regions of the brain. The importance of the amygdala in emotions is significant because it is “more consistently involved in emotions than any other area between the hypothalamus and the neocortex. However, it is not involved in all emotions and commonly draws from areas outside of the limbic system.” (p. 50)

Deak (2011) notes that recalling or imagining an emotional experience activates the insula. Moreover, he suggests the insula plays a role in coordinating sensory motor responses when the organism feels threatened, identifying distinct emotions such as disgust in others, and mediating the intensity of emotions toward consciousness of the felt emotion. The anterior cingulate cortex plays a role in monitoring, evaluating, and regulating emotions (Deak, 2011). The orbitofrontal cortex plays a role in ascribing “emotional and motivational value to a stimuli” (Deak, 2011, p. 75) and is activated during the feeling of emotion (Berridge & Kringelbach, 2013). The dorsolateral cortex contributes to emotional experience integration with cognition and memory (Deak, 2011). The feeling of emotions appears to occur more in the subcortical regions, especially in the “hotspot circuits in the nucleus accumbens (NAc) and ventral pallidum” (p. 294).

Finally, one must become consciously aware of an emotion in order to engage in cognition concerning the emotion (Franks, 2006). These cognitions mediate how we will perceive, pay attention to, appraise, and represent the emotion via feedback loops to memory storage that, in turn, influence learning and the experience related to future felt emotions (Franks, 2006). Moreover, Franks (2006) wrote “bodily feelings associated with emotional experience are, figuratively speaking, ‘marked’ and then retrieved when similar situations reoccur” (p. 57).

UNDERSTANDING INTERPERSONAL PROCESS THROUGH NEUROSCIENCE

The definition of the term interpersonal process is nebulous. Some definitions focus on the interpersonal aspect, whereas others focus on components of the process. For the purpose of this chapter, interpersonal process will be defined as the interaction or relationship between two or more people in which there is a reciprocal giving and/or receiving of information. Giving and/or receiving information (i.e., sending a message and receiving feedback) is dependent on personality traits, previous experience, and patterns of relating (i.e., attachment style).

Attachment

Key to interpersonal process is the interactions and relationships existing between individuals. Research from Giles, Glonik, Luszcz, and Andrews (2005) indicates the development and treatment of mental and physical disorders is impacted by social situations and relationships. Of these relationships, attachment is described in many studies as key to brain development, developing self-regulation, and having future, functional relationships (Schore & Schore, 2008; van der Kolk, 2003). The importance of play and attachment is noted by van der Kolk (2003), who says,
“The development of normal play and exploratory activity requires the presence of an attachment figure who helps modulate the child’s physiologic arousal by providing a balance between soothing and stimulation” (p. 295).

The area of attachment neurobiology provides one of the best descriptions of functional and/or dysfunctional interpersonal processes. Attunement between child and caregiver is a necessary component of attachment (Schore, 2009a; Schore & Schore, 2008). When attuned, the caregiver’s response to the child’s distress impacts the behavioral organization of the child. If the caregiver response is positive or appropriate, the child’s brain is stimulated in an intended fashion and the brain wires toward prosocial interactions (Perry, 2009; van der Kolk, 2006). When the caregiver fails to respond to the needs of the child or the response is dysfunctional, neurons necessary for attachment and developing relationships fail to be appropriately stimulated. Over time, when neurons geared toward prosocial interactions are not stimulated, the brain prunes these neurons because they are seen as unnecessary (Schore, 2001). Therefore, appropriate stimulation leads to what may be called the intended organization of the brain, personality, and future, functional patterns of relating (Schore, 2003; Siegel, 1999). Lack of stimulation leads to a disorganized, dysregulated brain with a potential dysfunctional personality and strained patterns of relating.

**Emotional Regulation**

Schore (2000, 2009b) notes, when describing his right-brain dual corticolimbic autonomic circuits, that in the attached brain (i.e., appropriately stimulated), the right hemisphere is involved in processing incoming sensory information and ends, ultimately, with emotional regulation. According to Schore (2000, 2009b), the right brain contains two types of circuitry to manage emotions. Lateral tegmental circuitry controls negative emotions, avoidance mechanisms, and passive coping. Ventral tegmental circuitry controls positive emotions, approach mechanisms, and active coping. Specific brain structures involved, in order of activation, are: the autonomic nervous system, which provides sensory information; the amygdala, which generates fight, flight, and freeze responses; the cingulate, which interprets social cues; and the orbitofrontal cortex, which provides executive control (Schore 2000, 2009b). When attachment is disrupted or fails to occur (i.e., lacks appropriate stimulation), the ventral tegmental circuitry is impacted by dysfunctional patterns of relating; hence, the approach process is disrupted and avoidance process goes unaffected Schore (2000, 2009b).

**Attachment Disturbances**

Thus far, attachment disturbances have been described as resulting from a lack of appropriate caregiver attunement and interactions (i.e., relational trauma, nonmaltreatment related). Attachment disturbances also occur as a result of other direct causes such as neglect, physical, mental, and sexual abuse, and natural disasters, as well as vicarious causes, such as witnessing domestic abuse or living in homes where a caregiver has substance abuse or mental health issues.

Zeanah and Boris (2000) and Zeanah and Smyke (2009) offer a unique approach to attachment disorder classification. They note that the traditional method for classification fails to accurately describe relationship-specific, secure base attachment distortions. Zeanah and Boris’s (2000) classification of disturbed relationship patterns includes: self-endangerment, vigilant/hypercompliant, and role-reversed types. These types may be confused with disorganized and/or ambivalent attachment patterns and occur as a result of caregiver–child interactions when the caregiver has a mental illness, has a substance abuse disorder, or experiences domestic violence. The neurobiological processes and brain regions involved in normal attachment and
attachment disorders are also involved in attachment distortions. The deficits that develop as a result of a lack of attachment may, however, be more severe in the disordered than in the distorted.

Numerous studies align childhood attachment disturbance, due to relational and non-relational maltreatment, with future childhood developmental issues as well as adult mental health issues (Coates, 2010; Neigh, Gillespie, & Nemeroff, 2009; Nelson, Bos, Gunnar, & Sonuga-Barke, 2011; Stirling, Amaya-Jackson, & Amaya-Jackson, 2008). The adverse childhood experiences study (Anda et al., 2006), a longitudinal study, implicates negative childhood experiences in the development of future mental health issues as well as chronic, physical health issues. The research evidence on the negative impact of the developmental trajectories established by attachment disturbances is ever-growing. Given this evidence, it is important for play therapists to be routinely and continuously trained in the diagnosis and treatment of attachment related issues and their effects both present and future.

Next, we will consider the importance of play therapists having a foundational knowledge of how emotional dysregulation is treated with medication. As with previous parts of this chapter, emotion, emotional regulation, and emotional dysregulation have been the focus. We now focus on emotional dysregulation specifically, because it is the causal factor that brings many children to play therapy. Emotional dysregulation may arise out of numerous events; however, it becomes a cluster of somewhat predictable, outwardly observable symptoms.

The Medicated Child in Play Therapy

The increasing number of children and adolescents who are medicated is alarming. Many adolescents were once medicated children, and many young adults were once medicated adolescents and children. Twenty-five years ago, medication use in children was the exception to the rule. Now medication is a common part of the treatment equation. Medications can be helpful, and some have relatively few side effects. However, all too often, during the process of finding regulation for the dysregulated child, improper assessment and diagnosis lead to over medication.

When taken as a single agent, a medication may cause an individual to display somewhat predictable side effects. The side effect profile is compounded and unpredictable in those taking multiple medications. Moreover, unpredictable side effects are frequently seen in emotionally dysregulated children because they often take multiple medications in addition to having altered brain regions. Consider the descriptions offered earlier in the chapter about attachment-disordered children. Regardless of the cause of the attachment issues, the child is likely dysregulated. These children have altered brain regions as well as neurotransmitter systems, and when medicated, they respond differently than non-attachment-disordered children. Neurobiologically, medication research is relatively sound; yet, much of this research has utilized nondisordered adults as research participants. Much is known about the developing brain, and much is known about the medicated developing brain. Much less is known about the medicated, disordered/dysregulated developing brain.

Of the medications classes utilized to treat children with disruptive behaviors, the mood stabilizers (atypical antipsychotics and antiepileptics), amphetamine psychostimulants and non-amphetamine psychostimulant medications, selective-norepinephrine reuptake inhibitors, and alpha-2 antagonists are utilized most frequently. Antidepressants may be utilized for mood stabilization, but are used to a lesser extent than other medications.

In children and adolescents, atypical antipsychotics are among the most frequently utilized medications to stabilize mood (e.g., aggression, agitation, and irritability). This stabilization is accomplished through several neurotransmitter systems (viz., DA, 5HT, NE; Brambilla, Barale, & Soares, 2003) by inhibiting or antagonizing the action of these neurotransmitters. The most
prescribed atypical antipsychotics include Risperdal (risperidone), Zyprexa (olanzapine), Seroquel (quetiapine), Geodone (ziprasidone), Abilify (aripiprazole), Invega (paliperidone), Saphris (Asenapine), and Latuda (lurasidone). Some of the side effects of these medications are lethargy, cognitive blunting and cloudiness, emotional blunting, fine and gross motor skill deficits, and coordination difficulties.

Antiepileptics also serve to stabilize mood (e.g., aggression, agitation, and irritability), but these work through the GABA neurotransmitter system (Levy & Degnan, 2013). As mentioned previously, since GABA is the brain’s primary inhibitor neurotransmitter, mood stabilization is brought about as GABA acts as a braking system for other neurotransmitters. Medications in this class include Tegretol/Carbatrol (carbamazepine), Depakote/Depakene (valproic acid), Neurontin (gabapentin), Lamictal (lamotrigine), Gabitril (tiagabine), Topamax (topiramate), and Trileptal (oxcarbazepine). The side effect profiles of antiepileptics are similar to atypical antipsychotics; however, these often produce less pronounced symptoms.

Psychostimulant medications are utilized to decrease hyperactivity and to improve attention, focus, and motivation. Amphetamine psychostimulants accomplish their effects through the DA neurotransmitter system by preventing the reuptake of DA so it remains in place longer and produces its intended effect (Sinacola & Peter-Strickland, 2011). Medications in this class include Dexedrine (dextroamphetamine), Desoxyn (methamphetamine), Adderall (amphetamine mixture), Vyvanse (lisdexamfetamine), and Provigil (modafinil). Nonamphetamine, psychostimulant medications have the same mechanism of action as the amphetamine psychostimulants and include Ritalin/Concerta/Metadate/Methylphenidate, Cylert (pemoline), Focalin (dexmethylphenidate), and Daytrana (methylphenidate, patch). Side effects for both classes may include agitation, irritability, aggression, hypervigilance, and tics.

The final group of medications used to treat hyperactivity and related symptoms are (a) Strattera (atomoxetine), a selective-norepinephrine reuptake inhibitor utilized to aid in attention, hyperactivity, and impulsivity, which produces its action by keeping NE around longer to produce the intended effect (Sinacola & Peter-Strickland, 2011); and (b) Catapres (Clonidine) and Tenex/Intuniv (guanfacine), alpha-2 agonists that aid in attention, impulsivity, and reduction of hyperactivity. These medications produce their action by supplementing the action of NE through binding to and activating receptors NE would activate (Sinacola & Peter-Strickland, 2011). Side effects of these medications may include agitation, irritability, and aggression.

Although most play therapists do not prescribe medications, they are in a position to offer important information to prescribers about how their clients tolerate medication and whether medications are helping or producing unintended side effects.

At the end of this chapter, a case study is provided demonstrating the use of play therapy to help a client overcome medication side effects.

**NEUROSCIENCE’S INFLUENCE ON THE THERAPEUTIC POWERS OF PLAY**

In the previous pages, a foundation was provided for understanding brain development. It included specifics about the neurobiological underpinnings of emotions, emotional regulation, and interpersonal process. When considered together, these elements determine much of how humans function. These elements also provide a springboard for discussing the present state of the mingling of play therapy and neuroscience research. Though interaction of the two and any related research is in its infancy, much of what has been learned from neuroscience research has been and is being applied to the practice of play therapy.
To demonstrate this interaction, Cacioppo et al. (2007) use the term social neuroscience to represent the intersection of neurobiology and the social sciences. “Social neuroscience capitalizes on biological concepts and methods to inform and refine theories of social behavior, and it uses social and behavioral constructs and data to inform and refine theories of neural organization and function” (p. 99). For play therapists, the most important concept in this description is the reciprocal relationship (i.e., neurobiology is used to inform practice and practice informs neurobiological research).

Next, to connect play therapy to neuroscience, it is necessary to extrapolate findings from play research as well as play therapy–specific research. In play therapy, much of what has been written about and much of what we refer to or cite comes from four primary domains of neuroscience research: attachment, trauma, disruptive disorders, and developmental disorders. It is also important to consider neuroscience research related to play therapist’s behaviors in order to develop a well-rounded, neurobiologically informed picture of what has been studied concerning the interaction between child and play therapist.

In preparing for this chapter, the authors conducted a search of the International Journal of Play Therapy (IJPT), from 1992 to 2014, for articles that included at least some reference to neuroscience or neurobiological processes. The term neurobiology yielded 11 articles; the word stem neuro, 4 articles; the term brain, 18; the terms cognitive and science, 12; the terms emotion and science or regulation, 8; and the terms behavior and science or regulation, zero. In total, we found 53 articles written over a 20-year period. Not to our surprise, the further back we looked, the fewer articles we found.

The first issue of IJPT included three articles related to attachment (Brody, 1992; Glazer-Waldman, Zimmerman, Landreth, & Norton, 1992; Mills & Allan, 1992). In earlier IJPT articles, attachment, secure or disordered, was explained simply by covering concepts of self and self–other relationships. Beginning in 2006, attachment, trauma, and neurobiology merge in the article “Development of the Trauma Play Scale: An Observation-Based Assessment of the Impact of Trauma on Play Therapy Behaviors of Young Children” (Findling, Bratton, & Henson), followed by Crenshaw and Hardy’s (2007) article, “The Crucial Role of Empathy in Breaking the Silence of Traumatized Children in Play Therapy.” At present, attachment and/or trauma-related articles tend to be the ones most likely to include neurobiological information. The articles on attachment and trauma have included studies of the homeless, those exposed to natural disaster, children in foster care, children with traumatic brain injuries, individuals with dementia, and children exposed to domestic violence. Child-centered play therapy and sandtray were the therapeutic modalities most often utilized in the interventions described in these articles.

The intersection of play and the developing brain was first mentioned in an IJPT article titled “Day by Day: Playing and Learning” (Kaufman, 1994). Kaufman states, “Physiologists find a close relationship between growth of various parts of the brain and corresponding play interests” (p. 13). Since this article, brain development, usually discussed in terms of cognitive development and cognitive processing, continues to be frequently explored in IJPT articles, along with many articles focusing on emotional regulation, emotional dysregulation, and self-regulation. Several articles, most written within the last 5 years, explored the benefits of right-brain regulation through art or sand play as well as ball play, general creativity, and neurosequentialing.

Other notable, neuroscience-related research considers those play therapist’s characteristics (i.e., attitudinal and dispositional) considered important during the process of developing a therapeutic relationship. Dion and Gray (2014) explored therapist authenticity and attunement, both of which have neurobiological foundations (i.e., mirror neurons), and Crenshaw and Hardy (2007), among others, described play therapists’ empathy. The neurobiological origins of empathy are related to insula, anterior, cingulate cortex, and amygdala (Shirtcliff et al., 2009).
THE FUTURE OF NEUROSCIENCE PRINCIPLES IN PLAY THERAPY PRACTICE

It is not difficult to speculate what, why, how, when, and where play therapists will utilize neuroscience research in the future. Much of what we do in play therapy existed before neuroscience research explained it in terms of brain structures and mechanisms. Today neuroscience confirms that what we do in play therapy is built upon a theoretical foundation and our beliefs that play is a beneficial, routine process throughout development. Why play therapists will incorporate neuroscience research in their work is the foundation for their understanding of normal and abnormal development, functional and dysfunctional behavior, and why abnormal development, dysfunctional behaviors, and disorders occur. After reading neuroscience research and reflecting, the how should be next. Specifically, how does a play therapist apply research about a neurobiologically based modality to a specific disorder in a specific client, and how might this research benefit the client? When and where will round out the decision and occur simultaneously. In the process of play therapy, when should neuroscience research be applied (e.g., during the therapeutic process), and where (as in which settings, e.g., in groups, in family sessions, as an individual, or in homes, in schools) is it best to apply the information?

Rushton (2011), in an article about neuroscience, early childhood education, and play, describes implementation of neurobiologically based practices when he suggests the development of brain-compatible classrooms. He describes this concept as a space where children are allowed to make their own choices, teachers course-correct during the process, and no child is taught with a rigid or cookie-cutter approach (p. 92). Rushton’s article is thought provoking and, although play therapists do not have classrooms, we do have playrooms, so it seems reasonable to ask: Are our playrooms brain compatible, and do they meet the general guidelines mentioned? If the play therapist operates from a child-centered approach, the answer is likely yes; however, how do directive and manualized approaches rate when compared to these guidelines?

CURRENT INFLUENCES OF NEUROSCIENCE ON THERAPEUTIC MODELS AND DIAGNOSTICS

In order for neuroscience research to further inform play therapy practices, specific neurobiologically based interventions must be created. The areas, to name a few, where this has already occurred are in the use of the neurosequential model of therapeutics (Perry, 2009; Perry & Hambrick, 2008), Theraplay® (Booth & Jernberg, 2009), and DIR/Floortime (Weider & Greenspan, 2003, 2005). With respect to including the neurobiological perspective in diagnoses, the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association [APA], 2013) includes neurobiological findings for most disorders. Unfortunately, developmental trauma disorder, which van der Kolk (n.d.) deemed a “rational diagnosis for children with complex trauma histories” failed to gain approval and was, therefore, excluded from the DSM-5.

Although play therapy currently embraces many neurobiologically informed practices, we still have much to learn and apply. As a short-term goal, play therapists as researchers should explore newer, neurobiologically based interventions (e.g., AutoPlay; Grant, 2012) to further determine their usefulness and applicability. An intermediate-term goal would be to conduct quantitative and qualitative research with a neuroscience focus, whether it involves the child

1 Theraplay is a registered service mark of The Theraplay Institute, Evanston, IL.
or adolescent, parent, or play therapist, on all existing neurobiologically informed modalities. Finally, as a long-term goal, neurobiologically informed modalities would be developed based on research findings rather than be explored after having been developed.

APPLICATION OF NEUROBIOLOGICALLY-INFORMED RESEARCH IN A PLAY THERAPY PRACTICE

Daniel

Like many 8-year-olds, Daniel loved to play. This was not evident until after he had been coming to play therapy sessions for 6 months. Since the age of 6, Daniel had experienced problems at school and at home. His home life was stable, but his caregivers, his mother and grandmother, worked at low-paying jobs and rarely had much money for extras. When Daniel's problems escalated at school, his mother took him to the local mental health agency. He was prescribed a stimulant for ADHD. Unfortunately, the medication made him hypervigilant and aggressive. At the next doctor's visit, he was prescribed the mood stabilizer, valproic acid. His mood did not stabilize, and his dose of valproic acid was increased a few months later. Over the next few months, he gained 40 pounds and became lethargic and cognitively blunt. He developed hand tremors and began to have problems with gross and fine motor skills. His grades dropped further, and at the end of the school year, he did not progress to the next grade. His mother also did not perceive him to be benefitting from sessions with child counselor he was seeing, so she took him to a local, nonprofit agency where they utilized play therapy.

Daniel began weekly play therapy sessions during the summer. During the first session, the play therapist noticed he was so lethargic he could barely stay awake. When he was awake, if he attempted to play with toys, he could not manipulate them, became frustrated, and would throw the toy down.

Between sessions and after receiving consent from Daniel's caregiver, the play therapist made a call to Daniel's doctor. The goal was to make sure the doctor was aware of the side effects that Daniel was exhibiting. The doctor thanked the play therapist for his input, but decided to leave Daniel on the medication.

During Daniel's next session, the play therapist introduced a simple puzzle with big parts. He had recently read an article about creativity and the right brain and the ability of the right brain to motivate and bring about alertness. As the therapist began to complete the puzzle, Daniel joined in the process. At the end of the session, the therapist noticed Daniel was, indeed, more alert.

The following sessions all began with a game, art, or sandtray, and with each session Daniel became more alert and more confident, so he explored more and played more. Also, as Daniel became more alert, he engaged more in the play therapy process. Over time, his caregivers noticed a change in his overall mood. He had become more compliant and more motivated.

This is just one way a play therapist utilized concepts he learned from neurobiology research to help his clients. Over the years, many of the clients that this play therapist had worked with were medicated. Depending on the medication, some of the play therapist's clients had exhibited medication-induced symptoms such as cognitive cloudiness, cognitive blunting, emotional blunting, lethargy, gross and fine motor skill deficits, general coordination difficulties, agitation, or aggression. From neuroscience research, the play therapist
learned that some children needed to warm up (i.e., become alert) before the session began and some needed to cool down (i.e., deescalate) prior to leaving, and some needed both. By engaging in these practices, the clients gained more from their sessions. Many games and activities are useful in helping alleviate the symptoms listed previously. When needed and over time, if sessions begin and end with some of the activities listed next, play therapists will notice an overall improvement in their client’s mood, energy levels, and motivation as the child’s brain moves past the side effects of any medications he or she may be taking.

- For cognitive cloudiness: simple games (require an attempt to focus), matching and card games, puzzles, mazes, guessing games, playing hangman
- For lethargy: experiential activities, walks, swinging, hopscotch
- For emotional blunting: rhythmic activities, dance, music, bibliotherapy, art (guided, representational, or abstract), jokes, cartoons
- For gross motor skills: finger painting, crafts, Hula-Hoops, Legos, blocks, marbles, Jenga
- For fine motor skills: beads, stringing shaped pasta, Pick-up Sticks, Tiddlywinks, the game Operation, ring toss games, fishing games
- For agitation or aggression: sandtray, working with clay, rhythmic activities, music

CONCLUSION

In the preceding case example, we demonstrated how common play therapy items and activities may be utilized to help clients overcome medication side effects. These activities are sequenced to particular parts of a routine play therapy session in order to help the client when he or she needs the most help. In general and also of benefit, working outside or walking may be utilized to alleviate many of the medication side effects mentioned. Sunlight and fresh air trigger awareness in the brain. Involving nature in the therapeutic process brings out an innate drive to roam free, interact, make sense of, and explore the environment.

REFERENCES


Neuroscience and Play Therapy: The Neurobiologically-Informed Play Therapist 597


Hortensia, a 6-year-old biracial child came into my (EG) office after being placed in foster care with an immigrant Korean family. She was having a difficult adjustment and had exhibited defiant and aggressive behaviors. She was very disrespectful to her foster parents and insisted that she didn’t have to do what they said. Her behavior in school was also dysregulated, although her teacher said she noticed Hortensia was distracted and tired. As soon as she came into my office, she looked at all the miniatures I had on my shelves, especially the people of different ages and ethnicities. She then took the Asian miniatures and grabbed them in her hand, took them to the trash can, and said, “These are smelly and stupid people, you shouldn’t have them in your room!” I was shocked by her comments and actions and asked myself immediately, “Say something or simply reflect?”

CULTURAL SENSITIVITY IN CLINICAL SETTINGS: AN EVOLVING FIELD OF STUDY

Contemporary wisdom supports ongoing education in the area of cultural sensitivity and competence in order to best serve a client’s needs utilizing a cultural lens. Although the concept of cultural competency is well integrated into our training programs and practice goals, it is often short-sighted or limited in its practical applications. For example, most professional licensing boards have made changes to educational requirements so they include courses on cultural competency, and most graduate programs now routinely offer courses on this topic. However, requirements are often for a one-time course, and these courses do not always include the experiential training that is necessary in achieving introspection and implementation of changes in practical, visible ways (Pope-Davis, Coleman, Liu, & Toporek, 2003).

As evidence continues to demonstrate, therapists can maximize their effectiveness by integrating their clients’ cultural worldviews. It is important to incorporate practical and relevant
knowledge. Rather than separating out cultural competency as an add-on, it should be woven into the fabric of professional development. A trend toward integration will build cultural competence into general competencies for all mental health practice.

Professional development in the area of cultural sensitivity first assumed every clinician should gather knowledge about other cultures. Several noteworthy books were informative and foundational in this regard (McGoldrick, Giordano, & Garcia-Preto, 2005). Later, culture-specific volumes also appeared (Boyd-Franklyn, 2006; Falicov, 2013; Lee, 2000). Knowledge is an important and helpful component to learning, but knowledge has to be carefully processed and integrated into practice. As the mental health field evolves, traditional ways of learning need to be challenged. It becomes most relevant with a topic such as this to include opportunities for self-exploration, discovery, and revision of prior conscious or subconscious attitudes and beliefs about cultural differences. Therapists are encouraged to engage in reflection about personal prejudices and beliefs, ensuring that clinical practices reflect their willingness to be culturally sensitive. Nowhere are these dynamics more evident than when working with children, who are less inhibited about their verbal statements, and for whom speaking is often accomplished through behavior, play, story, and art.

THE HISTORY OF INTEREST IN CULTURAL ISSUES IN CLINICAL PRACTICE

In the field of mental health, the Vail Conference in 1973 drew attention to the matter of multicultural competence. It was not until the late 1990s that literature began to focus on these issues and the American Counseling Association (ACA) and American Psychological Association (APA) endorsed guidelines and ethical standards for multicultural competence (Pope-Davis et al., 2003; Watson, Herlihy, & Pierce, 2006).

Sue (2001) has been a pioneer in conceptualizing our current understanding of multicultural competence and proposed cultural competence had three distinct domains: therapist awareness, knowledge, and skills. First, therapists must be aware of their own cultural assumptions and values and how they interact with the cultural assumptions and values of the client. Second, therapists must gain knowledge about other cultures and how Euro-American systems of government and counseling (and Western practices in general) affect cultural minorities. Third, therapists use a wide range of skills (specifically developing verbal and nonverbal communication skills), as well as a willingness to intervene systemically in order to best meet the needs of their clients. These three components remain foundational in the literature on multicultural competence (Beckett & Dungee-Anderson, 1997; Carney & Kahn, 1984; Sue, 2001).

In addition, Sue (2001) encourages the clinician to consider four levels of systems (individual, professional, organizational, and societal) and five culture groupings (African American, Asian American, Latino/Hispanic American, Native American, and European American). Culturally competent clinicians consider the influence of each system on the client's cultural experience and recognize that cultural competence can take on different meaning according to cultural grouping. Individually, professionally, organizationally, and societally, we need to consider our ethnocentric values and how they inform our models of therapy, ethics, practice, and definitions of competency.

Other competencies have been introduced, including multicultural counseling relationships, alliance building, familiarity with multicultural terminology, and understanding the process of racial identity development (Constantine, Juby & Liang, 2001; Sodowsky, Taffe, Gutkin & Wise, 1994). Definitions of culture have also extended to include race, ethnicity, social class, gender, sexual orientation, and religion. There is, however, controversy over an inclusive or exclusive

Pthomegroup
definition of culture. Sue (2001) argues that an inclusive definition may water down the distinct oppressive struggles of racial and ethnic minorities. In a tripartite framework of cultural identity that includes universal, group, and individual levels of identity, Sue (2001) describes group identity as a unique blend of various cultural identities that, in addition to race and ethnicity, includes age, social class, gender, marital status, sexual orientation, disability, geographic location, and religion. In essence, every therapy session is a multicultural encounter. Using a more inclusive conceptualization, subcultures also warrant special considerations, for example, the culture of gay, disabled, blind, and physically impaired individuals; soldiers; religious groups; the mentally ill; and the wealthy or the poor, to name a few.

Since the explosion of literature and establishment of multicultural guidelines in the late 1990s, programs have developed specific training, licensing exams assess for competence, and continuing education for counselors requires ongoing training in this area (American Psychological Association, 2003; Pope-Davis et al., 2003; Toporek, Lewis, & Crethar, 2009). Common elements of these programs focus on educating students about Caucasian racial identity development; providing experience with other cultures; and teaching multicultural research and how community, social, cultural, and political systems affect individuals (Pope-Davis et al., 2003).

The literature is rich in conceptualization, but still scant in empirical studies that have tested therapy models across cultures. While attention to multicultural issues has flourished in the past few decades, there still is much to be researched, learned, and applied to increase our sensitivity and effectiveness in a multicultural world community. Particularly, the field of play therapy provides a vast frontier for exploration, application, and research with multicultural issues.

CULTURAL ISSUES IN PLAY THERAPY

The Association for Play Therapy (APT) has endorsed the importance of multicultural competence, adopting new policies related to multicultural competence in February of 2010 (APT, 2014). The APT mission states the association seeks to promote the “recognition, incorporation and preservation of diversity in play therapy” (APT, 2014, p. 3), and organizational policies indicate play therapists and play therapist supervisors obtain training to enhance multicultural competency.

Play therapists have a unique skill base that enhances their cross-cultural competency, given their fluency in the nonverbal, universal language of play. However, play is not wholly universal (Drewes, 2005; O’Connor, 2005). Cultural attitudes and uses of play vary. Play is a language used by children and adults. Caregivers from different cultures may view play as simply play, as work, or as instruction in safety, morals, or societal roles (Drewes, 2005). Pretend play will reflect the roles and interactive styles of distinct cultures. Play comes in many cultural dialects. Play therapists must be prepared to recognize and respond to cultural nuances presenting themselves in play dramas.

Sue and Sue (2003) emphasize an important aspect of multicultural counseling is to “recognize client identities to include individual, group and universal dimensions” and to use both “universal and culture-specific strategies and roles in the healing process” (Sue & Sue, 2003, p. 16). Therefore, simultaneous to embracing the universal and archetypal hero’s journey of each client that transcends individual and cultural differences, play therapists must consider how they facilitate expression and exploration of cultural and group identity and how they incorporate culture-specific strategies in their work with children and their families.

Facilitating expression and exploration of cultural and group identity will be enhanced with knowledge of and experience with systemic theory, which enhances awareness of the function
of behavior in a cultural context. As described by Sue (2001), the client exists in four levels of systems (individual, professional, organizational, and societal). In addition, the client exists in a family system and other cultural systems that are a blend of ages, family constellations, gender, race, ethnicity, religion, and socioeconomic strata. Systems theory posits that individual behaviors should be considered in the context of a systemic whole (Whitchurch & Constantine, 1993). Therefore, play therapists will increase their multicultural competence by understanding how the systems to which the client belongs impact the expression or oppression of a client's cultural identity. This knowledge will increase therapists' confidence and willingness to engage systemically on behalf of their clients. A relevant example of the application of systems thinking is in how play therapists interact with or involve their clients' caregivers and families. Because caregivers are the source of children's cultural learning, we must recognize that their involvement in the therapeutic process is essential for ultimate efficacy.

In the film South Pacific, the lyrics of one of the songs seem relevant in this discussion. "They have to be taught to hate" (Adler & Logan, 1958) was a reference to children's innate tendency to be accepting of others and the important influence caregivers can play in the development of their children's awareness of their own and others' cultural identities. When children express cultural insensitivities or racism, they seem to learn these attitudes and verbal expressions from their caregivers. Hinman (2003) notes caregivers are also teaching their children how to respond to racial slights and prejudices, and she recommends family play therapy as an optimal choice of intervention "as it is important that the play therapist partner with the parent in helping the child deal with prejudice" (p. 118). Truly, corrective interventions have to be made with children in combination with their caregivers if they have any chance of being implemented in the long term.

Another application of systemic thinking is how therapists view parenting behaviors in the context of the client's cultural system. An example of this is that children of color are overrepresented in the child abuse reports that are made to authorities. Child advocates have identified this as a problem area and suggested careful consideration of knee-jerk responses to risk factors in families of different cultural values. At the same time, families of higher social economic status or families of privilege might escape child abuse reporting when clinicians find themselves underreacting due to unidentified prejudices about the types of people who are prone to violence. In addition to emphasizing the important skill of systemic thinking and conceptualization of client behaviors, we propose that cultural competence has the potential to lead to social action in the form of advocacy. Child advocates go outside their clinical roles to single out problem areas and injustices and suggest corrective actions through direct feedback, whether those suggestions are sought out or not.

What are some examples of cultural nuances and culture systemic interactions that specifically present in a play therapy context? O'Connor (2005) states play is not necessarily universal and there are contextual differences dependent on the cultural background of the child. He also notes direct expression is inconsistent with some cultures' values. Play therapists who use play as a bridge to direct expression of emotions may encounter resistance from cultures who value subtle or indirect approaches to emotional expression. Some cultures view psychotherapy from an expert, medical perspective and may expect the therapist to take a more directive role than some play models utilize. Achievement and goal orientation are other cultural values that may conflict with a nondirective play approach. In addition, the informality of the therapist–child relationship may engender confusion or resistance with cultures in which there is a strong sense of patriarchal hierarchy (O'Connor, 2005).
Drewes (2005) suggests play therapists should be sensitive to varying cultural values regarding family, particularly the range between valuing autonomy and egalitarian ideals versus interdependency and patriarchy. Play therapists also need to consider how the family culture interacts around issues of privacy and trust (Drewes, 2005). Both O’Connor (2005) and Drewes (2005) note there are spiritual or cultural explanations for mental and emotional plagues, and our awareness of these explanations and the family’s level of belief in these explanations is vital. Play therapists should be mindful of language barriers, as Drewes (2005) notes having a bilingual child translate for immigrant caregivers could pose systemic problems. Finally, different cultures have different physical space boundaries, and this should be taken into consideration in the assessment of healthy versus problematic boundaries (Drewes, 2005).

We must increase our awareness and knowledge of cultural issues as they present in play therapy. Then comes the most difficult task: translating our awareness and knowledge into action. Gil (2005) describes active competence as a step from knowledge to behavior and depicts the process as “a circular pattern of thought and response” that starts with “attention … to internal experience, the response to that experience, the behavioral attempt, and the reshaping of this attempt based on external feedback” (Gil, 2005, p. 10).

Literature and research in the field of play therapy reflect wider multicultural competence definitions and trends (Hinman, 2003; Gil & Drewes, 2006; O’Connor, 2005; Penn & Post, 2012). Hinman (2003) examines culture-specific attitudes toward play and its functionality and provides perspective on the practical application of cultural awareness to joining with caregivers of other ethnicities, assessing a child’s play, and engaging children in play therapy. She notes identity is a common area of assessment and work with children of minority cultures. She also emphasizes the importance of working with the child’s wider cultural system, composed of caregivers and community (Hinman, 2003). When working with immigrant families, the child and caregiver’s acculturation levels must also be assessed, as well as whether a parallel acculturation process exists versus a wide acculturation gap that can greatly affect relational patterns.

Chang, Ritter, and Hays (2005) conducted a survey of 505 APT members to assess play therapists’ perceptions of cultural trends in their therapy practices. Perceptions and awareness of cultural issues varied. Some noticed no difference in their ethnic minority clients and believed play was universal. Others noticed increases in ethnic minority clients and differences in play and in caregivers’ attitudes toward play for ethnic minority clients.

Cultural trends included observations that ethnic minority children noted the presence or lack of culture-specific play materials; presented with more prevalent confusion around cultural identity; presented themes around trust, safety, and protection; and enacted more aggressive play. In addition, it was observed children would “try on clothing of different cultures and act out what they believed to be the behaviors of other cultures” (Chang et al., 2005, p. 76). With ethnic minority caregivers, play therapists noted more skepticism about play therapy and observed more dysfunction in ethnic minority client families (Chang et al., 2005). This qualitative review of play therapists’ perceptions of cultural trends is also reflective of bias and level of awareness for practitioners of play therapy.

While there are increasing case examples and literature discussing cultural issues in play therapy, there is little empirical support for the effectiveness of play therapy with cultural minorities. For example, Bratton, Ray, Rhine, and Jones’ (2005) meta-analysis of the efficacy of play therapy interventions notes ethnicity was not reported in the majority of studies. However, there have been some strides in filial therapy research with Chinese, Korean, and Native American populations (Chau & Landreth, 1997; Glover & Landreth, 2000; Lee & Landreth, 2003), as well
as group play therapy with Puerto Rican and Taiwanese populations (Martinez & Valdez, 1992; Shen, 2002). More studies like this are needed. Play therapist researchers must better consider the importance of cultural diversity and represent minority cultures in their empirical research on play therapy practice and effectiveness.

In addition to discussion of cultural issues and practice in the play therapy literature, there are strides being made in development of training in multicultural competence. Vandergast, Post, and Kascak-Miller (2010) describe an experiential training program for advanced graduate students learning child–parent relationship therapy (CPRT). After didactic instruction, these students led an 8-week CPRT group for inner-city families of low socioeconomic status. The students reported a positive experience that broadened their competence. Vandergast et al. (2010) recommend “partner[ing] with community programs to reach under-served populations” because it trains students in practice and social advocacy (p. 206).

Social advocacy is another trend in advancing multicultural competence. Ceballos, Parikh, and Post (2012) emphasize the importance of developing social justice attitudes and practices. They explain it is not enough to have cultural awareness, knowledge, and skills. Similar to Sue’s (2001) more expansive multidimensional model of cultural competence, Ceballos et al. (2012) explain multicultural awareness must extend to recognize the systemic nature of the development and perpetuation of our cultural biases. It is important to understand the pressures oppressive, inequitable systems place on clients’ self-actualization (Ceballos et al., 2012). Some systemic interactions and pressures include the teachings children receive from their caregivers and in their families about their own and other cultures, as this is a breeding ground for narrow, racist attitudes and views, as well as for subtle society-wide views and practices that perpetuate racism.

WORKING WITH CHILDREN AND THEIR CAREGIVERS: A CULTURAL SYSTEMS CONTEXT

Acculturation can contribute to confusion around cultural identity, and children can experience acculturation as a stressor because demands from prior and current cultures can differ. These stressors include feelings of looking or being different, feeling isolated or singled out for attention, being asked to behave in ways contrary to learned values or to participate in activities that may not feel acceptable, as well as developing feelings of inferiority and isolation. Children may also have to adapt by learning different systems of response for each cultural environment. Examples of this are evident in play therapy: Children may be taught to respect adults in positions of authority and yet are introduced to a play therapy culture in which the therapist follows the child’s lead or attempts to establish a more equal relationship. Some children may have been taught to comply with adults’ requests, whereas others may feel the freedom to refuse. Oftentimes children’s expressiveness is viewed differently cross-culturally, and they may be taught to speak only when spoken to, to keep their feelings to themselves, or to learn to “suffer in silence” without betraying family privacy.

Family values around loyalty and protection also engender internal conflict in the process of acculturation. Immigrant families, especially those who may not have papers, may teach their children to keep quiet, disclose nothing voluntarily, and distrust English-speaking professionals. Thus, a child of undocumented caregivers may use a police officer miniature in his play not as a sign of protection or safety, but as a sign of danger and concern. Allowing children opportunities to use toys as projection allows us to understand their cultural worldview.

Clinical reflection and preparation will likely lead to culturally sensitive and confident responses and prevent the therapist from being caught off guard. In one specific situation, a child
said, “The police are going to cause trouble, they’re always wanting to catch us doing something bad so they can put us in jail.” There are a host of clinical responses that could be utilized with different implications and clinical impact. A pure, child-centered reflective response, such as “So the police cause trouble and want to put you in jail,” reflects the child’s view of police. From a more directive perspective, it may be helpful to expand on this play with statements such as, “So sometimes the police cause trouble and put people in jail. I wonder what other kinds of things police might do?” or “I wonder what the police would do if they weren’t causing trouble?” This might provide some psychoeducation about police, but it also involves challenging broader family/cultural issues. It might be best to meet with the whole family to do this. The therapist could invite the family to a therapy session and ask them to make a collage that includes what makes them feel safe and what makes them feel frightened about living in their new country. It’s possible police would be introduced in a negative manner, and this could be explored without negating or challenging the family’s experience.

Thus, therapists’ consideration of their responses along a continuum in which they move from reflective and nondirective to a more direct educational or challenging stance in order to address cultural biases and values is useful. Having a flexible set of responses, applied purposefully, may help the child gain perspective.

ESTABLISHING A CULTURE-INCLUSIVE PLAY THERAPY OFFICE

Children may take note of the play therapy environment as it pertains to cultural issues. They may notice what is in the room and what is not. This is evident in many children who make bold requests for play therapists to add certain favorite toys or games. Therapists must take care to communicate a welcoming, inviting stance from the moment children open the door to the office until they leave. There are many opportunities to display mindfulness about cultural diversity with art work hanging on the walls or the literature in the waiting room magazine rack. Other simple ways to communicate cultural sensitivity are by picking music, fabrics, or images in details such as accent pillows. These are small but concrete ways to be mindful of diversity issues and broaden the welcome to children from all backgrounds. Hinman (2003) notes, “Decorations that convey beliefs in the perspectives of many cultures … may serve to encourage the ethnic minority client to explore these dimensions of their lives” (p. 117).

The play therapy office is also a place of therapist-to-child communication, verbally or non-verbally. Therapists communicate how they feel about play therapy and children in general by the care they take in setting up their offices and the purposeful or less careful ways they choose the toys in their rooms. Play therapists include different types of toys, although most adhere to a list of toys created early in the development of the field (Axline, 1981; Landreth, 2002). In addition to toys, it is important that play therapists consider the art materials presented to children, to ensure many skin tone colors are available.

For those therapists who utilize sand therapy work with children, it is similarly important to consider the selection of miniatures. Traditionally, sand therapists tend to introduce their sand therapy collections by referring to their collections as including symbols of everything in life (Homeyer & Sweeney, 2010). A typical collection includes categories of sand tray miniatures that attempt to be all-inclusive. For example, for the broad category animals, there is inclusion of prehistoric, wild, domesticated, and fantasy animals. Other categories include minerals (rocks, fossils), vegetation (plants, rocks, cacti), buildings, transportation objects (cars, planes, boats), people, spiritual symbols, and elements of earth, fire, air, and water. Historically, cross-cultural toys have been difficult to identify and obtain, which is perhaps a reflection of supply and demand.
However, cross-cultural sand figures and toys have become increasingly more available, as have culturally sensitive bibliotherapy resources.

**WHEN CHILDREN EXHIBIT RACIST OR PREJUDICED ATTITUDES**

It is important to know whether to respond, reflect, or intervene when children make positive or negative comments related to cultural diversity. Here are several examples:

- An 8-year-old African-American boy says, “My mom says Spanish people are sneaky and rob people.”
- A 6-year-old Hispanic girl says, “I can’t do that, my friends say only Chinese girls can get As.”
- A 16-year-old Caucasian girl says, “The Black kids just want sex with White girls so they can show us off! I would never let a Black kid touch me!”
- A 12-year-old Asian boy says, “There’s a kid in school who plays the piano and I think he’s gay. I don’t hang out with him because I’d knock him out if he tried to do weird stuff with me.”

Reading these statements may create discomfort, but they are bound to occur in play therapy. The question is how to respond, if at all. Some therapists might elect to overlook or ignore the comment as a child’s passing statement, others may simply reflect, and some may feel it is critical to guide the conversation or provide psychoeducation. A therapist’s comfort level will direct potential responses. It is essential that one learns to respond with cultural sensitivity.

Hortensia, the child in the introductory vignette, clearly introduced racist views into the therapy session. Young children usually get these points of view through the influence of others, including caregivers, teachers, printed media, TV, the Internet, or peers. They may have direct, negative experiences that affect how they think or feel. If a child is bullied by a child of a different culture, it is possible that fear or concern will develop about other children who share that culture.

**The Role of the Clinician in Responding to Prejudiced Comments and Behaviors**

In responding to prejudiced statements or behaviors, therapists can choose anywhere along the continuum from a reflective stance to a more direct educational or exploratory position. How therapists respond, and whether responses are made directly to children or to caregivers, must always be carefully considered. We suggest that clinicians be introspective when they are confronted with statements such as those listed. Some of these commentaries refer to social justice issues, but most of them are based in prejudices, stereotypes, or racism.

**Case Example of Cultural Issues in Treatment**

Hortensia was 6 years old when she first came to therapy (with EG); she was the youngest daughter of an African-American father and a Central-American mother. She was placed in foster care due to neglect by her single mother. Her placement was with an immigrant Korean family of five: father, mother, and three young children under the age of 5. Hortensia was angry about being removed and worried about her mother; she had taken the role
of her mother’s caretaker in a classic role reversal. However, in foster care, she was incredibly disrespectful to her foster parents, and she pushed and shoved the younger children in the home. It seemed as if she was trying to get herself kicked out of foster care, believing she would be sent home again. Her foster parents were uniquely patient and exhibited great compassion toward her. During the intake with Hortensia and her foster parents, the ways she was fighting the placement and remaining fiercely loyal to her mother were candidly discussed. I understood that and shared the foster parents’ empathy to her situation. I met with them monthly to discuss how things were progressing, and they readily accepted my guidance and recommendations. We often role-played difficult situations that arose between themselves and Hortensia, and they were receptive to specific language that corrected her behavior without sending her negative messages that could leave her feeling unloved or rejected.

Keeping a narrow view on the cultural issues she displayed in play therapy, Hortensia had strong reactions to the Asian figurines she found in my office. During our first two meetings, she found the Asian figurines I had on my miniature shelf and threw them in the trash. There were a number of responses I considered, including statements such as these:

- “You’re throwing the Asian miniatures in the trash, calling them names, and telling me I shouldn’t have them in this room.”
- “You’re throwing the dolls in the trash; it seems you don’t want to look at them.”
- “Looks like you have some strong feelings about the Asian miniatures and you want to throw them out.”
- “Looks like you have some strong ideas about Asian figurines.”

I decided to carry it a little further and said, “I wonder what it’s like for those Asian people to get thrown into the trash.” I went over to the trash can and put my ear to it. “Wait,” I said to her, “they’re saying something, I can hear them.” She put her ear on the trash can and did not hear anything. I asked her to listen more closely, and still, she did not hear. “If you could hear them talking, Hortensia, what do you think they would be saying?”

“That’s easy, they would ask for help,” Hortensia said.

“Oh, it sounds like they would be smart enough to ask for help, and someone might come help them.”

“I don’t want anyone to help them,” she said, “because I don’t want to live with them.”

“I see,” I said, “you don’t like them because they are not your mom, and you don’t like living there.”

“I hate it there,” she insisted.

“You just want to be with your mom.”

“Yeah,” she said.

I reached out and held her hands, saying, “It’s really hard for you to be away from your mom.”

She cried a little, wiped away her tears, and said, “Come on, let’s play.” I told her we would play together, but I wondered what we should do with the Asian figures in the trash who needed help. “Okay, okay,” she said impatiently, “I’ll put them over here.”

“I see,” I said, “you found another place for them to be in the room, but decided to take them out of the trash.” I made a mental note that I would find a way to talk more about these ideas. I wondered whether they were racist comments, as I had initially suspected, or reflective of her refusal to accept anyone in a caregiver role. Interestingly, when I met Hortensia’s mother later in the therapy, she made similar comments about how the foster
parents smelled funny, had “weird food,” and thought they were better than her. It became clear her mother had conveyed some of these ideas to Hortensia, and subsequent family therapy included some direct work on these racist attitudes. In the meantime, I thought it was important for Hortensia’s foster parents to address racism more directly, and I encouraged them to talk to Hortensia about the transition they had made when moving from Korea to live in the United States of America. Hortensia listened attentively and was able to identify some comparisons about her mother’s experiences and theirs.

In family therapy, Hortensia and her mother had opportunities to express their beliefs and discuss how their ideas came to be. Once given the green light for reunification services, they did an exercise in which a piece of poster board was cut in half with curved lines. The two halves were separated so she and her mother could acknowledge their experiences while separated. They were both asked to use collage pictures to show each other what had been going on in their lives while they were apart (Gil, 2014). Slowly but surely, Hortensia showed Asian food, some Asian caricatures, and a nose being held, which she labeled “Me, holding my nose from the stinky food.” Hortensia and her mother laughed together. I noticed the laugh and said, “Some people feel that way about burritos, different condiments, and different smells.” They were told there was another project to complete when they were done.

The next project was regarding cultural differences between Hispanics and Asians. I noted that Hortensia had an opportunity that doesn’t happen too frequently—she got to live with a family from another culture. I told her some teenagers get this opportunity when they are older and their schools offer exchange programs, but she had a different kind of chance to visit another culture when she went into foster care.

We discussed how she now knew things about Asians that her mother might not know, and her Asian foster parents had learned more about Hispanics as well. Thus, we began making two poster boards titled “My culture” and “The culture I visited.” Hortensia and her mother were asked how they thought other people felt about their culture, and they were asked to think about how Hispanics are portrayed on TV or in the movies. They quickly identified that people think Hispanics have really big accents and they are funny. They also said sometimes Hispanics in movies were the bad guys or the servants. Mom said, “Yeah, Jennifer Lopez played a maid once, as if!” We then talked about Asians, and Hortensia and her mother’s impressions prior to meeting the foster parents. They had a lot of stereotypes between them, but they acknowledged Asians “probably aren’t bad people either.” They noticed that in movies, Asians were either smart, inventors, or criminals. Mom remarked, “Kind of like us, except the smart part.” I asked if she knew any Hispanics that were smart and she said, “Yes, my father was a very brilliant man and studied law.” She thanked me for both activities and whispered, “I know what you’re trying to do.” I told her it was very important to raise our children without prejudices and she agreed, stating her parents had not liked her marrying an African-American man. I said, “Sometime we should talk about that as well, because Hortensia is highly identified with you as a Latina, but she’s also half African American, and I’m not sure she acknowledges that.” The mother smiled and said, “That’s a whole other story,” and I followed up with her to hear more.

THE FUTURE OF CULTURALLY COMPETENT PLAY THERAPY

Clinicians will benefit from more active and ongoing exploration of their own cultural attitudes and a shift in perspective about how to grow and expand cultural competency. Self-exploration
is the first step toward developing a responsible and ethical approach to working with children and being attuned to issues of cultural diversity. This exploration must be continuous and not limited to a single course or to training that may have little practical application. More open, extensive, and even uncomfortable dialogues need to occur about how to approach these issues in the context of play therapy. Play therapy supervisors should keep a steady eye on issues of cultural competency, often with a willingness to challenge the therapist’s countertransference responses. Sometimes clinical reactions and responses are quickly evident in therapy sessions; other times, there are subtle and less visible ways in which therapists’ own beliefs and worldviews rise to the surface. Supervision and consultation are key opportunities to address these issues head-on, encouraging self-exploration and a deeper understanding of what clinicians inherently bring into the therapy relationship.

CONCLUSION

Multicultural competence in play therapy involves increasing awareness of cultural issues, increasing cultural knowledge, and building skills. It also involves developing a systemic understanding of how racist and prejudiced views can be taught and perpetuated in families and other social systems. Multicultural competence is integrating this knowledge into preparing an intentionally welcoming and inclusive play therapy environment, involving families in play therapy, and acknowledging and responding to cultural nuances that present in the here-and-now of the play therapy room and in the therapist–child–family relationships. Beyond an enhanced understanding of cultural identity in one’s self, as well as in children and their family systems, multicultural competence involves being present, aware, and active and being willing to explore and respond to cultural issues as they arise in play therapy.

Delving into the realm of multiculturalism entails a struggle of identity and affirmation for both the therapist and child. It is through this struggle that clinicians have the opportunity to develop personal and professional competence and facilitate healing with children and their families.

Play therapists and clients are on a journey, much like that of the little girl in the book Old Turtle and the Broken Truth (Wood, 2003). In this story, people fight over possession of a broken truth that affirms you are loved. One little girl travels a long distance to learn from Old Turtle about the missing half of the broken truth that will bring peace to the people of the earth again. She discovers the complete truth, “You are loved, and so are they.” The story concludes, “The people looked. And looked. And looked. Some frowned. Some smiled. Some even laughed. And some cried. And they began to understand. . . Slowly, as the people met other people different from themselves, they began to see themselves” (Wood, 2003, p. 46–48).

REFERENCES


Pthomegroup
Technology in the Playroom

KEVIN B. HULL

Taylor, a bright 10-year-old, enters the playroom accompanied by her play therapist, Wendy. Taylor is carrying an Apple iPad and is excited to show Wendy a new game she downloaded from the App Store called Minion Rush. They sit on the floor and she shows Wendy the object of the game and how to play. She invites Wendy to try the game. They laugh as the Minion Wendy is guiding runs into a car it was supposed to jump over. After a few more tries, Taylor announces she wants to play the game Wendy introduced to her last week and show Wendy how many levels she has completed. The game, Rush Hour, is a trial-and-error game in which a player must strategically move cars that are blocking an exit. Wendy introduced it to Taylor to help her learn better impulse control and increase her frustration tolerance. She shows Wendy her progress and states she has been able to play “without getting frustrated or losing my temper.” Taylor is proud of herself because she has earned extra privileges at home and school for her positive behavior choices. After a few more tries at the game, Wendy and Taylor review the journal of feelings Taylor keeps on her iPad. She also shows Wendy her drawings she made on a drawing app on the iPad. Wendy instructed her to use the drawings as a way to channel her frustration and create a picture for her feelings. The drawings Taylor shows Wendy were done on a day when she was very frustrated with her younger brother.

“I really wanted to knock his head off for messing with my stuff,” said Taylor. “But instead I drew a picture about how mad I was. After I drew it, I wasn’t as mad anymore.”

“I see there is a lot of dark red on this one,” Wendy said.

“Yeah,” replied Taylor, “I used the dark red to show how mad I was.”

Wendy and Taylor explore the positive feeling of Taylor’s good choices and the consequences that result. Taylor writes these in the journal section of her iPad. Taylor then sketches a picture using the drawing app that represents her good feelings.

“It’s sort of like a rainbow, but with lots of sparkles,” Taylor remarks.

Wendy and Taylor finish the session by playing the game Parcheesi on Taylor’s iPad.

Taylor was referred for play therapy because of poor impulse control and her inability to tolerate negative emotions. Taylor became frustrated easily, and she often lashed out at those around her. She told Wendy in their first session, “I’m always in trouble, and I can’t control myself. Nobody
likes me.” During the initial caregiver consultation with Wendy, the parents shared Taylor’s love of electronic devices, particularly her iPad. Wendy encouraged Taylor’s parents to allow her to bring it to her play therapy sessions. During the first session, the iPad served as a window into Taylor’s world. She showed Wendy her favorite games, apps, drawings she created, and pictures she had taken. The iPad provided a platform for connection and helped establish a sense of trust and rapport between therapist and child. Wendy’s enthusiasm about electronic devices and knowledge of the iPad drew Taylor into the play therapy process and laid a foundation for their play. As their sessions progressed, the iPad was used outside of the playroom as a tool for Taylor to journal thoughts and feelings and to draw when she felt emotionally overwhelmed. The iPad proved to be valuable in play therapy and was an important part of Taylor’s growth and change.

**CLINICAL CONSIDERATIONS**

Technology continues to advance rapidly in modern culture. Smartphones, tablets, and personal computing devices have become a normal part of everyday life. Information is available with the swipe of a finger. Tasks that required a powerful computer can now be accomplished from a device small enough to fit in one’s pocket. Children comprise a large segment of the population affected by the advances of technology. Smartphones and tablets are a common sight among children of all ages. The classroom has changed as well, with tablets replacing books, and technological devices such as smart boards becoming an important part of teaching subjects such as history, mathematics, and science. Laptop computers, reading devices, and computer/video games are a routine part of a child’s everyday life. Considering technology’s wide impact on modern culture, particularly in the lives of children, certain questions are raised. What role does technology play in the play therapy process? Can and should technology devices such as smartphones, tablets, and video/computer games be included in the play therapy milieu? What are the benefits of including technology in play therapy and what are the potential risks? Before these questions can be answered, it is important to examine the evolution of the use of technology in the helping professions.

**Review of Technology Use in the Literature**

The first articles regarding the role of technology in psychotherapy began to appear in the 1990s (Hull, 2009). Gardner (1991) demonstrated the use of a Nintendo game system in helping children with impulse control, separation anxiety, and social anxiety. The video games helped the therapist assess the children's problem-solving abilities, and provided the children with insight regarding the consequences of poor choices. Other benefits included improved emotional control and improved cognitive ability in recalling information, and the games provided a bonding experience as the therapist and child worked together to accomplish goals (Gardner, 1991). Resnick and Sherer (1994) found video/computer games to be useful tools with young people to increase self-control and improve decision making, as well as to change antisocial attitudes and behavior. Kokish (1994) found computer games to be effective in helping an abused and neglected child express emotions through the characters created in the game. Computer games were also helpful for a child referred for antisocial tendencies in reducing those tendencies and increasing the child’s self-control.

Clarke and Schoech (1994), noting how many adolescents are resistant to therapy, designed a video game to be played during the first half of the therapy session, followed by traditional psychotherapy. The game, called Personal Investigator, involved a series of scenarios in which the player, acting as a detective, was rewarded for making positive choices and received consequences
for making poor choices. The authors observed the use of the game increased verbal communication as well as impulse control, and the adolescent’s caregivers reported a decrease in behavioral problems. Over time, the authors noted there was a positive increase in the adolescent’s decision-making skills. Aymard (2002) used a computer game with children who “have trouble separating from their parents and feeling comfortable during the early stages of play therapy” (p. 14). Children are asked to create a face on the computer corresponding to their thoughts and feelings about a particular topic in order to get them to communicate with the therapist. Aymard (2002) discovered the game was a useful tool in getting adolescents to express thoughts and feelings and be less resistant to the therapy process. Bertolini and Nissim (2002) used several different types of video games with children and found them useful in helping children communicate thoughts and feelings with the therapist. Further, the authors used metaphors from the characters and situations in the games to increase the coping skills of the children and reduce anxiety. Bertolini and Nissim (2002) encourage therapists to use video games to observe children having an “emotional experience—a genuinely joyful and meaningful one” (p. 323).

Dahlquist (2006) noted the use of video/computer games was beneficial in increasing the pain tolerance of children undergoing chemotherapy, as well as improving the overall mood and emotional control of the children. Riviere (2008) examined the use of e-mail, social media pages, and electronic music devices (MP3 player/iPod) with adolescents in psychotherapy. He found the sharing of content in the adolescent’s social media pages strengthened the therapeutic relationship and provided valuable information about the adolescent’s sense of self-worth and self-image. E-mail between therapist and client was a useful means of discussing therapeutic issues, and the sharing of music through the use of an MP3 player aided in building a foundation of trust and understanding. The overall benefits of the use of technology included lessening the adolescents’ resistance to therapy and providing the therapist with a greater understanding of the adolescents’ thoughts about the world, their self-images, and their coping skills. Finally, the use of technology was valuable in increasing the adolescents’ abilities to communicate thoughts and feelings through a medium with which they were familiar.

Hull (2009) discovered video/computer games were useful as a play therapy tool to reduce emotional disturbances in children. They enhanced the children’s abilities to communicate thoughts and feelings to the therapist, and the therapist was able to apply several themes and metaphors from the games to help increase the children’s coping skills and overcome feelings of sadness. Fanning and Brighton (2007), Skigen (2008), and Hull (2011) explored the use of the video/computer game The Sims with children and adolescents. The Sims is a life simulation game in which the player makes strategic decisions that mimic real-life events. The player creates an avatar, a representation of the player that interacts with a make-believe world in which the player can work, navigate relationships, live in a house, and pay bills. Skigen (2008) found Sims play provided a high-tech version of sandplay in which the child could “develop self-awareness in an understanding, safe environment” (p. 20). Hull (2011) explored the use of Sims play with adolescents diagnosed with Asperger’s syndrome who are struggling with transitions. Sims play provided the opportunity to practice “decision making skills and finding balance through prioritizing and organization” (p. 107).

Snow, Windburn, Crumrine, Jackson, and Killian (2012) discuss the usefulness of using the iPad as a play therapy tool. The iPad proved to be valuable in helping children express thoughts and feelings and was instrumental in helping a boy talk about his sexual abuse experience and subsequently aided in his healing journey. Overall, the authors note the use of the iPad and applications (apps) provide as many opportunities for healing and growth as traditional play therapy toys. Granic, Lobel, and Engels (2014) cite the cognitive, motivational, emotional, and social benefits of video game play and note that video games are valuable in forming the therapeutic
relationship. The games provide therapists with ways to overcome challenges in therapy with young people by providing valuable ways to teach “new forms of thought and behavior” (Granic et al., 2014, p. 75).

Rationale for Using Technology in the Playroom

The previous examples from the literature demonstrate the uses of various forms of technology in the helping professions. From a play therapy perspective, the use of technology is often debated. The main argument against the use of video/computer games or smartphones/tablets is the child may become isolative and the traditional therapeutic bond built through interaction with the therapist as either joint participant or observer is lost. Those who employ the use of technological devices in their delivery of play therapy disagree. One benefit of the use of technology in the playroom is it can make the playroom more inviting and the process of therapy less threatening (Richardson, Stallard, & Velleman, 2010). An adolescent who is allowed to bring a tablet into the session may be less resistant to the therapeutic process, and a child may feel less apprehensive when he or she sees a familiar video game console.

A second benefit of technology is to provide a foundation for bonding between therapist and child/adolescent during the initial stages of play therapy. Hull (2009, 2011) discusses the use of video/computer games in helping strengthen the therapeutic relationship by lessening fears, creating trust, and increasing the young person’s willingness to be engaged in play therapy. Children and adolescents are often excited to learn their therapist knows about a certain game or app with which the young person is familiar. This shared familiarity helps form and strengthen the therapeutic bond.

A third benefit of the use of technology in the playroom is the imagination and creativity opportunities devices such as tablets or computers offer (Snow et al., 2012). Programs and apps are available for drawing, building, sculpting, and even making music. Pictures, sculptures, and songs are created and can be shared, modified, and saved to be worked on later or archived as part of the child’s growth process. Technology allows the child to create alone with the therapist observing, or both can join in the activity. Children or adolescents who may be hesitant or self-conscious when it comes to picking up a pencil or crayon may find it easier to create through an app or computer program. For those play therapists who work in rural settings or who may not have the convenience of an office, a portable computer or tablet offers a trove of games and applications to prevent the therapist from having to carry boxes of toys from place to place.

Fourth, technology offers powerful opportunities for metaphors and life applications to be made through the various games and apps that are available. Hull (2009) discusses the rich metaphors that can be gleaned from video/computer games. For example, the concept of overcoming obstacles while working toward a goal is present in most video/computer games, and this mirrors the struggles most young people face on a daily basis. Other metaphors found in games include self-worth, impulse control, asking others for help, and learning to get along with others. Online game play introduces a young person to a virtual social world in which thoughts and feelings about relationships can be explored.

A fifth benefit of technology is it offers a diverse approach for young people with special needs. Children who have physical, mental, or emotional limitations may be challenged to navigate a playroom with typical toys. Technological devices such as tablets, computers, or video game consoles offer children with special needs opportunities to engage in play in which they may otherwise have difficulty. For example, children on the autism spectrum who struggle with communicating thoughts and feelings may be more comfortable in a playroom that offers technological devices. Tablets, computers, and portable gaming consoles can be of great value to play
therapists who work in unique settings such as schools, hospitals, or inpatient settings where clients with special needs demand a specialized approach.

A sixth benefit of technology is it allows the therapist to gain a greater understanding of the child's strengths and weaknesses and provides a platform upon which the strengths can be celebrated and the weaknesses improved. By observing the way a child plays a particular computer/video game, a play therapist can determine the child's level of motivation, frustration tolerance, emotional state, and social awareness. For example, a child who is introduced to a new game may show fear and hesitation. When questioned about the fear, the child states she is afraid she will not succeed, revealing perfectionistic thinking and self-doubt. As the child gains mastery over the game, fear is reduced. As the therapist introduces more new and unfamiliar games, the child is able to work on her specific problem in a fun and challenging way that will generalize to her life outside of the playroom.

A seventh and final benefit of technology is in the area of therapeutic group play. Hull (2013) discusses the use of video/computer games in group settings with children and adolescents on the autism spectrum. Games were found to be useful in teaching social skills, impulse control, and increasing the frustration tolerance of group members. While some children were familiar with the games used, others were not. This allowed for children to assume a teaching role, aiding in the child's development and resulting in an increase in self-worth. Technological devices such as portable gaming systems and tablets (complete with Wi-Fi capability) allow a play therapist to create a network within the playroom in which group members can work together in a fun and meaningful manner.

Characteristics of the Technologically Minded Play Therapist

Play therapists that are not familiar with the technological devices many of today's young people use may feel resistant to the idea of using technology in the playroom. Snow et al. (2012) state there is a divide in the field between those who wish to use traditional toys in the playroom and those who believe the games and apps offered through technology yield the same results. Play therapists who consider incorporating technology into their repertoires may feel as though they are compromising therapeutic integrity by veering from the traditional play therapy path. This is certainly not the case. Technologically minded play therapists share several important characteristics. First, the play therapist that uses technology is open minded and seeking. As evidenced earlier, a good deal of research exists regarding the use of technology in the form of video/computer games and tablet apps. Seminars, books, and articles demonstrating the use of technology in the playroom are readily available for those wishing to expand their practices. As video/computer games have become more “complex, diverse, realistic, and social in nature” (Granic et al., 2014, p. 66), a growing body of literature claiming the benefits of the use of video/computer games has emerged.

Imagination plays an important role in using technology in play therapy. The play therapist relies on his or her ability to see the game the child is playing through the child’s eyes and to envision what the child is seeing. The play therapist must attempt to feel what the child is feeling, imagining the motivation for why the child is attempting to play the game and visualizing the joy the game brings the child. Imagination is also important in understanding and appreciating the therapeutic value of certain games. For example, the open world game MineCraft contains elements of sequential thinking, patience, and frustration tolerance that can be used in play therapy with children who have difficulty with these issues. Play therapists who bring their imaginations to the therapeutic process find there is no end to the applications of various games and activities in electronic platforms.
A third characteristic necessary for the play therapist incorporating technology into his or her play therapy regimen is having the mindset of a student. Children and adolescents of today are very tech savvy and are aware of the latest games and trends in the video/computer game universe. Play therapists can learn a great deal from their clients. Armed with tablets, smartphones, and portable gaming devices, children and adolescents can teach the play therapist about games and apps that are meaningful to the child, but also about games and apps the play therapist can use with other clients. A willingness to be taught by a young person will not only enhance the therapeutic relationship, but can also increase the client’s sense of self-worth and assist with identity formation.

Fourth, the technologically minded play therapist should have good boundaries and expectations and be able to communicate these to the young person with whom they are working. While technology has many benefits to assist the play therapist, it is also a vast wonderland in which therapist and client can get lost and spend the entire session simply surfing various Internet sites, gaming options, and watching YouTube videos having nothing to do with helping the young person grow and heal. The therapist must be committed to theory and practice while using technological devices, and he or she must develop and follow a clear treatment plan. The therapist communicates early in the session the role technology will play, what games will be used, what sites are allowed and not allowed, and how much time will be spent in certain activities. Informed consent is also necessary so caregivers are aware of the role technology plays in the play therapy process. The caregivers should be aware that age-appropriate games are used, and caregiver permission should be sought for games containing themes of violence or fantasy. The rationale for the use of those games should be provided. Each play therapist wishing to incorporate technology into the play therapy regimen should adhere to the APT’s best practices (2012) and seek consultation with other professionals in the event that ethical questions arise.

A solution for the play therapist wishing to use technology and avoid getting lost in the vast world of computer or tablet play is to employ a prescriptive play therapy approach. The prescriptive play therapy approach (Schaefer, 2001) involves the play therapist prescribing “a specific intervention to alleviate a client’s problem” (p. 61). The same boundaries of “the sand is not for throwing” can be applied as, “You can choose any of the games you see on the iPad, but we won’t be using it to go on the Internet.” Similarly, “These are the games you may choose from today,” helps the young person know what choices are available and narrows the focus of the playtime. For children with boundary or impulse control problems, a tablet or gaming console offering a plethora of games can be overwhelming, similar to a playroom overcrowded with toys and play options. Snow et al. (2012) recommends forming “category folders” (p. 2) containing specific games for specific age groups on the computer or tablet to assist the play therapist in delivering play options to clients.

Fifth and last, the technologically-minded play therapist offers his or her clients the same choices for play through technological media as with traditional toys. Snow et al. (2012) used Kottman’s (2011) categories for play when implementing the use of an iPad in the playroom. These categories of play included nurturing, fantasy, expressive, aggressive, and scary. The authors found a variety of apps and games in each of these categories and offered suggestions for each category. For example, a 7-year-old boy used an app called My PlayHome (Young, 2011), a virtual dollhouse in which characters can be moved around and made to interact with each other. Over several sessions, the boy used the app to disclose sexual abuse and express his emotions about the incident. With a minimal amount of effort, the technologically minded play therapist can build a virtual playroom on a tablet or smartphone and offer children and adolescents unique play opportunities.
BENEFITS AND USES OF TECHNOLOGY IN THE PLAYROOM

Themes and Metaphors

Video/computer games offer rich and varied themes and metaphors. Themes found in games range from overcoming challenges, relying on friends for help, dealing with failure, conquering enemies, and gathering attributes to allow a player to “level up.” Regardless of whether the game is played on a tablet, smartphone, computer, or gaming console, these themes will usually be found. Metaphors found in the games allow the play therapist to “connect the dots” (Hull, 2009, p. 77) to the issues the child is struggling with in the real world. For example, children who are fearful of new situations can be put in the position of playing an unfamiliar game. As they play, they must overcome self-doubt, overcome the fear of failure, and navigate a new situation, all of which mirror the tasks and challenges they face in real life. Similar to traditional play therapy materials, game play through the technological medium offers a safe emotional distance from the real issues so children can examine the themes in a fun and creative way. As game play progresses, other metaphors will surface and translate to helping in a real-life situation, such as asking for help, learning to resist fear and panic, and concentrating on the task at hand.

Diagnosis, Assessment, and Insight

Observing young people play video/computer games produces valuable information regarding the children's thinking processes, emotional states, and levels of resilience and coping. The play therapist can assess how children make decisions and process information and how they will navigate a new situation. Will they learn from their mistakes? Do they try again? Do they blame themselves for poor performance? Will they generalize what they have learned to new situations? Observing the outcomes of these questions provide the play therapist with valuable information for treatment planning.

I worked with a boy who struggled with impulse control problems, behavior problems, and a very low sense of self-worth. A lover of Mario Bros., he was overjoyed to see my Nintendo Entertainment System and we began playing Super Mario Bros. I immediately noticed he repeatedly failed when encountering a common scenario presented in the game, and he became increasingly frustrated. It seemed as though he did not have the ability to learn from his mistake and take corrective action. Psychological testing supported this observation and revealed processing issues, especially in situations where he had to process a lot of information before making a decision. This theme proved to be exactly what was happening in his real-world environment, leading to his impulsive behavior and negative consequences. Armed with this new information, the boy and I played through the game and he practiced surveying the upcoming situation, assessing what his next move would be, and then following through on his decision. His decision-making ability greatly increased and his behavioral problems were greatly reduced, resulting in a greater sense of self-worth. The gaming experience proved valuable because it helped the boy gain greater self-understanding and provided a safe, fun, and unique path to help him overcome his challenges.

Growth and Development

The technology of today offers play therapists rich opportunities to assist in a client’s cognitive, emotional, and social growth. From a cognitive perspective, games and activities available on a tablet, smartphone, computer, or gaming console provide useful tools to increase a child’s decision-making skills through practicing to think ahead and organize information. Many games, such as MineCraft, contain elements of building that require sequential thinking and spatial skills. For children struggling with impulse control problems, games involving the completion of
a series of steps in order to level up can assist children in learning to slow their thinking process so they can take in more information. Minion Rush, a fun and free app, can be used with children who struggle with awareness of their environment by teaching them to pay attention to what is going on in the present moment and look ahead to see what is going to happen.

Emotional problems are a common reason for children to be referred to therapy (Wagner, 1995). Negative emotions such as fear, anger, and sadness are common among children who enter the playroom. Competitive games can be useful for children who struggle with frustration by providing them with a fun way to explore the emotion and learn to control it. Games and apps that allow creativity and expression can be useful for children who are struggling to express sadness, fear, and anger. Apps such as Crayola Paint and Create allow a child to express emotions through art, and the creations can easily be saved to be modified later. Positive Penguins, an app to help children identify, understand, and communicate about emotions is a fun way to introduce them to understanding the link between thoughts and feelings. Smiling Mind is a meditation and mindfulness app designed for children as young as 7, and it can be used for adolescents and adults as well. The app teaches young people the power of self-awareness as a tool to ward off stress and foster resilience.

Technology offers play therapists wonderful opportunities to model and teach social skills. Through collaborative electronic play, child and therapist explore themes such as working together, communication, and building and sustaining social connections. Games such as the LEGO game series (Star Wars, Harry Potter, Indiana Jones, etc.) have two-player options, allowing the play therapist to join the young person in collaborative play. Collaborative gaming encourages communication and allows children to take leader/teaching roles if they desire. Games and apps such as The Sims, My Playhome, and MineCraft are full of social skill building material, allowing a play therapist to teach social skill building and observe the child’s level of social awareness.

**Narrative Play Therapy and Technology**

Narrative therapy is a powerful tool in play therapy to help young people “express and explore their experiences of life” (Cattanach, 2006, p. 83). Technology offers young people unique and exciting opportunities to create stories about the pretend world and the life of the self that is constructed during play. The stories evolve through play sequences and are told either through the use of technological devices, such as a tablet or computer, or through a narrative tool embedded within the game or app. For example, the app Sock Puppets (Smith Micro Software, 2012) allows children to create characters, develop a story, and add voices and music to customize their creations. Toontastic (Launchpad Toys, 2014) is an app for children to create a story in a movie form and develop a number of various characters. The movies can be saved and modified later or shared with others. LEGO Movie Maker (The LEGO Group, 2013) is another app for users to create stories with stop-motion movie effects. Children and adolescents who are LEGO fans find this app very fun and are inspired to tell stories using LEGO minifigures and materials, but they can also incorporate other materials in the playroom such as stuffed animals and puppets. Technology in the form of apps such as these demonstrates the many resources available to make the narrative experience fun and meaningful, as well as tapping into the client’s creative process. These apps provide fun and creative ways for those who have suffered a traumatic experience such as physical or sexual abuse to release thoughts and feelings about the event and create a path for healing. Children and adolescents facing difficult events such as divorce or loss can explore the themes of these experiences and create narratives in the form of a movie or play in which they are in the director role.
Computer/video games have intricate and meaningful backstories and characters with which many young people identify. Characters such as Naruto, Captain Jack Sparrow, and Desmond Miles are powerful characters with backstories containing themes of rejection, bravery, and self-reliance. Rubin (2007) states these characters help young people “make sense of their world by creating and then living their stories—their own personal mythologies” (p. 4). Young people find these characters and stories provide a sense of strength and resilience in the face of adversity. Computer/video games allow for the opportunity to play as these characters and move from imagination to real simulations of living as the character in the story. Technological devices allow play therapists to observe young people in play as chosen characters and provide opportunities for young people to create meaning between their life stories and those found in the games.

Group Play Therapy and Technology
Technology in the form of smartphones, tablets, and computer/video games provides unique opportunities for play therapists who conduct group play therapy. Hull (2013) states that computer/video games are useful in the group therapy setting to teach social skills, increase perspective-taking, and increase one’s sense of self-worth. Technology not only provides a plethora of games, apps, and gaming platforms, but also provides a way for the members of a group to connect. For example, I conduct a social skills group in which each member of the group is able to play the game MineCraft on a smartphone or tablet. The wireless router at my office provides networking capability on the devices so everyone can be in the same world at the same time and can work together on specified goals. The players take turns sharing ideas and each gets the chance to be the director of the action. I can monitor the action as well as join in, and I can zoom to each area of the MineCraft world to see how the teams of group members are progressing. Progress is saved and can be worked on in later groups. Following the game play, elements of social skill building behavior such as communication, dealing with frustration, and working together are discussed as a group and applications are made to the young person’s real world.

Group therapy offers opportunities to increase a young person’s sense of self-worth by allowing him or her to be the expert and to teach the group about something dear to him or her. A computer, tablet, or gaming console provides a unique tool through which a group member can show the other members a video he or she has created or a game that he or she likes. This puts the member in the teaching role and not only helps promote social skills, but also helps to raise the young person’s sense of self-worth by being in a director role. Many young people are tech savvy and enjoy sharing their knowledge, and many see their tablet, smartphone, or gaming device as an extension of themselves. Some examples of uses of technology in group play are group computer/video game play, filming scenarios and sequences of play, and using movie and video clips to create discussion and understanding of social skills.

THE FUTURE OF PLAY THERAPY AND TECHNOLOGY:
IMPLICATIONS FOR FUTURE RESEARCH
Technology has had a significant impact on children and families of today. As children’s lives are affected by technology, so too are the play therapists that provide valuable services through the medium of play. Children who come to play therapy expect to find toys and games with which they are familiar, and technological devices in the playroom offer rich opportunities for play. While it is clear children of all ages are drawn to technology and incorporate it into their play, much is still
unknown about the impact of technological play as it relates to play therapy. Much of the early research regarding video game play focused on the negative impact and potential harm, but in the past 5 years there has been an increase in studies related to the benefits (Granic et al., 2014).

Two basic areas should be investigated when considering the merging of technology and play therapy. First, specific play therapy techniques involving the use of technology need to be studied, applied, and shared with future generations of play therapists. For example, virtual versions of sandbox play (The Sims) or virtual dollhouse play (My PlayHome) are excellent electronic substitutes for the real thing, but what are the applications? How might a play therapist unfamiliar with these games and apps learn to use them? What specific clinical issues and challenges can be helped by what games/apps and in what way? These questions are important to consider so the vast amount of games, apps, and devices on which they are played can be fully understood and applied. Long-term studies of the efficacy of games and apps are necessary to fully understand the relationship between technology and play therapy. Future research should also incorporate a strong theoretical base and connect theory with practice when the application of certain video/computer games and apps is considered. Play therapy has always had its critics (Bratton, Ray, Rhine, & Jones, 2005), and it is important for those who use play therapy to continue to demonstrate its efficacy, particularly in studying the role technology can and will play in the future. Play therapists who use technology should be willing to teach those unfamiliar with this medium. Seminars, webinars, and workshops are excellent ways for play therapists to share their ideas, practice, and research.

Another area when considering the future of play therapy and technology is the development of specific games and apps designed by play therapists for use in the playroom. Due to the increasing complexity and versatility of computer/video games developed in the past few years, it is possible to build into games specific therapeutic elements to use with young people in the playroom. Apps and computer/video games have begun to be developed for use in psychotherapy. For example, researchers at the University of Auckland have developed a CBT-based video game called SPARX (smart, positive, active, realistic, X-factor thoughts). Players move through situations that mimic real-world scenarios and practice elements of CBT in a fun and explorative manner. Early studies have shown the game to be as productive as traditional forms of treatment for depression, such as medications or therapy (Chan, 2012). Simon Mayrat at Sigmund Freud Private University in Vienna, Austria, and Paulo Petta at the Austrian Research Institute for Artificial Intelligence are currently developing a video/computer game (Trauma Treatment Game) to help children heal from childhood trauma and “comorbid disorders such as anxiety and depression” (Mayr & Petta, 2013, p. 68). The authors state while many video/computer games can be used in psychotherapy with young people, very few have been developed to address specific therapeutic needs. Considering the significant number of children who are referred to play therapy for trauma issues, this game would be a tremendous asset to play therapists. These are two examples of many exciting games/apps that either have been developed or are in development, but more are needed.

**Case Example**

Katelyn, a 10-year-old girl, was referred for play therapy because of emotional and behavioral problems. She was diagnosed with and took medicine for ADHD, and her mother said Katelyn had not seen her birth father in years. Her mother remarried 2 years ago, bringing two younger stepsiblings into the family. Her mother reported Katelyn “caused chaos at home” and she and her husband disagreed as to how to handle her, causing marital stress.
There was no history of physical or sexual abuse. Katelyn struggled in school and told her mother “everybody hates me.” When frustrated she became physical, lashing out at those around her. She often broke toys and threw things. Katelyn appeared to have no friends, and her mother said she “pushed people away.” Her mother said Katelyn was “odd” and did not seem like other girls her age. “All she wants to do is sit inside and play a silly game on the iPad and computer,” she said with a dismissive tone. I told Katelyn’s mother of my use of video/computer games and tablets in play therapy. “Well, I don’t know about me paying for her to come here and play those silly games, but if you think it will help I guess it’s okay with me.”

Upon entering the playroom for her first session, Katelyn appeared apprehensive and reserved. She did not speak to me and made little eye contact. As she explored the room, she noticed a picture on the wall a boy had drawn of a figure in MineCraft. Instantly, her face lit up.

“I love MineCraft!” she said excitedly. “Do you know about MineCraft?” she asked.

I told her I had MineCraft Pocket Edition installed on the iPad in the playroom. MineCraft is a game about building in which a player uses blocks that can be placed and broken up. The game contains worlds with forests, mountains, and beaches in which players build landscapes to explore. The player uses geological elements to make tools and mine elements, and the player can gather materials in order to survive. There are two modes: creative mode and survival mode. Creative mode provides the player with all the elements and tools available in the game. There are no enemies, and the player can fly in creative mode. Survival mode mimics real life. The player must find food, sleep, fend off enemies, and make tools and build structures with the most rudimentary elements. A player’s health must be monitored in survival mode or the player will die and the game is over. Progress is automatically saved in both modes of play and it is easy for a child to continue play at the exact point where play was stopped.

Katelyn began to talk, telling me all about the worlds she created. She talked about being afraid to play in survival mode because of all the various creatures that “could attack you.” She preferred creative mode, allowing her to explore and create without worrying about “those crazy zombies getting me.” She also said she really liked to fly, and she wished she could fly in real life. As I assured her I understood what she was talking about, her anxiety and apprehension lessened. I waited for her to notice the iPad sitting on a table in the playroom, and after a few minutes she found it. She shyly asked if she could play MineCraft on the iPad.

“Yes, everything you see in this room can be played with. If you’re not sure, just ask,” I replied.

She told me her mother did not like MineCraft and never wanted to see the worlds Katelyn created. I inquired as to why and Katelyn said her mother thought it was a “waste of time.” Katelyn slowly opened the iPad and I showed her the folder containing MineCraft. She sighed with relief as the home screen appeared. “Ahhh,” she said. “Good ole MineCraft.” She eagerly showed me her knowledge of the game and quizzed me about the characters, elements, and tools.

“It seems like you want to make sure I really know about MineCraft,” I said.

“Oh, adults say they know about stuff but they really don’t.”

The first session ended with Katelyn asking if she could bring her iPad to the session. I said she could.

The next few sessions consisted of Katelyn bringing her iPad and showing me the worlds she created in MineCraft. Three themes were evident in Katelyn’s play involving
MineCraft: fear/safety, destruction/dismantling, and escape/fantasy. Regarding the fear/safety theme, Katelyn liked to build elaborate cave homes complete with hidden tunnels, trap doors, and rooms filled with chests of weapons. She labeled this world “My World” on the home screen. I inquired about her need to keep herself safe, bringing up the fact there were no enemies in creative mode. Katelyn acknowledged she knew this, but said a Creeper might sneak in somehow and that you have to be careful. She built tall walls around the openings to her caves and placed signs at the entrances such as “Turn back or you will die!!!” She said she felt most safe deep inside her cave homes where “I know no one can get me.” This play allowed us to explore how she felt about peers at school and her family members. She revealed she did not feel safe around people. “You never know when they might hurt you. Just like Creepers.” When I inquired about abuse, she revealed kids picked on her at school. She said they called her names. She said there were a few who were nice to her, but Katelyn did not know if they would “keep being nice or turn mean like everyone else.”

The second theme evident in Katelyn’s MineCraft play was destruction/dismantling. In the second session, she showed me a world she labeled “Nothing World” and told me it was top secret and no one had ever seen it before. She opened the tab and a gray, rocky landscape appeared. There were no trees, green grass, or pretty beaches. “I blow it all up in this one,” she said. When I inquired about this, she said she used dynamite to blast everything. She did not build anything in this world. She simply destroyed. Katelyn went to this world “when I’m really mad.” This opened up discussion about the things about which she was angry. She talked about the kids at school, her step-siblings (“they took over my house”), and missing her father. She showed me a place in Nothing World where she went when she thought about her father. She repeated the phrase “I’ve never shown anyone this” several times as she showed me this part of the world. It consisted of deep craters lined with gray and brown rocky crags. Katelyn then switched to her inventory screen and selected TNT and placed several blocks of dynamite inside a crater and lit it, then stepped back to watch it explode. She clapped her hands with excitement as the sound of the explosion and the sight of the destruction occurred simultaneously. Katelyn said her goal in Nothing World was to “blow everything up and leave nothing.” She said she felt better after using TNT and watching how it made large holes in the ground. Her revealing Nothing World to me opened discussion about her feelings about her father. Katelyn said her mother told her to not talk about him; he was gone and that was that. Katelyn said this made her sad, and then she felt mad and went to Nothing World.

Escape/fantasy, the third theme in Katelyn’s MineCraft play, was evident in her use of the flying feature in Creative mode. “I just zoom away whenever I want,” she said. She said she wished she could fly away often, especially at school or when her mother was angry with her because of her behavior. She said flying made her feel free and hopeful. “You see things differently when you fly, way up in the sky.” She showed me “Sky World,” in which she created a floating castle high in the sky, complete with gardens and other buildings around it. She said this world was where she came when she felt happy and hopeful. The only way to get up to the castles was to fly. I remarked how this world felt very different from the others worlds she showed me. Katelyn did not destroy anything in Sky World, and she had even put an observatory in part of the castle in which one could look down on the mountains, trees, and rivers below.

During the fourth session, Katelyn asked if I could join her in her worlds using my iPad. I joined her server and instead of simply observing her worlds, I was now able to walk through them with Katelyn as my tour guide. She giggled with excitement as she locked me in a
room I had no idea how to get out of in My World’s underground labyrinth of tunnels and hidden rooms. She loved to play hide-and-seek in the caves and tunnels and was ecstatic when I couldn’t find her, and she was equally overjoyed when she quickly found me. While in My World, she talked about her feelings about her classmates and said she wanted to make friends. We talked about how to make friends and I used our experience of playing together as a foundation for Katelyn to learn to trust others and give the nice people in her school a chance. She said at first it was hard to let me into her worlds, but once she did she realized it was lots of fun. We visited Nothing World together and she invited me to blow up some TNT. I felt sad and lonely in Nothing World as I took in the bleak landscape and charred remains of trees and dried river beds. We talked more of her missing her father and she revealed feelings of despair and believing perhaps she had done something wrong and made him leave. We soared together in Sky World, laughing and visiting all the rooms in the castle. I showed her how to build a roller coaster that went through the gardens to the castle, and she was delighted to ride it repeatedly.

Over the next year, Katelyn experienced immense growth. Through the game of MineCraft, she experienced what Green (2012) calls individuation: the process that “characterizes a progress from psychic fragmentation toward wholeness” (p. 177). Our play together enabled Katelyn to connect her play worlds in MineCraft to the real-world issues that previously had caused her so much distress. Her social skills increased and her behavioral problems at school lessened. Her mother reported fewer tantrums at home and the throwing/breaking behavior ceased altogether. Her ability to verbalize feelings increased, particularly about her father. Her self-worth improved as evidenced by increased socialization and better behavior choices. MineCraft became a way for Katelyn to communicate her thoughts and feelings to her mother and step-father during subsequent family play sessions. As a result, her mother and step-father joined her in MineCraft play, which helped them understand her and build a relationship with her.

CONCLUSION

Technology offers the play therapist immense opportunities to connect with children and help them on their developmental journeys. As play therapists look to the future of play therapy, it is certain technology will play a role. Children and adolescents are drawn to the imaginative and creative tools created by the advances in technology. It is important for play therapists to learn to utilize technological devices, and the games and apps played on those devices, and to make sure the child’s needs are being addressed through this powerful medium. Play therapists need not fear the changes technology may bring, but instead should commit to learning and growing along with the amazing young people with whom they work.

REFERENCES


Mayr, S., & Petta, P. (2013). Towards a serious game for trauma treatment. In M. Ma, M. F. Oliveira, S. Peterson, & J. B. Hauge (Eds.), Serious games development and application: Lecture notes in computer science, 8101, 64–69. Berlin, Germany: Springer Berlin Heidelberg. doi:10.1007/978-3-642-40790-1_6


Pthomegroup
PART 8

Research
CHAPTER

34

Methodologies Suited to the Study of Play Therapy

DEE C. RAY AND HAYLEY L. STULMAKER

Research in play therapy has a long history and is replete with evidence to support the effectiveness of play therapy with children of various populations and presenting issues. However, there are gaps in the literature regarding the use of play therapy; specifically, there is a need for research demonstrating play therapy is an empirically supported treatment. Continued efforts to conduct research are necessary to the development, refinement, and applicability of play therapy. Treatment interventions evolve over time to meet the needs of the current culture. Over the years, researchers in play therapy have explored the structure, theoretical constructs, delivery format, and effect of play therapy in accordance with contemporary standards of research design and methods. Yet, there is more to do. In order for play therapy to thrive, researchers must repeatedly offer evidence to support intervention, monitor changes in protocol implementation, and develop theoretical constructs for intervention.

The purpose of this chapter is to provide the play therapy researcher and practitioner with an overview of research methods that are viewed as credible and correspond to the nature of play therapy intervention. We will present the basics of each method, discuss its compatibility with play therapy, and provide examples from the play therapy literature when available. We seek to provide play therapists with ideas to help in the implementation of research design in order promote the intervention of play therapy, especially as an empirically supported treatment. Furthermore, the designs we present will help practitioners enhance their play therapy through a more thorough understanding of how play therapy works. In addition, practitioners can utilize research to promote their practice, understand processes within play therapy, and demonstrate their effectiveness with supervisors, parents, and prospective clients.
PLAY THERAPY RESEARCHER QUALIFICATIONS

To begin a research agenda in play therapy, a play therapist researcher will need the following qualifications.

Knowledge and comprehension of theoretical constructs related to the play therapy modality being employed

Research requires the isolation of variables affecting the outcome of therapy. In order for a researcher to identify such variables, there should be a deep understanding of constructs that serve as a basis for change for the play therapy modality being used. Questions a play therapist needs to ask before embarking on the construction of research may include: What is the mechanism of change for the type of play therapy being used? What is the purpose of providing toys/materials to the child? What is the role of the therapist in therapeutic change? What specific outcomes might be expected from play therapy?

Clinical experience

Because the implementation of play therapy in research design can be challenged with therapeutic and ethical issues, relevant clinical practice is essential for the play therapist researcher. During a research study, the therapeutic care of each child is prioritized over all research project goals; hence, the researcher's practitioner role becomes fundamental in implementation of the design. In addition, Himlelein and Putnam (2001) warned that when researchers do not practice, there is a stronger probability the research is divorced from real-world needs and concerns.

Basic to extensive knowledge of research design

Regardless of the type of research design used, a play therapist researcher should be well trained in the implementation of that design. Formal education in research design is a preferred qualification, and prior membership in research teams is helpful.

Knowledge of the appropriate use of statistical analyses

Although it is not necessary for play therapist researchers to be experts in statistics, they should have ample knowledge of statistical approaches for their chosen designs. More complicated experimental designs require advanced statistical knowledge, while single case designs tend to utilize simpler statistical analysis. Formal training, membership on research teams, and continued education opportunities are beneficial to increasing statistical knowledge and application.

Although these qualifications appear daunting, we encourage play therapists to seek additional training and practice experiences to improve their research and statistical knowledge. Some research designs are easily conceptualized, and play therapists may find themselves more competent and interested than they expected. Online educational opportunities have increased over the last decade, allowing for greater opportunities for learning.

EVIDENTIARY BASE FOR MENTAL HEALTH TREATMENT

The empirically supported treatment movement in mental health has been a moving target for researchers over the last two decades. Initiated as an effort to ensure quality services to clients, this movement has fragmented in multiple directions, leaving most researchers scrambling to
determine current criteria needed for quality studies. Criteria for empirically supported treatments continually change and are interpreted differently by organizations and government agencies. Although criteria for this label can be unclear, most researchers agree that a multiplicity of designs, when conducted with rigor, can potentially offer evidentiary support for a treatment intervention. We provide two examples of criteria found in the literature that highlight different perspectives in reviewing evidence-based literature.

Nathan and Gorman (2007) provided standards to evaluate intervention according to “methodological adequacy of the research studies from which the outcome data were derived” (p. vii). They suggested there are six types of studies ranging from most to least rigorous. Type 1 studies are the most methodologically sound and involve randomized clinical trials (RCTs). Criteria for type 1 studies include comparison groups with random assignment, blinded assessments, clear inclusion and exclusion criteria, strict diagnostic methods, adequate sample size, and detailed statistical methods. Type 2 studies involve clinical trials, yet they have some flaws that prevent a type 1 designation. None of the flaws of a type 2 study is considered fatal, and these studies offer substantial contributions to the literature. Single-case experimental designs (SCED) are sometimes categorized as type 2 studies. Type 3 studies have significant methodological flaws and are typically open treatment studies that focus on the collection of pilot data. Type 3 studies provide information regarding the worth of the treatment in pursuing a more rigorous design. Type 4 studies are typically reviews of secondary data such as meta-analyses. Type 5 studies are reviews of treatments without secondary data analysis. Type 6 studies are of marginal value and include reports such as case studies, essays, and opinion papers.

In the paradigm established by Nathan and Gorman, rigorous RCTs are considered the best sources of information regarding the effectiveness of treatment, and case studies are considered the least evidentiary.

In an effort to help practitioners identify treatments that are empirically supported in real-world settings, Rubin and Bellamy (2012) proposed an alternate structure for determining the effectiveness of interventions. They identify systematic reviews and meta-analyses as level 1 studies in the research hierarchy, citing replication of a single intervention as being the most credible source of evidence. Level 2 studies are multisite replications of randomized experiments. Level 3 studies are individual randomized experiments, and level 4 studies are quasi-experimental, characterized by the nonrandomization of participants. Single-case experiments are categorized as level 5 studies. At level 6, correlational studies provide evidence of relationship but do not allow for causal inferences. Level 7 studies include case studies, single group pre-/posttest studies, and qualitative studies. The structures provided by Nathan and Gorman (2007) and Rubin and Bellamy (2012) emphasize the variations and commonalities in the current state of evidence-based reviews. RCTs are highly valued as being the gold standard in most conceptualizations of research. However, many research designs are considered valuable in the understanding of how an intervention works. Case studies and qualitative methods are typically considered of lesser value in the evidence-based movement, yet they can still offer constructive information.

We propose many and various research designs are contributory to the understanding of play therapy. RCTs and the replication of RCTs (meta-analyses and systematic reviews) for specific presenting problems and issues serve as the most credible evidence supporting the use of play therapy. However, RCTs are only one source of information on the process and outcome of play therapy. Small-group experimental, correlational, single-case experimental, and qualitative designs offer substantial information on the format and process of play therapy. In using these methods, play therapists benefit by conducting research through rigorous design implementation and staying within the confines of the design limitation when stating conclusions about their
findings. Research studies conducted with detail and integrity offer valuable information to the field, even if they are limited in addressing the overall effectiveness of play therapy.

**QUANTITATIVE RESEARCH DESIGNS**

Within the hierarchy structure of evidentiary research, quantitative designs rise to the top. RCT, quasi-experimental, SCED, and mediator/moderator exploratory designs require the use of statistical analyses based on quantifiable data collection. Knowledge of each type of design helps the play therapy researcher to conceive the appropriate types of design and analyses to answer questions regarding the effectiveness and limits of play therapy.

**Randomized Controlled Trials (RCTs)**

RCTs, also termed classical experimental design or randomized experiment, are considered one of the most stringent research methodologies in social science research (Bryman, 2008; Creswell, 2009; Rubin & Bellamy, 2012). RCTs help determine the effectiveness of an intervention on a particular outcome. The distinguishing aspect of RCTs from other methodologies is the randomization of participants into groups. This randomization of participants allows consumers of research to conclude whether the intervention, as opposed to alternative factors, is the cause of the found effect. Randomizing participants allows for the assumption the groups are equal, with the only difference being the intervention provided for each group (Bryman, 2008; Rubin & Bellamy, 2012).

The traditional RCT design consists of two groups of participants, randomly assigned to each group, who receive pre- and posttests on an outcome measure. Typically, one group is a treatment group, with participants receiving the intervention, and one group is a control group, with participants not receiving an intervention. This type of design allows researchers to determine the impact of an intervention compared to no treatment. However, RCTs can also encompass multiple treatment groups, allowing for comparison of effectiveness between treatments (Bryman, 2008; Creswell, 2009; Rubin & Bellamy, 2012). RCTs are considered more rigorous when an experimental treatment is compared to an empirically supported treatment.

**RCT Procedures**

The following procedures indicate the steps necessary for the most basic RCT design. More complicated RCT designs with multiple groups may also be created; however, in an attempt to simplify these concepts, a two-group design is utilized for this discussion.

The first step to initiate a RCT is to determine the intervention that will be utilized. In play therapy research, the intervention is typically play therapy; however, the type of play therapy or theoretical orientation may be varied. When choosing an intervention, it is important that a treatment manual exists to ensure the intervention is delivered properly and consistently across research studies. Play therapy researchers, specifically child-centered play therapists, lacked a treatment manual until recently when Ray (2011) published a CCPT manual. Creating manuals for other types of play therapy will continue to strengthenthe researchbase for those therapies.

The next step to designing an RCT is to determine the independent variable (the intervention that will be used) and the dependent variable (the outcome the researcher would like to observe). The intervention may be individual cognitive-behavioral play therapy, group CCPT, filial therapy, or many other possibilities. Dependent variables may include child’s level of depression, anxiety, externalizing behaviors, and so forth. The dependent variable needs to be an outcome that can be measured in some way, allowing for repeated measures (e.g., pre-/posttest).
After determining the intervention and points of measurement, it is important to select a sample of participants. When selecting a sample, participants should be children who best represent the greater population being studied (Kendall, Comer, & Chow, 2013). For example, if a researcher wants to examine anxiety in preschool children, it would be important to recruit children spanning all ages of preschool who are anxious. Having a representative sample (that reflects the greater population of children to whom conclusions will be applied) allows researchers to generalize results beyond the children who were utilized in the study. An additional consideration in choosing a sample is diversity of the sample (Kendall et al., 2013). Study results can only be generalized to the greater population that was sampled (i.e., if all children in the study were of Latino heritage, the results cannot be assumed to be true for children who are African American).

After deciding the population from which the sample will be drawn, the next step is to determine the number of participants needed. Many researchers use an a priori power analysis to determine necessary sample size. A priori means the power analysis is conducted prior to beginning the research project, and is considered a more stringent practice (Kraemer, 2013). Power analyses help to ensure accuracy of results. Power is the probability the researcher will find statistical significance when a difference actually exists, helping combat the inherent flaws in null hypothesis statistical testing. Calculating a power analysis and having a high-powered study allows researchers to have more confidence in their results and ensures they will detect an effect if an effect is truly present. Power analyses take into account desired effect size, alpha level, the statistical analysis being used, number of variables, and sample size. Typically, power analyses are used to determine sample size. Play therapy researchers conduct power analyses with the following considerations: high power, moderate effect sizes, and a fixed alpha, leaving number of variables, analysis, and sample size to be flexible. However, the more variables that are measured, the more participants are needed. Furthermore, different statistical analyses produce the need for different sample sizes.

Following the aforementioned steps, participants will need to be recruited and consent will need to be obtained. Participants complete the pretest measure prior to the initiation of the intervention phase. The participants who meet criteria for the study and give consent to participate are randomized into the two groups, either participating in intervention or a wait-list control group. Then the intervention phase can begin, with participants in the treatment group receiving the intervention and the participants in the waitlist control group not receiving the intervention. At the end of the intervention period, both groups are administered the same assessment they were given at pre-test to determine the change that occurred over time.

The researcher conducts a treatment fidelity check to ensure the treatment was implemented as intended and the results are valid. Treatment fidelity is a way of determining how closely facilitators adhered to the treatment manual. Typically, play therapy researchers review session recordings and use some level of measure to determine the therapist’s adherence to the protocol. For example, CCPT manual protocol suggests the use of the play therapy skills checklist (Ray, 2011), a checklist of categories of responses that align with the CCPT protocol, to determine percentage of adherence to CCPT implementation. Researchers select a percentage of sessions to review and calculate whether therapists adhered to the protocol above a predetermined set percentage point. If play therapy was not delivered in compliance with the manual, the researcher removes data related to that therapist or addresses this lack of adherence as a limitation of the study, weakening the results.

After the completion of data collection, data is analyzed through statistical methods, typically through data software programs. Finally, the wait-list control participants are provided with treatment after posttest assessments are collected.
Steps for Conducting an RCT

1. Determine intervention and desired effect.
2. Determine sample and sample size.
3. Recruit participants/obtain consent.
4. Administer pretest.
5. Randomize participants into treatment and control groups.
6. Provide intervention.
7. Administer posttest.
8. Check treatment fidelity.
9. Analyze results.
10. Provide treatment for control group.

RCT Play Therapy Examples

Schottelkorb, Doumas, and Garcia (2012) conducted a stringent RCT comparing CCPT and trauma-focused cognitive behavioral therapy (TF-CBT) with traumatized refugee children. This study was the first RCT conducted comparing CCPT with an empirically supported treatment, promoting CCPT as an empirically supported intervention. Although the sample size was small for the study ($n = 31$), the stringent design and comparison against an already established treatment provided evidence of CCPT's effectiveness with traumatized refugee children beyond a simple pilot study. The implications that can be drawn are more meaningful based on this comparison with an already established intervention.

Another example of an RCT utilizing play therapy was conducted by Stulmaker and Ray (2015) comparing CCPT to an active control group with children who are anxious. This study had 53 participants, making it a large and highly powered RCT. Because of the high power of this design, the results can be trusted more than lower powered studies. Children who received play therapy had statistically significantly lower scores, with moderate to large effect sizes, on an anxiety measure after receiving treatment when compared to children who were in the active control group. Due to the rigorous design of this study on anxiety, the only study in the field of play therapy specifically designed to measure general anxiety in young children, causal implications were concluded demonstrating participation in play therapy reduced anxiety.

These RCT examples highlight the complicated nature of RCTs and the effect these stringently designed studies can have on the field of play therapy. By conducting RCTs properly, play therapy can be viewed as an effective intervention by other professionals and consumers of mental health services. This promotion of play therapy can increase the accessibility of treatment and the support from funding sources for conducting play therapy.

RCT Necessary Resources

RCTs require a large sample size for intervention research in order to have adequate power. Large samples allow research studies to be highly powered, allowing for more confidence in the obtained results. In addition, the number of variables being measured and the type of analysis will influence the sample size needed. Therefore, researchers may need access to many children who meet study criteria and are in need of a particular intervention. A large number of child participants in a play therapy study necessitates the involvement of multiple therapists to conduct sessions. In addition, pre- and posttest measures are utilized for each participant. Therefore, researchers need access to standardized assessments that are often costly.

In addition to practical considerations, researchers need to have an understanding of basic research and statistical knowledge. RCTs are quantitative designs, signifying their analyses will
include statistics. At a minimum, the researcher benefits from knowledge of analysis of variance (ANOVA) and knowledge of data analysis software programs. Researchers who are well versed in more complex statistical analyses have the ability to design more intricate quantitative studies that increase the understanding of play therapy effectiveness.

**Common Obstacles**

Barriers to conducting RCTs typically include access to resources such as participants, therapists, and assessments. RCT designs need large samples, which are difficult to obtain in intervention research. Oftentimes, clinicians do not have access to a large population from which they can draw their samples. A substantial barrier to performing RCTs is the ability to randomize participants. Participants for RCTs are frequently recruited slowly and over time, which prevents randomization from occurring at one time. Researchers engage in block randomization and other creative methods to ensure randomization procedures. In addition, for a high-powered RCT, the researcher will need a large number of therapists to facilitate play therapy. Outside of a research environment, it is often difficult to recruit therapists who are well trained and agree to follow specific research protocols. The need for a large sample and randomization of participants ensures the stringency of an RCT, yet also negatively impacts the practicability of such a design.

**RCT Modification: Small Trial Pilot Designs**

Often, play therapy researchers do not have adequate resources to support the implementation of a large-scale RCT. Barriers to rigorous RCTs include a large number of participants to provide adequate statistical power, recruitment, randomization procedures, treatment fidelity, and enough play therapists to provide treatment. However, Gallo, Comer, and Barlow (2013) encourage the use of small pilot trial designs. Small pilot RCTs are conducted with similar rigor, yet they do not require the same level of power needed for a traditional RCT. Pilot trials provide essential evidence regarding viability and effectiveness of treatment with small numbers of participants. Gallo et al. (2013) cited the following functions of small pilot studies: (a) they provide preliminary information on the feasibility and acceptability of the experimental treatment; (b) they provide preliminary indication of the effectiveness of treatment; and (c) they provide preliminary information on the feasibility and acceptability of the research design itself. Small pilot RCTs can help researchers identify challenges to the research study prior to the implementation of a large-scale RCT. In addition, small pilot studies provide observation and analysis of play therapy variables that may need modification prior to conducting a large-scale RCT.

Ray, Stulmaker, Lee, and Silverman (2013) conducted a small pilot RCT with 37 children identified with reported levels of functional impairment. The specific purpose of using a small pilot for this study was to provide evidence regarding the impact of CCPT on impairment, a construct that had not been previously explored in play therapy research. In addition, the authors used results to speculate on theoretical implications of treatment regarding its interaction with child functioning. Data and conclusions from the study were used to provide pilot data for a grant proposal to support a large-scale RCT. Researchers are careful to avoid making definitive conclusions from small pilot RCTs that support a specific intervention, as they serve only as preliminary evidence of a treatment’s efficacy.

**Quasi-Experimental Group Designs**

Nonrandomized comparison group designs are almost identical to RCTs, except participants are not randomized into their groups (Bryman, 2008; Creswell, 2009). In a nonrandom comparison group research design, participants are typically assigned to a group out of convenience and not
through randomization. For example, a nonrandomized comparison group study might place the first 15 participants who sign up for the study into the treatment group while placing the following 15 participants in the control or comparison group. Nonrandom comparison group designs are a type of quasi-experimental design. They are considered less stringent designs than RCTs due to the lack of randomization of participants and, therefore, the lack of comparability of groups (Bryman, 2008; Rubin & Bellamy, 2012). Lack of randomization allows for the possibility that groups could start at different levels on the variable of interest (e.g., the first 15 participants may be more motivated to participate because they are more depressed than the second set of 15 participants). Steps such as preliminary statistical analyses or matching participants may be taken to ensure comparability of groups without random assignment, and these are detailed in Rubin and Bellamy (2012).

**Quasi-Experimental Procedures**

The following procedures indicate the steps necessary for a basic nonrandom comparison group design. Similar to RCTs, nonrandom comparison group designs can utilize multiple groups and comparisons; however, in this example, one treatment and one control group are used.

The first step to initiating a nonrandom comparison group design is to determine the independent variable (the intervention that will be used) and the dependent variable (the outcome that will be observed). When considering an intervention in this design, it is important to consider access to a sample from the population and the setting in which research will be conducted. It may be helpful to determine what established groups already exist in the research setting, such as clients who enter treatment and those on a waitlist.

Once these variables have been addressed, participants will need to be recruited and consent obtained. Participants will complete the pretest measure prior to the initiation of the intervention phase. Participants may be in an established group or may intentionally be assigned to one group over the other. The intervention phase begins and participants in the treatment group receive the intervention while those in the wait-list control group do not receive any treatment. At the end of the intervention period, both groups are administered the same assessment they were given at pretest to determine the change that occurred over time. After all data is collected, it is analyzed through statistical methods, typically with a database software program. Finally, the wait-list control participants are also provided with treatment after posttest assessments are collected.

**Steps for Conducting a Nonrandom Comparison Group Design**

1. Determine intervention and desired effect.
2. Recruit participants/obtain consent.
3. Administer pretest.
4. Provide intervention.
5. Administer posttest.
6. Analyze results.
7. Provide treatment for control group.

**Quasi-Experimental Play Therapy Examples**

Quasi-experimental comparison group designs tend to be rare in play therapy research due to the preference to randomize participants and complete a RCT. However, Ray, Blanco, Sullivan, and Holliman (2009) conducted a quasi-experimental play therapy study with aggressive children in elementary schools. In their study, 41 children were placed into the play therapy group or
wait-list control group for the treatment phase. The researchers did not randomize participants due to the schools’ request to accommodate referred children as soon as possible. Children who were referred first were assigned to the play therapy intervention, and children who were referred later were assigned to the control group. The researchers chose to place clinical concerns over strength of the research study in this example, weakening the stringency of design but also serving clients based on therapeutic need. Although this research study was less stringent, conclusions can still be drawn regarding the effectiveness of play therapy with children who are aggressive. Limitations include the ability to say with certainty that the two groups were equal, allowing for the possibility the play therapy children were more aggressive at initiation of the study and improved over time rather than attributing change to the therapeutic intervention.

**Quasi-Experimental Necessary Resources**

In order to conduct a nonrandomized comparison group design, many resources are necessary. Similar to RCTs, a large sample size is required for group intervention research in order to have enough participants for each group. Therefore, researchers need access to many children who meet similar thresholds on the dependent variable and are in need of a particular intervention. Multiple counselors are also necessary in order to serve all of the participants; however, a system may already be in place to address this issue when utilizing this design (e.g., comparing current clients with wait-list clients in an agency setting). Additionally, pre- and posttest measures are utilized for each participant. Therefore, researchers need access to assessments.

In addition to practical considerations, researchers need to have an understanding of basic research and statistical knowledge. Nonrandomized comparison group designs are quantitative designs, meaning their analyses will include statistics. At a minimum, knowledge of analysis of variance (ANOVA) is necessary, in addition to knowledge of statistical software programs.

**Common Obstacles**

The most challenging obstacle to utilizing a nonrandomized comparison group design is obtaining a large enough sample, which is frequently difficult in intervention research. Often, clinicians do not have access to a large population from which they can draw their sample. Obtaining large enough samples may be easier in agency versus private practice settings that may not have the number of counselors or clients to support these comparative group designs.

**Single Group Pre/Post Designs**

The history of intervention research demonstrates that participants selected because they meet psychological threshold criteria often improve naturally over time. This particular phenomenon is referred to as maturation (Rubin & Bellamy, 2012), and it serves as a threat to the validity of research findings. RCTs control for maturation by comparing a randomly selected experimental group to another comparison or control group. If one group improves over another group at a statistically significant level, it is concluded the experimental group did not improve solely due to the passage of time but change can be attributed to the intervention. Single group designs employ the examination of one group of participants during intervention and typically utilize a pretest/posttest instrument to measure change. In single group pre/post designs, there is no control for maturation and hence, there can be no causal assumption that change is due to intervention. Single group designs are considered weak in regard to their contributions to empirically supported research. However, single group designs can contribute support by offering evidence the intervention can be implemented in a viable way and exploring the use of research protocol to determine if changes are needed prior to use in a comparison design. Baggerly (2004) used a single group
design to examine the use of group play therapy in a homeless shelter with 42 children. Results revealed significant improvement in self-concept, significance, competence, negative mood, and negative self-esteem related to depression and anxiety. Although Baggerly was unable to conclude group play therapy was an effective intervention due to the lack of a comparison group, it can be concluded the intervention and research protocol were feasible matches for a homeless shelter, an environment that can be difficult to control for research implementation.

Mediators and Moderators Outcome Designs
Research to investigate the mechanisms that promote change can deepen understanding of play therapy interventions. Mediators and moderators are mechanisms of change that begin to explain why therapy works, with mediators describing the process of change and moderators describing characteristics influencing the level of change (Kazdin & Nock, 2003). Many researchers have stressed the importance of assessing mediators in intervention research, insisting this investigation is likely the best short- and long-term investment for improving clinical practice and client care (Kazdin & Nock, 2003).

An understanding of preexisting conditions that predict intervention outcome and how interventions work for subgroups of people improves clinical practice and training. This understanding is geared toward investigating moderators, the characteristics or variables related to the client, therapist, or other inherent and concrete aspects of counseling (such as treatment format) that influence change outcome. Understanding moderators within therapy can ascertain which clients will benefit most from which treatments (Kazdin & Nock, 2003; La Greca, Silverman, & Lochman, 2009).

Investigating mediators is a recommended practice that rarely occurs in play therapy research (Baggerly & Bratton, 2010; Kazdin & Nock, 2003; La Greca et al., 2009; Phillips, 2010). Mediators are the cause or process of change that occurs in a phenomenon (Baron & Kenny, 1986; Holmbeck, 1997; Kazdin & Nock, 2003). In counseling outcome research, mediators are the reason why change occurs. For example, in a hypothetical play therapy RCT, a study concluded play therapy was the causal agent in reducing children’s scores on externalizing behavior. Although knowing that the intervention resulted in decreased scores is important, understanding the reason for the change by examining mediators can inform future play therapy interventions.

Investigating mediators of change can enhance research and practice. Mediators help in ranking best treatment practices. If a component of counseling is a mediating factor of change, therapies containing that factor should be utilized more than therapies that do not. Mediators can optimize therapeutic change by focusing practice and training on the mediating variables. Understanding which variables mediate change can help narrow moderators of change. Target populations can be identified and treatment can be matched more easily to these populations. In a traditionally structured RCT that does not explore mediators or moderators of change, it is difficult to ascertain the component of therapy leading to change, such as the age of the child (moderator), strength of the therapist–child relationship (mediator), or amount of time spent in free play (mediator).

Mediator/Moderator Procedures
Baron and Kenny (1986) included a detailed account of how to assess mediators and moderators in intervention research depending on the design and variables utilized in the research. When assessing mediators and moderators, single group designs can be used, making the examination of these mechanisms of change easier to conduct. However, the statistical analyses and conceptual understanding necessary to perform these investigations requires a high level of statistical
knowledge, including multivariate statistics and methodological understanding. It is beyond the scope of this chapter to provide an in-depth description regarding mediators and moderators.

**Mediator/Moderator Play Therapy Example**

Very few play therapy studies have addressed the examination of mediators and moderators in play therapy. Stulmaker (2014) explored the role of the therapeutic relationship in play therapy as a mediator in reduction of anxiety symptoms. We recommend play therapy researchers begin to investigate mechanisms of change to strengthen the research base of play therapy (Baggerly & Bratton, 2010; Phillips, 2010). Mediators and moderators can be incorporated into research to determine inherent characteristics (such as age, sex, race/ethnicity, etc.) influencing change and the aspects of play therapy (relationship, toys, responses, etc.) that are most facilitative of the change process.

**Mediator/Moderator Necessary Resources**

In order to explore mediator and moderator effects, researchers must understand complicated statistical analyses, such as multiple regression, structural equation modeling, path analysis, and discriminant analysis. A thorough understanding of research methodology, assessment, and mechanisms of change is also necessary in order to successfully design a study to assess the role of mediators or moderators.

**Common Obstacles**

Although play therapy research demonstrates the effectiveness of play therapy, researchers have largely ignored the examination of mechanisms of change within play therapy. The complicated nature of these methodologies and necessity for larger sample sizes may be obstacles to conducting this type of research. Play therapists would benefit from attaining advanced statistical knowledge in order to conduct research on the role of mediators and moderators in therapeutic change.

**Single-Case Experimental Designs (SCED)**

SCED is a type of research used to demonstrate experimental control within a single case and rigorously evaluate intervention with one or a small number of cases (Kazdin, 2011). This single case can be an individual person, a family, or a group of individuals (Morgan & Morgan, 2009). These designs are often known as \( n = 1 \), single-subject, small \( n \) designs, or SCEDs. Experimental control is established in single-case designs by using the individual case as its own control. Thus, in a single-case experiment, all conditions are kept the same, except for the independent variable (i.e., play therapy) that is introduced and then withdrawn to see the effects on the participants’ behavior. SCEDs typically involve multiple participants in order to determine replication of effectiveness. Gallo et al. (2013) proposed research designs that examine individuals offer greater understanding of mechanisms of change in treatment. Researchers are quick to distinguish SCEDs from case studies (Kazdin, 2003; Morgan & Morgan, 2009). Case studies provide information about relationships between conditions and are helpful in understanding an individual client (Morgan & Morgan, 2009). However, in case studies, variables are not manipulated and repeated measures data are not collected and analyzed; thus, strong conclusions about cause and effect cannot be determined.

SCEDs offer variation for implementation. The most basic design, the reversal design or the ABA design, requires a baseline (no-intervention) phase (A), followed by a treatment phase (B), and it ends with a return to a no-intervention phase (A). In the ABA design, researchers assess
for change from the baseline phase to the intervention phase. In the final A withdrawal phase, the researcher ceases intervention and continues to assess the targeted behavior. In the more stringent ABAB design, intervention is repeated again following withdrawal phase of intervention. ABAB is considered a more rigorous and interpretable design because it can provide stronger evidence the target behavior is affected by intervention. The SCED widely considered the most contributory to evidence-based practice is the multiple baseline design. Multiple baseline studies involve three possible applications, including measurement of two or more targeted behaviors for one participant, a target behavior across two or more settings, or the same target behavior across multiple participants.

Kazdin (2011) cited three essential features of all SCEDs, including continuous assessment, baseline assessment, and stability of performance. Continuous assessment requires the researcher conduct repeated observations of the participant’s behavior over time. The single case researcher identifies a target behavior that serves as the outcome variable for assessment. Frequent assessment or observation of the target behavior allows the researcher to determine the impact of treatment on the identified behavior. In play therapy research, the target behavior may be an emotional variable assessed by a caregiver or teacher report, such as anxiety symptoms, or may be an externalized observed behavior, such as incidents of aggression over a week. Baseline assessment involves the measurement of the target behavior of a child across the time period prior to intervention. Researchers use the baseline phase to observe and define a preintervention level of performance, providing the researcher with information about the extent of the identified problem and determining the stability of the target behavior without intervention (Ray & Schottelkorb, 2010). The third feature of SCED is the stability of performance within phases. Stability of performance is indicated by an absence of a trend or slope in the data and little variability in the assessment of the target behavior (Kazdin, 2011). A stable baseline signifies the child’s behavior is not improving on its own, and it will provide evidence of change during the intervention phase. Although SCED researchers recommend a minimum of three data points are collected for the baseline phase (Kennedy, 2005), they also recommend data be collected until the baseline data are fairly stable (Morgan & Morgan, 2009).

**SCED Procedures**

Ray and Schottelkorb (2010) suggested the following steps for SCED implementation:

1. **Identify target behavior (dependent variable).** The goal is to identify symptoms or behaviors that may be affected by a play therapy intervention and allow for measurement of change.
2. **Identify subject(s).** Although single case by definition requires only one participant, identification of multiple participants is encouraged to ensure completion of a full single-case design and to allow for the possibility of conducting a stringent multiple baseline study. Participants should meet criteria related to the dependent variable, indicating treatment for the targeted behavior is needed.
3. **Choose a measurement/instrument.** In order to address the dependent variable adequately, the play therapy researcher identifies an assessment measure that will dependably assess change. The instrument should meet acceptable guidelines for reliability and validity as well as allow for measurement of the targeted behavior. The measurement must allow for multiple administrations within a short period of time. Because data will be collected over multiple points and typically over a short period of weeks or months, the instrument must be valid if administered often.
4. **Define a play therapy treatment protocol.** The play therapy researcher clearly describes the play therapy intervention including philosophy, methods, techniques, order of delivery,
therapist qualifications, materials, and setting. Preferably, the play therapy researcher is following a manualized version of a play therapy intervention. However, if no manual is available, the play therapy researcher will need to develop details related to the utilized intervention (Ray & Schottelkorb, 2010).

5. **Define a design phase protocol.** The play therapy researcher selects a phase protocol to follow for the study. ABA, ABAB, and multiple baseline, among others (see Kazdin, 2011), are possible options for play therapy studies. Prior to the study, the play therapy researcher outlines the amount of time delegated to each phase and what intervention will be implemented at what intervals throughout the phases. Due to the importance of stability within phases in single-case design, phase length may be altered to allow for the measured behavior to stabilize.

6. **Establish a baseline.** The baseline phase is initiated to document the type of behaviors demonstrated by the child over time when no intervention is implemented. Three data collection points are recommended as the minimum number of observations (Kennedy, 2005). However, because stability in child behavior tends to be difficult to attain, play therapy studies may require longer baseline phases.

7. **Implement phase protocol and measure at multiple observation points.** The researcher is now ready to start the study. Data collection points will be frequent, such as weekly, biweekly, or daily.

8. **Data analysis.** For data analysis, single-case researchers typically conduct visual analysis of the data through the level, trend, and variability. The *level* is the mean of the phase; the *trend* is the slope of the data; and the *variability* is the amount of difference between the trend and each individual data point within a phase. Analysis also includes examination of between-phase patterns, including assessment of overlap, which involves exploring the proportion of data in one phase that overlaps with data in the previous phase. Low overlap indicates a larger effect of treatment (Kratochwill et al., 2012). Finally, inspection of the immediacy of effect provides information on how quickly the intervention took effect as evidenced by change in data patterns following phases of withdrawal. Although effect size estimations are applied to single-case data, there is little consensus on what estimations are the most credible (Kratochwill et al., 2012). Parker, Vannest, and Davis (2011) provided a review of effect sizes typically used in single-case analysis, citing the strengths and weaknesses of each statistic.

**Common Obstacles**

Ray and Schottelkorb (2010) cited several challenges in the implementation of single-case design for play therapy, including attaining stability of child behavior, identification of appropriate measures, and use of manualized protocol implementation. The behaviors and moods of young children are often difficult to capture through traditional forms of observation and measurement. In addition, childhood behavior is often unpredictable and can be erratic from day to day. Yet, one of the central features of single-case design is establishing a stable baseline prior to treatment. For successful completion of an SCED in play therapy, we suggest researchers be prepared to extend phase periods to establish stability of the targeted behavior. Extension of phases may be problematic if the researcher is working from a rigid timeline or the child’s behavior indicates the need for immediate intervention. The play therapy researcher will have to balance these conditions with the need for stable data points. Second, the play therapy researcher may find it difficult to identify appropriate measurement instruments. The instrument should allow for multiple points of data collection, demonstrate appropriate levels of reliability and validity, measure the targeted behavior, and preferably rely on unbiased report/observation. The researcher should expect the search
for a usable instrument to take time and should plan accordingly. Finally, there is a historical lack of description of play therapy intervention in research (Bratton, Ray, Rhine, & Jones, 2005). In order for SCED to be considered in the empirically supported intervention movement, such rigor demands a continued concentration on providing manualized descriptions of interventions (Ray & Schottelkorb, 2010). Play therapy researchers will need to provide detailed descriptions of play therapy intervention in order to meet the necessary rigor for SCEDs.

**SCED Play Therapy Examples**

There are several examples of rigorous SCEDs in the published literature on play therapy. Schottelkorb and Ray (2009) conducted an SCED with four children identified as meeting criteria for attention-deficit/hyperactivity disorder (ADHD). Using classroom observations for on-task behaviors, researchers found two children responded with a substantial reduction and two demonstrated a questionable reduction in off-task behaviors after participating in a play therapy/teacher consultation intervention. Swan and Ray (2014) applied an SCED design to a study of the effect of play therapy on problem behaviors of two children identified with an intellectual disability. They found play therapy was very effective for both children in reducing problem behaviors. Although these studies represent a growing trend of rigor in the application of SCED to play therapy research, we encourage play therapist researchers to increase their use of SCEDs to examine the effects and process of play therapy with individual children.

**QUALITATIVE RESEARCH DESIGNS**

The empirical support focus in intervention research commonly dominates the research landscape, often minimizing the contribution of qualitative studies to the practice and understanding of therapy. Qualitative research on therapeutic intervention is the study of therapy in context (Hays & Singh, 2012) and provides a way of knowing that acknowledges the intersubjectivity of the therapeutic experience (Glazer & Stein, 2010). Nathan and Gorman’s (2007) structure of examining the effectiveness of treatments does not include an address of qualitative research, while Rubin and Bellamy (2012) place the impact of qualitative research in the least contributory category. Kazdin (2003) noted that some scientists view quantitative methodology as the only approach to research. However, qualitative research provides a unique perspective on the complexity of the therapeutic experience. Qualitative designs examine research questions about the “how” or “what” of therapy (Hays & Singh, 2012), magnifying the process of how therapy works and what occurs during therapeutic intervention. Qualitative research provides information on what is happening during therapeutic intervention, a question unanswerable through quantitative methods. Glazer and Stein (2010) asserted qualitative research is the natural extension of the play therapy process and “qualitative inquiry is the way we want to engage with those who can share their experiences and thoughts on issues in play therapy” (p. 55).

The early qualitative work of Clark Moustakas (1953, 1955; Moustakas & Schalock, 1955) examined therapeutic processes taking place in play therapy. Moustakas became one of the leading figures in phenomenological research (Hays & Singh, 2012), developing methods of inquiry that led to a greater understanding of the play therapy relationship and how children progress through play therapy. Moustakas observed and transcribed thousands of play therapy sessions, then analyzed and coded copious amounts of data to construct an elegant yet accessible understanding of the play therapy process. Qualitative research has continued to thrive in the field of play therapy; however, the majority of studies concentrate on the therapist’s experience of the play therapy relationship. Glazer and Stein (2010) encouraged play therapists to use qualitative
research to build an understanding of the process and relationships in therapy in order to construct models and theories of change within play therapy.

**Traditions and Approaches in Qualitative Research**

Hays and Singh (2010) noted five clusters of research traditions in qualitative design. Each tradition includes approaches that fit the philosophical framework of that grouping. Cluster 1 is the universal tradition and includes the case study approach to research. Snow, Wolff, Hudspeth, and Etheridge (2009) noted the importance of case studies to in-depth understanding of specific types of problems or populations in play therapy. In reviewing case study literature and criteria, Snow et al. (2009) applied the following guidelines to determining the rigor of a case study: (a) The purpose of the case study must be made clear; (b) the literature review supports the purpose of the study by comparing similar cases; (c) the literature review supports the purpose of the study by defining the object of interest within the bounded systems; (d) case study approach is defined; (e) data collection is described; (f) participants, setting, and relevant information are described; (g) role of researcher is defined; (h) narrative description of events are included; (i) key issues of the case are addressed in the results; (j) results are described in context of the purpose of the study; and (k) the conclusion indicates contribution to play therapy effectiveness. Ryan and Madsen (2007) analyzed a case study through the process of working with a family who adopted a young male who had been abused. The researchers followed the family over a year through their participation in filial family play therapy and after, finding a positive influence of play therapy. This particular study met all criteria presented by Snow et al. (2009).

Cluster 2 tradition posed by Hays and Singh (2012) includes qualitative approaches highlighting experience and theory formulation. This cluster includes grounded theory, phenomenology, heuristic inquiry, and consensual qualitative research, all approaches concentrating on discovery, direct experience, phenomenon, and subjectivity. Of these approaches, qualitative research in play therapy has been exemplified most frequently in grounded theory and phenomenology. Grounded theory approaches search for theory behind the participants’ experiences in order to generate theory that expands understanding of the phenomenon. Bowers (2009) examined the development of the early relationship in nondirective play therapy by interviewing individual therapists about their experiences in the beginning of a play therapy relationship, observing sessions from these early relationships, and holding focus groups with therapists. Her study resulted in a grounded theory that identified relevant themes of early relationships in play therapy and how these themes facilitate the therapeutic process between child and therapist. Alternatively, the purpose of phenomenology is to explore the meaning of participants’ lived experiences (Hays & Singh, 2012). In order to understand the perceptions of African-American caregivers regarding play therapy, Brumfield and Christensen (2011) conducted a phenomenological qualitative study exploring the views of eight African-American caregivers. Initial interviews were conducted, recorded, and transcribed for the eight participants, and then follow-up interviews were conducted with three of the participants. Following phenomenological methods of data analysis, results indicated two themes regarding the caregivers’ perceptions of play and receptivity to counseling. These exemplary studies represent the need for qualitative methods in capturing nuances regarding process of play therapy and understanding specific populations served through play therapy.

The final three clusters represent rich traditions in qualitative research, yet they have been underutilized in play therapy research. The cluster 3 tradition (Hays & Singh, 2012) highlights the meaning of symbol and text and concentrates on language, symbols, story, identity, and context. Approaches in this cluster are symbolic interaction, semiotics, life history, hermeneutics, and narratology. Cluster 4 tradition attempts to capture cultural expressions of process and
experience, highlighting culture, engagement, participant observation, and fieldwork. This tradition includes ethnography, ethnomethodology, and autoethnography as approaches. Finally, cluster 5 addresses research as a change agent and includes the participatory action research approach that focuses on change of the context, researcher, and participants.

IMPLICATIONS FOR THE PRACTITIONER AND TRADITIONAL RESEARCHER

We close this chapter with a focus on the use of the aforementioned methodologies for traditional researchers and practitioners. Traditional researchers, typically found in university settings, have access to resources allowing for more stringent quantitative designs. We encourage researchers supported by these resources to conduct rigorous, experimental designs to promote credibility to the effectiveness of play therapy. Although experimental designs are not necessarily the most substantial studies or contributory to the understanding of play therapy, they are required for play therapy to be accepted by the evidence-based communities that use only quantitative statistics for decision making. All rigorously designed and implemented research studies positively affect the field because they provide information on the practice of play therapy. However, we suggest researchers may have different, yet equal, roles in the contribution of research to play therapy. Practitioners and researchers who have access to fewer resources may best contribute by selecting research designs that support play therapy through providing better understanding of the process. Practitioners can make substantial contributions to the field through the use of single case experimental designs, case studies, or qualitative approaches focusing on the therapeutic process.

We suggest the following recommendations to help practitioners become part of the research community:

- Partner with a traditional researcher, mostly likely affiliated with a university or academic setting. University faculty members often seek partnerships in order to have access to real-life therapeutic environments. Such a partnership benefits both parties by providing the researcher with client participants and providing the practitioner with design and analysis resources.
- Network within professional organizations to build research support. In organizations such as the Association for Play Therapy, many members are interested in research but often need a support system to initiate and implement designs, as well as to maintain enthusiasm throughout the process.
- Seek continuing education related to evaluation of client services and accountability procedures. Generally, workshops that focus on evaluation and accountability are using research methods to help practitioners provide evidence to support their practices. Many of these simple evaluation procedures, such as pre- and posttesting for clients, can be used to contribute to the play therapy research base.
- Seek continuing education related to research design and statistical analysis. Although practitioners may initially demonstrate little interest in these areas, workshops may sometimes spark enthusiasm when applied to real-life clients.
- Prepare clients to become part of the research base. Practitioners can begin conversations with clients at the initiation of therapy regarding the importance of measuring effectiveness of treatment or further understanding the process through additional interviews or measurements. When research feels safe and noninvasive, clients are more likely to participate, especially when they believe their experiences can help others. Practitioners
Methodologies Suited to the Study of Play Therapy 647

will need to address issues related to research in informed consent documents in order to disclose possible research procedures being used by the practitioner.

- Read research. In almost every issue of the *International Journal of Play Therapy*, quantitative and qualitative research is being published. Practitioners benefit from reading current research literature in their work with clients, and reviewing literature also initiates ideas regarding research that can be conducted in various settings.
- Consider research designs suited for clinical practice. Specifically, SCEDs, case studies, and other qualitative designs lend themselves to application in the practice setting.

CONCLUSION

Research in play therapy has progressed well over the last 80 years. Researchers within the play therapy community have responded to current standards by increasing knowledge and application of rigorous design and statistical procedures. Graduate students in play therapy are often exposed to research as an integral component of training to become a practitioner. The *International Journal of Play Therapy* continues to publish and disseminate the latest research in the field. However, there is still a need for research to move the field toward a greater understanding and provide support for play therapy. Quantitative approaches to research allow the examination of effectiveness of play therapy for a variety of presenting problems or populations of children. Yet, the field would benefit from more studies focusing on specific issues, such as diagnostic syndromes, conducted with the highest level of rigor applied to RCTs. In addition, quantitative methods should be utilized to determine change mechanisms in play therapy, such as the role of play, the therapist, the child, and the relationship. Researchers in play therapy have yet to apply complicated statistical designs to the understanding of change in play therapy. The exploration of mediators and moderators would serve the field by providing greater specificity to the factors that facilitate change in play therapy. Regarding less quantitatively based studies, the application of SCEDs, case studies, and qualitative designs to clinical practice contributes to a larger understanding of how play therapy works when applied to real-life clients. Practitioners can contribute to the empirical support of play therapy by allowing traditional researchers to partner with them in practice or by implementing smaller scale designs to offer in-depth exploration of play therapy. We emphasize there is a role for all experienced play therapists in the world of research, a role through which play therapists can contribute to the lasting and broad impact of play therapy.

REFERENCES


CHAPTER 35

The Empirical Support for Play Therapy: Strengths and Limitations

SUE C. BRATTON

The field of child therapy has changed dramatically since the publication of the first two volumes of the Handbook of Play Therapy (O'Connor & Schaefer, 1994; Schaefer & O'Connor, 1983). In a climate of managed health care and cost control, today's mental health professionals face increasing pressure to engage in evidence-based practice. In addition, play therapists are ethically bound by their professions (American Counseling Association, 2014; American Psychological Association, 2010; Association for Play Therapy, 2014; National Association of Social Workers, 2008) and are accountable to their clients to provide treatments for which there is sound evidence and for which they are adequately trained.

The increased emphasis on the use of empirically supported treatments (EST) with children (Chorpita et al., 2011; Weisz & Kazdin, 2010;) and the national focus on the shortage of services tailored to the growing number of children with a mental health disorder (Mental Health America, 2013; President's New Freedom Commission on Mental Health, 2003; U.S. Public Health Service, 2000) have been an impetus for an upsurge in research in the field of child psychotherapy, including play therapy. The thrust to disseminate information about ESTs for childhood disorders resulted in several prominent publications to guide professionals regarding interventions with evidentiary support (Baggerly, Ray, & Bratton, 2010; Chorpita et al., 2011; Kazdin & Weisz, 2003; Reddy, Files-Hall, & Schaefer, 2005; Russ & Niec, 2011; Silverman & Hinshaw, 2008; Weisz & Kazdin, 2010), although other than Baggerly et al. (2010), these sources have focused scant attention on play therapy interventions. Government agencies and professional groups have also created websites dedicated to publicizing information regarding ESTs for children (National Center for Education and Evaluation, 2014; Society of Clinical Child and Adolescent Psychology, 2014; Substance Abuse and Mental Health Services Administration, 2014); yet, again, play therapy interventions are grossly underrepresented despite seven decades of continuous research.
Despite the marked increase in focus on ESTs since 2000, the number of children who go untreated continues to increase (Centers for Disease Control, 2013; MHA, 2013; National Center for Children in Poverty, 2014). Estimates indicate that up to 20% of children have a diagnosable mental health disorder (MHA, 2013), and less than one-fourth of these children receive appropriate help (NCCP, 2014). One possible explanation is the lack of currently recognized ESTs responsive to the developmental needs of children (Weisz & Kazdin, 2010). Play therapy is recognized for its child-specific developmental and healing properties (Landreth, 2012; Schaefer, 2011), yet it is criticized for lack of empirical support (Phillips, 2009; Russ & Niec, 2011). The goal of this chapter is to address this misperception by providing an up-to-date review of the evidence base for play therapy, including strengths and limitations of the research. Through a comprehensive summary of contemporary play therapy studies meeting criteria for methodological rigor, this chapter provides researchers and practitioners with a guide to understanding and using play therapy’s considerable research base.

HISTORICAL OVERVIEW

During the 2000s, play therapy researchers have responded to the ongoing criticism that play therapy is not supported by sound scientific investigation (Baggerly & Bratton, 2010) by producing (a) comprehensive systematic reviews of outcome research (Bratton, 2010; Bratton, Landreth, & Lin, 2010; Bratton & Ray, 2000; Landreth, 2012; Ray, 2011; Ray & Bratton, 2010); (b) meta-analyses of controlled studies (Bratton, Ray, Rhine, & Jones, 2005; LeBlanc & Ritchie, 2001; Lin & Bratton, 2015; Ray, Armstrong, Balkin, & Jayne, 2015); and (c) increased stringent research (Center for Play Therapy, 2014).

According to Rubin’s (2008) evidentiary hierarchy, meta-analyses and systematic reviews of controlled outcome studies are two of the strongest methods for identifying empirically supported treatments. Independent research teams of LeBlanc and Ritchie (2001) and Bratton et al. (2005) reviewed five decades of controlled play therapy research published prior to 2001. In the largest meta-analysis of play therapy to date, Bratton et al. (2005) concluded from reviewing 93 controlled, outcome studies that play therapy, including filial therapy, demonstrated a large treatment effect of 0.80 for a broad range of childhood disorders and presenting issues, whereas LeBlanc and Ritchie reported an overall moderate treatment effect of 0.66 for the 42 studies reviewed. Both research teams reported parent involvement and duration of intervention were significant predictors of treatment outcome. Bratton et al. recognized the lack of scientific rigor inherent in early studies as a major limitation to their findings, and they recommended that future researchers adhere to stringent research design, methodologies, and reporting guidelines (Nezu & Nezu, 2008).

Two recent meta-analyses focused exclusively on treatment efficacy of contemporary child-centered play therapy (CCPT) outcome research and screened studies for methodological rigor. Lin and Bratton (2015) employed rigorous hierarchical linear modeling (HLM) methods to examine the overall treatment effect from 52 controlled outcome studies completed between 1995 to 2010. Findings revealed a statistically significant overall effect size of 0.47, indicating a moderate treatment effect for play therapy interventions following CCPT methodology, including filial therapy. Ray et al. (2015) reviewed 23 controlled studies evaluating effectiveness of CCPT conducted in elementary schools. Meta-analysis results were explored using a random effects model and results revealed statistically significant effects for outcome constructs including externalizing problems \( (d = 0.34) \), internalizing problems \( (d = 0.21) \), total problems \( (d = 0.34) \), self-efficacy \( (d = 0.29) \), and academic progress \( (d = 0.36) \).
Play therapy researchers have produced several comprehensive systematic reviews since 2000. Due to space limitations, only those published since 2010 are included. Ray and Bratton (2010) reviewed 25 experimental and quasi-experimental studies conducted between 2000 to 2009 in which play therapy was carried out by a mental health professional. The authors noted that, compared to their previous review of six decades of play therapy research (Bratton & Ray, 2000), methodological rigor and research productivity made significant gains in the 21st century. Bratton (2010) reviewed 51 school-based play intervention outcome studies published between 1990 to 2009 in which the intervention was conducted by a mental health professional (n = 30) or a specially trained and supervised paraprofessional (n = 21). Bratton reported 75% of the included investigations were conducted since 2000, which signified a 100% increase in the number of studies conducted in schools compared to the five decades prior. Three additional reviews focused on specific theoretical models of play therapy. Landreth (2012) and Ray (2011) included comprehensive research reviews focused exclusively on CCPT approaches in their respective texts and independently concluded that CCPT research demonstrates sound evidence for its use with a variety of childhood disorders. Landreth included 53 CCPT and CPRT studies conducted between 1995 to 2010, and Ray reviewed 62 CCPT studies conducted between 1947 to 2010. Bratton et al. (2010) offered a comprehensive review of 32 controlled investigations of the child–parent relationship therapy (CPRT, Landreth & Bratton, 2006) model of filial therapy published between 1995 and 2009 and concluded that, according to APA’s standards for ESTs (Silverman & Hinshaw, 2008), CPRT met criteria for “promising” or “probably efficacious” for several childhood presenting problems.

Several conclusions can be drawn from the meta-analyses and reviews regarding the efficacy of play therapy. Research supports play therapy’s use for a range of childhood disorders in real-world settings. Play therapy demonstrates beneficial effects in relatively few sessions (10–13 sessions on average) and appears to show stronger outcomes when caregivers are involved in treatment (e.g., filial therapy). Contemporary research demonstrates improved research rigor over the five previous decades, including larger sample sizes, use of manualized protocols and procedures to ensure treatment fidelity, as well as increased use of randomized assignment to treatment groups and standardized assessments of outcomes. In spite of the significant gains in the quantity and quality of play therapy research over the past decade, reviewers called for more stringent research methods and increased productivity in order to elevate the credibility of play therapy research.

CURRENT STATUS OF PLAY THERAPY RESEARCH

For the purpose of examining the strengths and limitations of contemporary play therapy research, I conducted comprehensive online and offline reviews of outcome research published since 2000 to identify studies that employed stringent methodology to measure the effectiveness of play therapy. Randomized controlled trials (RCTs) are generally considered the gold standard in determining treatment efficacy (Nezu & Nezu, 2008). With the objective of conducting a more rigorous analysis than had been applied to systematic reviews conducted thus far in this millennium, I decided to review only studies that used randomization to assign participants to treatment groups. I employed the following inclusion criteria to refine the search: (a) intervention was identified as play therapy; (b) intervention used a randomized, control group design; (c) participants were between 2 and 12 years of age; (d) studies were published since 2000; (e) studies were published in English in a peer-reviewed journal or book; (f) studies reported child outcome measures and used standardized assessments; and (g) studies employed and reported descriptive information on intervention. I initially found 118 studies whose abstracts appeared to meet criteria. After
reviewing 112 studies for which the full text was published in English, only 70 studies met the randomization requirement. The omitted studies used designs generally considered less rigorous (Nathan & Gorman, 2007) to measure play therapy outcomes, including nonrandomized control group, repeated measures single group, and single-case designs. Studies coded as using randomized group assignment included block and stratified randomization to control for extraneous variables such as school or location in the case of multiple research sites, classroom environment, and participants’ schedules.

An additional 46 studies failed to meet the remaining criteria, most notably the requirement for the intervention to be identified as play therapy. Consistent with previous meta-analyses and systematic reviews of play therapy research, I restricted studies to those that used the term “play therapy” to describe the experimental treatment and appeared to meet the definition provided by the APT. APT defines play therapy as “the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development” (APT, 2014). Due to filial therapy’s historical recognition as a play therapy intervention (Guerney, 1983; O’Connor & Schaefer, 1994), I included studies using filial therapy. Twenty-four studies that meet the criteria are summarized in Table 35.1. I coded studies according to theoretical model/intervention type and control group type. Intervention models included: nine individual CCPT, four group CCPT, eight child-centered filial therapy using the CPRT model, one individual Adlerian Play Therapy (AdPT), one group sandtray, and one unidentified play therapy model that used structured activities. There was a noticeable absence of research on other play therapy interventions traditionally used in child therapy, such as Gestalt, Jungian, Ecosystemic, Prescriptive, existential, experiential, cognitive-behavioral, and Theraplay® (O’Connor & Braverman, 2009; Schaefer, 2011). A noticeable improvement in 21st century research is the use of active controls (n = 7) and comparison treatments (n = 4) groups, although the majority of studies continued to compare play therapy intervention to no treatment (e.g., wait-list control/delayed start groups, n = 13).

In the case of studies that used duplicate participant data including follow-up studies, I reported only the original study data. All but two investigations reported treatment providers’ training, a significant improvement from Bratton et al.’s (2005) review. Except for CPRT studies in which paraprofessionals (i.e., parents, teachers, mentors) provided intervention under the direct supervision of a CPRT/filial therapy–trained play therapist (noted in Table 35.1), researchers reported treatment was provided by degreed play therapists or advanced play therapy students under the supervision of a professional play therapist. Studies were conducted in the United States of America unless otherwise noted. Only 3 studies failed to report the use of manualized protocols; 10 followed CCPT protocol (Ray, 2011), 8 adhered to CPRT protocol (Bratton, Landreth, Kellam, & Blackard, 2006), 2 followed group CCPT/activity therapy protocol (Ojiambo & Bratton, 2014), and 1 used AdPT protocol (Kottman, 2009). The majority of studies published since 2010 reported procedures for fidelity checks to ensure treatment integrity. Unless specified, active control and comparison groups participated in the same intensity and duration of intervention as the experimental group.

Due to the large number of participants (total of 1,014 with a mean of 42 participants per study), several conclusions can be drawn from reviewing the 24 outcome studies. Research indicated that participation in play therapy resulted in positive outcomes for externalized problems, disruptive behaviors, aggression, ADHD, internalizing problems, anxiety, academic achievement,

¹Theraplay is a registered service mark of The Theraplay Institute, Evanston, IL.
<table>
<thead>
<tr>
<th>Study</th>
<th>Intervention Model/Control Group Type</th>
<th>Sample</th>
<th>Child Outcome Variable/Target Problem</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baggerly and Landreth</td>
<td>Modified CPRT/WC</td>
<td>Behaviorally at-risk students (n = 29)</td>
<td>Internalized behavior problems; self-esteem</td>
<td>Compared to the WC, parents of experimental group children reported a statistically significant reduction in internalizing behavior problems. Parents also reported greater improvement in overall behavior problems and self-esteem for the CPRT group over the WC, but not at a statistically significant level.</td>
</tr>
<tr>
<td>(2001)</td>
<td>CPRT-trained fifth-grade mentors</td>
<td>Age: 5–6; M = 5.7, 76% Cauc, 14% AfAm, 10% Lat</td>
<td>Age: 5–6; M = 5.7, 76% Cauc, 14% AfAm, 10% Lat</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>58% male</td>
<td>58% male</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blanco and Ray (2011)</td>
<td>CCPT/WC</td>
<td>Academically at-risk 1st graders (n = 43)</td>
<td>Academic achievement</td>
<td>Compared to the WC, children in the CCPT group demonstrated statistically significant improvement on a standardized achievement test, which indicated an increase in children’s overall academic abilities. The treatment effect was in the medium range.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Age: M = 6.4, 46% Cauc, 34% Lat, 17% AfAm</td>
<td>Age: M = 6.4, 46% Cauc, 34% Lat, 17% AfAm</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>63% male</td>
<td>63% male</td>
<td></td>
</tr>
<tr>
<td>Bratton et al. (2013)</td>
<td>CCPT/AC</td>
<td>At-risk, low-income Pre-K students (n = 54)</td>
<td>Clinical disruptive behaviors</td>
<td>According to teachers who were blinded to treatment groups, CCPT demonstrated statistically significant improvements and large treatment effects on disruptive behaviors, attention problems, and aggression, compared to the AC (mentoring) group over three points of measure; 78% of children in CCPT moved from clinical levels of concern to more normative functioning following treatment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Age: 3–4; M = 4.1, 42% AfAm, 39% Lat, 18% Cauc</td>
<td>Age: 3–4; M = 4.1, 42% AfAm, 39% Lat, 18% Cauc</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>67% male</td>
<td>67% male</td>
<td></td>
</tr>
</tbody>
</table>

(Continued Overleaf)
### Table 35.1 (Continued)

<table>
<thead>
<tr>
<th>Study</th>
<th>Intervention</th>
<th>Description</th>
<th>Sample Characteristics</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| Carnes-Holt & Bratton (2014) | CPRT/WC | - 7 play sessions  
- 1/wk; 30 min  
- Community agency  
- *CPRT-trained parents | Adoptees (n = 61)  
- Age: 2.5–10; M = 5.7  
- 47% Cauc, 15% Lat, 9% AfAm, 18% other  
- 55% male | Attachment difficulties; clinical comorbid behavior problems | Statistically significant findings and large treatment effects on all measures indicated the effectiveness of CPRT over the WC on (a) reducing adopted children's externalized behaviors and global behavior problems, and (b) increasing parental empathy as measured by objective raters blinded to the study. |
| | | | | Clinical Comorbid Behavior Problems; | |
| | CPRT/WC | At-risk, low-income preK students (n = 48) | Age: 3–4; M = 4.3  
- 100% Lat  
- 56% male | Expressive Language; Receptive Language | Compared to the AC (speech therapy only), CCPT plus speech therapy demonstrated a large treatment effect on improving speech-delayed children's expressive language and a moderate treatment effect on receptive language; between group differences were not statistically significant. |
| Danger and Landreth (2005) | Group CCPT/AC (groups of 2) | Speech-delayed preK students (n = 21) | Age: 4–6; M = 4.9  
- 81% Cauc; 19% Lat  
- 86% male | | |
| | Fall, Navelski, and Welch (2002) | CCPT/WC | Special education students (n = 66) | Age: 6–10; M = 8.3  
- 98.5% Cauc  
- 64% male | Behavior & Social Problems | Teachers reported statistically significant decreases in children's problematic behaviors and social problems, but not in children's self-efficacy, for the CCPT group compared to the WC. Case manager ratings showed a significant decrease in anxiety for CCPT group, but not for the WC. |
<table>
<thead>
<tr>
<th>Study</th>
<th>Intervention</th>
<th>Participants</th>
<th>Comorbid Behavior Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flahive and Ray (2007)</td>
<td>Group sandtray/WC (groups of 3)</td>
<td>At-risk 4th–5th graders ((n = 56))</td>
<td>According to parent and teacher reports, the CCPT group demonstrated statistically significant improvement on externalizing problems, as compared to the WC group. Teachers also reported a statistically significant between-group improvement on the CCPT groups’ internalizing and total problems.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Age: 9–12</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>62% Lat, 9% AfAm, 28% Cauc</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>52% male</td>
<td></td>
</tr>
<tr>
<td>Garza and Bratton (2005)</td>
<td>CCPT/COMP</td>
<td>Behaviorally at-risk students ((n = 29))</td>
<td>According to parents who were blinded to children’s treatment group, culturally responsive CCPT demonstrated a statistically significant benefit (large treatment effect) on externalizing behavior problems compared to the COMP treatment (empirically supported manualized guidance intervention). CCPT demonstrated a medium beneficial treatment effect on children’s internalizing problems, although not a statistically significant difference. Cultural considerations were discussed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Age: 5–11; (M = 7.4)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>100% Lat</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>59% male</td>
<td></td>
</tr>
<tr>
<td>Jones and Landreth (2002)</td>
<td>CCPT/AC</td>
<td>Insulin dependent children ((n = 30))</td>
<td>According to parent report, children in the CCPT group demonstrated a statistically significant improvement in diabetes adaptation compared to the AC (diabetic camp activities). At follow-up, there was no statistical significant between group differences, but the CCPT group continued to show greater improvement. Both groups reported decreased anxiety and improvement in behavior problems.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Age: 7–11; (M = 9.4)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>87% Cauc, 3% AfAm, 7% Lat</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>57% male</td>
<td></td>
</tr>
<tr>
<td>Jones, Rhine, and Bratton (2002)</td>
<td>Modified CPRT/ COMP</td>
<td>Behaviorally at-risk preK–K students ((n = 26))</td>
<td>Parents who were blinded to children’s treatment group reported CPRT group children demonstrated a statistically significant decrease in internalizing and total behavior problems, compared to the COMP group, PALS®, which used a manualized curriculum. According to blinded raters’ direct observation, CPRT mentors demonstrated a statistically significant improvement in empathic interactions with their child of focus compared to PALS mentors.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Age: 4–6; (M = 5.4)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>96% Cauc</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>57% male</td>
<td></td>
</tr>
</tbody>
</table>

(Continued Overleaf)
<table>
<thead>
<tr>
<th>Table 35.1 (Continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meany-Walen, Bratton, and Kottman (2014)</strong></td>
</tr>
<tr>
<td>16 sessions</td>
</tr>
<tr>
<td>2/wk; 30 min</td>
</tr>
<tr>
<td>School</td>
</tr>
<tr>
<td><strong>Morrison and Bratton (2010)</strong></td>
</tr>
<tr>
<td>16 weeks</td>
</tr>
<tr>
<td>Daily center time play</td>
</tr>
<tr>
<td>Head Start school</td>
</tr>
<tr>
<td>*CPRT-trained teachers</td>
</tr>
<tr>
<td>10 sessions over 4 mo.</td>
</tr>
<tr>
<td>1 hr</td>
</tr>
<tr>
<td>Iranian community clinic</td>
</tr>
<tr>
<td><strong>Oijambo and Bratton (2014)</strong></td>
</tr>
<tr>
<td>16 sessions</td>
</tr>
<tr>
<td>2/wk; 30 min</td>
</tr>
<tr>
<td>Ugandan orphanage school</td>
</tr>
</tbody>
</table>
Packman and Bratton (2003) Group CCPT/WC (groups of 3)
- 12 sessions
- 1/wk; 1 hr
- School for learning differences (LD)

Students diagnosed with LD ($n = 24$)
- Age: 10–12; $M = 11.4$
- 92% Cauc; 4% Lat; 4% AfAm
- 75% male

Learning Differences; Comorbid Behavior Problems
According to parent report, group CCPT demonstrated medium to large treatment effects on all outcome measures compared to the WC. The CCPT group demonstrated statistically significant improvement on internalizing problems as well as overall behavioral functioning compared with the WC. Between-group differences were not significant for externalizing behaviors.

- 12–16 sessions
- 2/wk; 30 min
- School

Clinically impaired children ($n = 37$)
- Age: 5–8; $M = 6.3$
- 38% Lat; 32% AfAm; 30% Cauc
- 78% male

Functional Impairment
Phase I: CCPT demonstrated a medium treatment effect on children's functional impairment when compared to the WC, although between group differences were not statistically significant. Phase II (both groups received CCPT): Within-group difference indicated that children in both groups showed statistically significant improvement with large effect sizes as a result of CCPT.

Ray, Schottelkorb, and Tsai (2007) CCPT/AC
- 16 sessions
- 2/wk; 30 min
- School

Students with ADHD symptoms ($n = 60$)
- Age: 5–11; $M = 7.5$
- 35% Lat; 17% AfAm; 45% Cauc
- 80% male

ADHD
According to teacher report, the CCPT group demonstrated statistically significant improvement on student characteristics, emotional liability, and anxiety/withdrawal over the AC (mentoring) group. No significant between group differences were found on children’s ADHD symptoms. Post hoc within-group analysis revealed that both groups demonstrated statistically significant improvement in ADHD, student characteristics, anxiety, and learning disability.

Schottelkorb, Doumas, and Garcia (2012) CCPT/TF-CBT
- 17 sessions
- 2/wk; 30 min
- School

Refugees with trauma symptoms ($n = 31$)
- Age: 6–13; $M = 9.2$
- 67.7% AfAm; 16.1% Middle Eastern; 9.7% Asian; 6.5% Other
- 55% male

PTSD Symptom Severity
Results indicate both interventions, CCPT and TF-CBT (SCCAP evidence-based treatment for trauma symptoms), demonstrated a statistically significant reduction in PTSD symptom severity in a subset of study children who met stringent criteria for PTSD; findings indicate both treatments are equally effective for this population.

(Continued Overleaf)
Table 35.1 (Continued)

<table>
<thead>
<tr>
<th>Study</th>
<th>Intervention</th>
<th>Group/Control</th>
<th>Sample Characteristics</th>
<th>Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schumann (2010)</td>
<td>CCPT/COMP</td>
<td>Aggressive K–4th graders (n = 37)</td>
<td>Age: 5–12; M = 7.3, 38% Lat, 24.4% AfAm, 37.8% Cauc, 86% male</td>
<td>According to parent and teacher reports, both CCPT and the COMP group (Second Step®, a SAMHSA evidence-based treatment) demonstrated statistically significant improvements in aggression, externalized problems, and internalized problems. Results indicate the effectiveness of both interventions for children identified with aggressive behavior. Qualitative feedback from parents was more positive for CCPT.</td>
</tr>
<tr>
<td>Sheely-Moore and Bratton (2010)</td>
<td>CPRT/WC</td>
<td>At-risk, low-income pre-K students (n = 23)</td>
<td>Age: 3–5; M = 4.2, 100% AfAm, 62% male</td>
<td>Statistically significant findings and large treatment effects on all measures indicated the effectiveness of culturally-adapted CPRT over the WC on (a) reducing children’s global behavior problems, and (b) decreasing parent–child relationship stress. Cultural considerations discussed.</td>
</tr>
<tr>
<td>Shen (2002)</td>
<td>Group CCPT/WC</td>
<td>Children at-risk for maladjustment following earthquake (n = 30)</td>
<td>Age: 8–12; M = 9.2, 100% Taiwanese, 53% female</td>
<td>Compared to the WC group, the CCPT group demonstrated statistically significant decreases in their overall anxiety, physiological anxiety, worry/oversensitivity, and suicide risk. CCPT demonstrated large treatment effects on anxiety, worry, and oversensitivity and small to medium effect on reducing suicide risk.</td>
</tr>
</tbody>
</table>
Smith and Landreth (2004)  

**CTRT/WC**  
- 7 play sessions  
- 1/wk; 30 min  
- Preschool for deaf  
- *CPRT-trained teachers*

Deaf and hard of hearing pre-K children (n = 24)  
- Age: 2–6; M = 4.1  
- 33% Cauc; 42% Lat; 25% AfAm  
- 54% male

Behavior Problems; Social-Emotional Functioning  

Compared to the WC, (a) children whose teachers participated in teacher-adapted CPRT (CTRT) made statistically significant improvement in behavior problems and social-emotional functioning; and (b) CPRT-trained teachers demonstrated statistically significant gains in their empathic interactions with students according to direct observation by independent raters.

Yuen, Landreth, and Baggerly (2002)  

**CPRT/WC**  
- 7 play sessions  
- 1/wk; 30 min  
- Community agency  
- *CPRT-trained parents*

Behaviorally at-risk immigrants (n = 35)  
- Age: 3–10; M = 6.4  
- 100% Chinese Canadians  
- 54% male

Comorbid Behavior Problems; Self-Concept  

Compared to the WC, the CPRT group demonstrated statistically significant improvements in (a) child behavior problems, parent–child relationship stress, and parental acceptance according to parent report; and (b) parental empathy according to raters blinded to treatment groups. CPRT group children also reported greater gains in perceived competence and social acceptance.

Notes: Control group type denoted by WC = wait-list/delayed start control, AC = active control, COMP = comparison treatment; AfAm = African American; Asian = of Asian decent living in U.S.; Cauc = Caucasian/European American; Lat = Latino/Hispanic  

* Denotes play therapy intervention delivered by parent/teacher/mentor under direct supervision of a CPRT-trained play therapist.
Table 35.2 Cross-Reference of Table 35.1 Studies by Target Outcome Variables

<table>
<thead>
<tr>
<th>Child Outcome Variable/Target Problem</th>
<th>Studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internalized problems including anxiety</td>
<td>Baggerly and Landreth (2001); Ceballos and Bratton (2010); Fall et al. (2002); Flahive and Ray (2007); Garza and Bratton (2005); Jones and Landreth (2002); Jones et al. (2002); Morrison and Bratton (2010); Naderi et al. (2010); Ojiambo and Bratton (2014); Packman and Bratton (2003); Shen (2002)</td>
</tr>
<tr>
<td>Externalized problems including disruptive behaviors, aggression, ADHD</td>
<td>Bratton et al. (2013); Carnes-Holt and Bratton (2014); Ceballos and Bratton (2010); Flahive and Ray (2007); Garza and Bratton (2005); Meany-Walen et al. (2014); Morrison and Bratton (2010); Naderi et al. (2010); Ojiambo and Bratton (2014); Ray et al. (2007, 2009); Schumann (2010)</td>
</tr>
<tr>
<td>Comorbid/global behavior problems including functional impairment</td>
<td>Carnes-Holt and Bratton (2014); Fall et al. (2002); Flahive and Ray (2007); Jones et al. (2002); Packman and Bratton (2003); Ray et al. (2013); Sheely-Moore and Bratton (2010); Yuen et al. (2002)</td>
</tr>
<tr>
<td>Trauma/attachment/PTSD</td>
<td>Carnes-Holt and Bratton (2014); Schottelkorb et al. (2012)</td>
</tr>
<tr>
<td>Academic achievement/speech disorder</td>
<td>Blanco and Ray (2011); Danger and Landreth (2005); Smith and Landreth (2004)</td>
</tr>
<tr>
<td>Social-emotional functioning</td>
<td>Fall et al. (2002); Naderi et al. (2010); Smith and Landreth (2004)</td>
</tr>
<tr>
<td>Self-concept/competence</td>
<td>Baggerly and Landreth (2001); Yuen et al. (2002)</td>
</tr>
<tr>
<td>Diabetes adaptation</td>
<td>Jones and Landreth (2002)</td>
</tr>
<tr>
<td>Other Target Outcome Variables</td>
<td>Studies</td>
</tr>
<tr>
<td>Caregiver–child relationship stress</td>
<td>Ceballos and Bratton (2010); Sheely-Moore and Bratton (2010); Yuen et al. (2002)</td>
</tr>
<tr>
<td>Caregiver empathy</td>
<td>Carnes-Holt and Bratton (2014); Jones et al. (2002); Smith and Landreth (2004); Yuen et al. (2002)</td>
</tr>
</tbody>
</table>

speech problems, PTSD symptoms, social emotional functioning, self-concept, comorbid behavior problems, and functional impairment. Table 35.2 provides a cross-reference of studies by target outcome variables. The use of active control and comparison groups and procedures to blind assessors to participants’ treatment group assignment in several studies lends further credibility to findings regarding treatment efficacy for specific child outcomes.

Play therapy appeared effective across cultures including race, ethnicity, gender, and international status. The majority of the outcome studies included a diverse sample of ethnicities, and four studies were conducted with samples outside of the United States of America (Uganda, Taiwan, Iran, and Canada). Across the 20 studies conducted in the United States of America, over 60% of the participants were non-Caucasian (33.1% Latino, 17.7% African American, 7.2% Asian American, and 3.6% other), and the vast majority of participants were identified as low-income. Play therapy’s successful application across cultural groups is a unique feature of this intervention and is likely a factor of the large number of studies conducted in real-world settings primarily low-income schools (n = 19). Participants’ ages ranged from 2.5 to 12 years, indicating play therapy’s responsiveness to the developmental needs of young children through preadolescence. In view of the shortage of ESTs for young children (Weisz & Kazdin, 2010), it is important to note that over 50% of studies reported a mean age of 6 and younger. Consistent with child therapy literature regarding the two-to-one ratio of males to females referred for psychotherapy, participants across studies were 63% male.
Findings also indicate that play therapy can be used as short-term intervention. The number of play sessions ranged from 7 to 25, with a mean of 13 and a mode of 16. The most frequently occurring format was 30-minute sessions conducted twice per week over approximately 8 weeks to conform to the needs of the school setting. Only three studies reported greater than 17 sessions. These findings represent a noticeable discrepancy from the meta-analytic findings of Bratton et al. (2005) and LeBlanc and Ritchie (2001), who reported similar findings indicating an optimal number of sessions ranging from 30 to 40 sessions. In the case of CPRT/filial therapy studies, session number indicates the total sessions in which children participated in CCPT-based therapeutic play sessions with their caregivers (mean = 7). Unless otherwise specified, caregivers and mentors participated in 10 two-hour group training sessions in addition to conducting 7 play sessions with their child.

The majority of included studies did not report a parent or teacher component as part of intervention, indicating that children demonstrated change without a systemic intervention. Among ESTs recognized for children 5 years of age and younger, there is a dearth of interventions without requirement for full parent participation (SCCAP, 2014; Weisz & Kazdin, 2010). The finding that young children are capable of change in therapy without direct intervention with caregivers addresses the gap in ESTs with younger children and makes play therapy particularly suitable for school settings where parents can be difficult to engage in the therapeutic process. However, the findings from the eight CPRT/filial therapy studies included in the review along with meta-analytic research (Bratton et al., 2005; LeBlanc & Ritchie, 2001) suggest that inclusion of parents and teachers in play therapy, when clinically indicated, results in stronger outcomes and in fewer sessions than traditional play therapy.

Finally, several well-designed studies were omitted due to difficulty with randomization resulting from constraints of conducting research in real-world settings (e.g., Ray, Blanco, Sullivan, & Holliman, 2009; Shen, 2007). I also omitted RCTs that reported play therapy’s beneficial effects on constructs such as caregiver–child relationship (e.g., Lee & Landreth, 2003; Ray, 2007), because child outcomes were not also reported. Furthermore, I did not include RCT studies that incorporated a play component in treatment, but failed to identify intervention as play therapy. Specifically, excluded interventions include parent–child interaction therapy (PCIT; Eyberg, Nelson, & Boggs, 2008), incredible years (IY; Webster-Stratton, Reid, & Hammond, 2004), and child–parent psychotherapy (CPP; Lieberman, Van Horn, & Ghosh-Ippen, 2005). The omission of these interventions (PCIT, CPP, IY) was further supported by their absence in major contemporary texts on play therapy approaches (O’Connor & Braverman, 2009; Schaefer, 2011). The Center for Play Therapy (CPT) at the University of North Texas maintains a comprehensive online data base of play therapy research summaries. The reader is encouraged to refer to the CPT data base for summaries of play therapy outcome studies not included in Table 35.1 including nonrandomized controlled studies, repeated measures single group design studies, and experimental single-case (CPT, 2014). Additional resources for empirically supported, play-based interventions that did not meet the criteria established for this review include Reddy, Files-Hall, and Schaefer (2005; 2015) and Russ and Niec (2011).

**SUMMARY OF STRENGTHS AND LIMITATIONS**

The review of randomized controlled studies published in this millennium revealed strengths and limitations to play therapy’s evidentiary support. The significant increase in research production and rigor since 2000 is illustrated through the studies included in Table 35.1 and represents a significant leap in developing a sound scientific foundation for play therapy. Yet, researchers must...
continue to build an even stronger evidence base using current criteria for research design and methods that will lead to recognition of play therapy as an EST for specific childhood disorders. Various systems for evaluating study rigor exist (Chorpita et al., 2011; Nathan & Gorman, 2007; Nezu & Nezu, 2008). Nathan and Gorman’s (2007) six-level classification system is one of the most widely used in psychosocial research. Type 1 studies are considered most rigorous and employ a randomized clinical trial and adhere to stringent methodology. Such studies are characterized by the use of treatment protocols, treatment fidelity checks, active control or comparison groups, clearly identified inclusion and exclusion criteria, accepted diagnostic methods, blinded assessments, a priori power analysis to determine adequate sample size, psychometrically sound measurements, and clearly described statistical methods.

Increased use of randomized group assignment, specified inclusion criteria, adequate sample size, and clearly reported statistical methods are among the most noteworthy improvements in play therapy research thus far in the millennium. Although the past decade of research demonstrated an increase in comparison and active control groups to examine the effects of play therapy, a majority of studies compared play therapy to a wait-list control group and concluded that the treatment was superior to no treatment. Demonstrating play therapy’s effectiveness compared to a well-established child therapy (SAMHSA, 2014; SCCAP, 2014) would strengthen the evidence base for play therapy. In addition, using a comparison or placebo treatment as a control provides greater assurance that assessors can be blinded to participants’ group assignment, particularly when teachers and parents are the source of measurement. In general, lack of blinded assessments to assess target outcomes represents a weakness in the reviewed research.

Use of protocols allow for replication of the intervention by practitioners and researchers and are essential to establishing treatment fidelity. The good news is there has been a marked increase in the development and use of play therapy protocols. For several studies, procedures to ensure adherence to protocol were not described or were unclear. However, the majority of studies published since 2010 reported use of protocol checklists and random viewing of video-recorded play therapy sessions by an objective rater to ensure treatment integrity. The use of psychometrically sound measurements has improved over the past decade. Yet, to increase confidence in findings, it is crucial that researchers use multiple informants including well-trained independent raters to assess target outcomes.

Although individual studies demonstrated beneficial outcomes on a variety of target disorders and outcomes, noticeably absent are replication and follow-up studies. In order to provide credible evidence of play therapy’s efficacy for specified populations and outcomes, investigators must replicate well-designed studies targeting specific disorders preferably with independent teams of researchers (Chorpita et al., 2011). The preponderance of play therapy research has been generated by researchers affiliated with a single university. Furthermore, follow-up studies are necessary to evaluate maintenance of therapeutic gains and to examine the premise that play therapy has the potential to prevent more serious problems across children’s life spans (Bratton et al., 2005).

Play therapy’s effectiveness for children who present with comorbid presenting issues represents both a strength and a weakness. One of the limitations of play therapy research is the low number of studies targeting specific disorders. The practice of targeting interventions according to childhood disorder is considered a hallmark of evidence-based practice. Increase of rigorous research focused on specific diagnoses will add to the credibility of play therapy. Yet, the majority of child therapy research reports well over 50% of children present with co-occurring diagnoses or issues (Weisz & Kazdin, 2010). The fact that children regularly present with multiple behavioral symptoms and complex histories suggests the need to study play therapy interventions that impact the holistic functioning of children.
Among commonly used contemporary play therapy interventions (O’Connor & Braverman, 2009; Schaefer, 2011), there is a noticeable lack of randomized controlled studies and manualized protocols for theoretical models other than CCPT, CPRT/filial therapy, and AdPT. All but three of the studies in the present systematic review of RCTs examining play therapy’s effects followed CCPT or CPRT/filial therapy protocols. Interestingly, in the initial volumes of the present text, only the chapters on CCPT (L. Guerney, 1983) and filial therapy (VanFleet, 1994) reported outcome research to support treatment efficacy. Play therapy practitioners who prescribe to other theoretical models would benefit from research to support the play therapy models they use with their clientele.

Play therapy research has unquestionably answered the challenge issued by proponents of the evidence-based movement to conduct research in real-world settings (Kazdin & Weisz, 2003; Weisz & Kazdin, 2010), primarily through the abundance of research conducted in school settings. The level of multiculturalism addressed in play therapy research is another strength that may be attributed to the large number of studies conducted in school settings where historically underserved populations of children can access services. Even so, research needs to be expanded to explore the transportability of interventions to a wider variety of practice settings.

Beyond proving that play therapy works and for whom under what conditions, the next generation of researchers are also challenged to design studies to better understand the complexity of the change process. Investigating mediators and moderators that impact the strength of treatment on child outcomes is crucial to advance the evidence base for play interventions to the next level.

**CONCLUSION**

Although limitations exist, there is considerable evidence that play therapy is an effective intervention with diverse populations of children throughout the span of childhood. The empirical support for play therapy’s effectiveness across cultures and in real-life settings is a particular strength and supports its transportability across practice settings and populations of children and parents. Research findings reported in this chapter dispute claims regarding play therapy’s lack of sound scientific evidence. My hope is that play therapy researchers and practitioners will accept the challenge to widely disseminate these findings to stakeholders and the broader mental health profession in order to promote acknowledgment of play therapy as an effective and developmentally responsive intervention for a range of issues that prevent children’s optimal functioning.

**REFERENCES**


Author Index

Ablon, J., 36
Abraham, K., 63
Abrahameze, M. E., 351
Abram, J., 385
Abramson, D., 466
Abt, T., 83–84, 87
Achenbach, T. M., 144, 178, 231, 400, 570
Adam, S. M. G., 447
Adler, A., 18, 491
Adler, E. M., 83–84, 87
Aesop, 259
Ainsworth, M. D. S., 48, 75, 139, 168–169, 178, 290, 383, 385
Aitken, K. J., 167, 169, 382–383
Akbiyik, D., 457
Albano, A. M., 123
Alexander, F., 44
Algina, J., 351–352
Alimovic, S., 400
Allan, J., 7, 28, 63, 79, 244, 592
Allen, F., 18, 22, 25
Allen, M., 228
Allen, V., 558
Allers, C. T., 419
Allin, H., 568
Altshuler, E., 346
Alvord, M., 51–52
Amatruda, K., 78
American Counseling Association (ACA), 490, 516, 529–530, 600, 651
American Psychiatric Association (APA), 374–175, 196, 203, 292, 418, 510
American Psychological Association (APA), 104, 516, 600–601, 651
American School Counselor Association, 485, 490–491, 493, 498
American Speech-Language-Hearing Association (ASHA), 399
Amerigroup Real Solutions in Health Care, 473
Ammann, R., 337
Ammen, S., 11–12, 27, 195, 213, 330, 410
Anda, R. F., 381–382, 418, 590
Andrews, G. R., 588
Andronico, M., 404
Anhalt, K., 351
Ansanziato, J., 123–124
Antalone, M., 170
Appleton, V., 279
Aran, A., 412
Argote, C., 351
Ariel, S., 30
Aristotle, 526–527
Arnold, K., 388
Arriaga, P., 46
Arthur, N., 41
Asarnow, J. R., 574
Asgari, P., 658
Aubrey, A., 263
Association for Play Therapy (APT), 4, 6–9, 11–12, 207, 245, 327, 490, 494, 506–507, 523–524, 534, 557, 564, 576, 583, 601, 618, 651, 654
Association for Sandplay Therapy, 245
Azer, M. K., 421
Arthanasoudou, E., 445
Ato, G., 388
Auerbach, S., 140
Austin, A. T., 260, 263
Austin, J., 129
Ayerh, J. I.
Ayalon, O., 457
Aymard, L. L., 615
Ayres, J. A., 359
Azar, S. T., 141
Baker, S. E., 567
Baker, W. L., 10, 456
Bakermans-Kranenburg, M. J., 383
Balkin, R., 488, 652
Bandura, A., 42, 125–126, 491
Barale, E., 590
Baranowsky, A. B., 460–461
Barba, H., 277
Barber, B. K., 140
Barber-Starr, N., 482
Barfield, S., 10, 386, 388, 391
Barlow, J. H., 444, 637
Barnaby, R., 305
Barrett, B., 351–352
Barrett, L. G., 47
Baron, R. M., 640
Barrett, L., 51–52, 234
Barron, R., 35–36
Bass, G., 47, 236
Bateson, G., 10
Bateson, M. C., 382
Bauermeister, J., 351
Baumrind, D., 168
Baumwell, L., 138
Bayat, M., 114
Bay-Hinitz, A. K., 234
Baylin, J., 171, 376, 386, 390
Beale, I. L., 480, 483
Beck, A. T., 178, 328, 491
Beck, K. W., 119–120, 122
Becker-Preise, K. A., 456, 458
Becker-Westman, A., 391
Beckert, J. O., 600
Bedrosian, R., 119–120
Beel, I., 69
Beeghly, M., 169, 170
Beeley, P., 419
Bekoff, M., 51
Bellamy, J., 633–634, 638–639
Bellinson, J., 310, 314
Below, R., 455
Bemporad, J. R., 64–65
Bender, L., 122
Benjamin, H. E., 25, 27, 233, 386, 388, 424
Bennett, J. A., 56
Bennett, L. R., 190
Bergin, A., 228
Berk, M., 29, 54
Berlin, L., 381, 383
Berlin, L., 121, 234, 567
Berman, J., 568
Bernal, G., 351
Berman, J., 549–550, 555
Bernier, J. B., 5
Berrett, K. C., 587–588
Bertero, C., 515
Bertoia, J., 28
Bertolino, R., 615
Beskorovainy, D. J., 420
Betensky, M., 277
Bethel, B. L., 425–426
Beutler, L. E., 8, 36, 227–228, 232
Bhatta, M., 234
Bluivan, N., 347
Biederman, J., 487
Bierman, K., 410
Bifulco, A., 137
Biran, G., 412
Biringen, Z., 190
Bixler, E. R., 23, 540
Bjorsh, A., 351
Black, M., 19, 24
Blackard, S., 260, 654
Blair, C., 343
Blair, K., 140
Blake, C. R., 345–346
Blakely, L. R., 456
Blakley, T. L., 10
Blanc, G., 63
Blancard, S., 260, 654
Blanco, P. J., 100, 411, 488, 500–501, 572–573, 638, 655, 662, 663
Blatner, A., 337
Blehar, M., 48, 139, 168–169
Blehar, M. C., 290, 383
Blenkiron, P., 260, 263
Bloch, Y., 572
Blosser, C., 482
Bluck, S., 358
Bohara, R. S., 343, 347, 351, 352, 568, 663
Bohart, A., 50, 230
Boik, B. L., 28
Boling, R., 479
Boll, L. A., 145
Bond, D., 459–460
Bonner, B., 567
Booth, P. B., 24–25, 166, 171, 174, 176, 178, 183, 189, 198, 211, 217, 234, 386, 388, 403, 427, 576, 593
Borcherdt, B., 46
Borsky, A., 430
Boritz, N., 589
Bormstein, M. H., 138
Borrego, J., 351
Borris, N. W., 383–384
Bos, K., 590
Boucher, E. E., 358
Boucher, J., 421
Bourgeous, N. M., 129
Bouron, L., 658
Bow, J., 336
Bowen, J. R., 465
Boyd, 331
Boyd, D. G., 327
Boyd-Franklyn, N., 600
Brabeck, M. M., 229
Bradway, K., 83–84
Brady, M., 482
Brambilla, P., 590
Brandt, M. A., 100
Brannon, K. H., 299
Branschneider, S. A., 345
Braswell, L., 127
Bratton, I. N., 512
Brausch, A., 568
Braverman, L. D., 654, 663, 665
Bredenkamp, S., 421
Breen, D. T., 336
Brennan, C., 174
Brestan, E. V., 351
Brestan-Knight, E., 346
Bridges, L. J., 138
Breier, J., 419
Briere, J., 458, 574
Brighton, C., 615
Brody, V. A., 25, 330, 403, 544
Bromberg, C. K., 7
Bromberg, P. M., 388
Bromfield, L. M., 404
Bromfield, R., 2
Brown, A., 572
Brown, G. K., 178
Brown, N. S., 234
Brown, S., 10, 174, 287
Bruck, M., 420
Bruckman, D., 375
Brumfield, K., 645
Bruner, J., 51
Bryman, A., 634, 637–638
Bryer, M., 178, 456–460
Bryan, T. P., 487
Budd, K., 234
Bungental, D. B., 335–336
Bundy, A., 402
Burgdorf, J., 54
Burke, J. D., 343
Burlingame, G., 430
Burns, C., 482
Burns, G., 239, 262
Burns, W., 5–7
Burstein, S., 234
Burton, J., 138
Butler, A., 351
Buttner, G., 400
Cacioppo, J. T., 592
California Evidence-Based
Clearinghouse for Child Welfare, 431
Callanan, P., 507, 527
Calzada, E., 234
Cameron, H. J., 404
Campbell, M., 47
Cangelosi, D., 27, 228, 260
Canosa, P., 189, 391–392, 576
Capaldi, D. M., 343
Caplan, E., 422
Caplan, T., 422
Cardwell, P., 404
Carey, L., 26–27, 30, 244, 252, 279, 337
Carlson, B., 421
Carlson, C. R., 51
Carlson, R., 42, 261, 264
Carmichael, K. D., 3, 11, 30, 407–409, 411
Carnes-Holt, K., 656, 662
Carney, C. G., 600
Caroll, F., 546
Carpentier, M., 573
Carroll, M., 549
Carruthers, P., 51
Carson, M., 388
Cassidy, K. D., 377
Casey, R., 568
Cassidy, J., 48, 290, 381, 385
Castonguay, L., 36
Casula, C., 263
Cattanach, A., 261, 263, 281, 285, 300, 303, 419, 421, 620
Cavedo, C. B., 136
Cavell, T. A., 139, 148
Cavett, A. M., 121, 129, 279, 424
Cawthorne, K., 351–352
Caye, J. S., 457
Ceci, S. J., 420
Center for Play Therapy, 652, 663
Centers for Disease Control and
Prevention (CDC), 100, 567, 652
Cermak, S., 53
Chaffin, M., 346, 352, 573
Chambers, C. L., 217
Chamblee, D. L., 37, 228, 235, 570
Chan, B., 622
Author Index 673

Glover, G. J., 102, 603
Goble, F., 335
Goetze, H., 110–111, 145
Gold, J., 480
Goldine, M. E., 345
Goldfried, M. R., 229, 232
Goldsmith, H. H., 584, 586–587
Goldstein, A. P., 228
Goldstein, S. E., 140, 227
Gomory, T., 6
Goodlin-Jones, B., 352
Goodman, J., 126
Goodman, R., 343, 470–480
Goodman, T., 540
Goodwin, E. A., 28, 244
Goodyear, R. K., 549–550, 555
Goodyear-Brown, P., 479–480
Gordon, J., 404
Gordon, N., 54, 128
Gorman, J., 50, 140
Grados, J., 51–52
Granger, D., 568
Granic, I., 615–617, 622
Grant, R. J., 593
Gray, J. S., 374–375
Gray, K., 592
Graza, 501
Green, E., 28, 278, 328, 625
Greenberg, L. G., 514
Greenwald, R., 263–264
Gregg, J., 235
Griff, M., 30
Griffith, E., 343
Grolnick, W. S., 138–140
Grotenhuis, M., 437
Grosskurth, P., 19
Gross-Tsur, V., 412
Griffin, E., 343
Grolnick, W., 110–111, 145
Habermas, T., 358
Haem, C., 299
Haleberstadt, A. G., 140
Haley, J., 261
Hall, L., 234
Hall, P. E., 419, 421
Hall-Marley, S. E., 419
Halls, S., 290
Hambrick, E., 593
Hambridge, G., 21
Hamby, M., 420
Hamby, S. K., 420
Hammond, H., 405
Hammond, M., 663
Han, S., 568
Hanbrick, E. P., 10
Handelman, M. M., 529–530
Hanline, M., 48, 53
Hansen, J. D., 420
Hansen, S., 234
Hanson, R. F., 567
Harding, E. M., 74
Hardy, K. V., 592
Harris, Z. L., 358, 360–364, 425, 431
Hart, L., 110
Hartnell, M., 178, 390
Harvey, S., 30, 289–290, 292–293, 296–301, 303–305, 337
Harwood, T. M., 227, 232, 352
Hasselhorn, M., 400
Hastings, L., 388
Hastam, D., 279
Havens, R., 227
Hayes, S. C., 235, 260
Haynes, R., 230
Hays, D., 644, 645
Hays, D. G., 603
Hazen, R. A., 473
Health Insurance Portability and Accountability Act (HIPAA), 524–525
Heaton, S. C., 352
Heck, J., 549
Helferline, R., 540
Heidarian, L., 658
Heimlich, E. P., 551
Helfa, B., 234
Helm, H., 260
Helm, H. M., 511
Hembree-Kigin, T. L., 343–346, 348–353
Henderson, D. A., 506
Henderson, J. L., 71
Henderson, P., 486
Hendricks, 105–106
Henson, R., 572
Henson, R. K., 418, 592
Herhity, B., 525, 527
Herhity, B. R., 600
Herman, J., 459
Herman, J. L., 426
Herschell, A., 234
Hess, E., 357, 361, 363, 365, 368, 372–373
Hetzel-Riggin, M., 568
Heung, K., 351–352
Heymans, H. S., 437
Heyne, D., 45
Higbee, G., 45
Higgins-Klein, D., 252
Hildebrandt, M., 260
Hill, C. E., 553–554
Hill, S. S., 512
Himelein, M. J., 632
Himman, C., 602–603, 605
Hinshaw, S. P., 651, 653
Hinshaw, W. P., 570
Hiripi, E., 343
Hirschland, D., 376
Hirsfeld-Becker, D. R., 128–129, 387
Hoffman, K., 139, 384
Holliman, R., 501, 572, 638, 663
Holmbeck, G. N., 640
Holmes, M., 461
Holmes, S. V., 36
Holt, K., 110–111
Homeyer, L., 28, 108–109, 188, 244, 247–249, 255, 260, 262, 272, 477
Homeyer, L. E., 567, 605
Hommed, K. A., 481
Hood, K. K., 351
Hood-Williams, J., 20, 66
Hooper, L., 129
Hooven, C., 140
Horn, M., 17, 21
Horne, A., 65
Howard, A. R., 190
Hove, N., 447
Hoy, B., 292, 299
Hubble, M. A., 4
Hudspeth, E. F., 587, 645
Huesmann, L. R., 234
Hug-Hellmuth, H., 3, 18–19, 65–66
Hughes, D., 576, 386, 390–391
Hughes, D. A., 169, 171
Hughes, L., 404
Hull, K., 614–617, 619, 621
Hunsley, J., 232
Hunt, K., 114
Hurst, T., 166
Hutterer, J., 386
Huus, K., 398
Huxley, F., 87
Hyman, M. T., 228
Iacoboni, M., 49–50
Ilouite, N. T., 451
Individuals With Disabilities Education Act (IDEA), 308–309, 409, 524–525
Ingalls, L., 339
Ingersoll, B., 339
Interdisciplinary Council on Developmental and Learning Disorders (ICDLD), 358, 361
Irwin, C., 457
Irwin, E., 4–5, 50, 122, 289–290, 296–297, 304
Isen, A., 51
Jackson, E., 615
Jacobi, M., 71, 74
Jacobson, A. E., 234
Jacoby, M., 539
Jaffe, A., 71
Jahromi, L. B., 360
James, B., 22, 171, 290, 418
James, O., 18, 23
James, W., 233
Jang, M., 110–111
Janis, I. L., 45
Jayne, K., 652
Jellie, L., 565
Jennings, S., 289–292, 304
Jent, J. F., 567
Johnson, B., 234
Johnson, M. R., 447
Johnson-Clark, K., 143–144
Joiner, K., 483
Joiner, K. D., 110–111, 143
Jones, A., 227, 572–573
Jones, C., 444
Jones, D., 339
Jones, E. M., 446–447
Jongh, M., 17–18
Jongh, R. T., 458
Jordan, A. E., 530
Juby, H. L., 600
Jung, C., 18, 51, 68–73, 69, 75, 79, 88, 243–244, 539
Jutve, M., 351
Juste, E. L., 140, 168–169
Kabateck, J., 120
Kaduo, H. G., 228, 234, 328, 336, 337
Kaffman, A., 418, 420
Kagan, S., 114
Kahn, K. B., 600
Kalander, R., 480
Kalat, J. W., 584–586
Kale, A., 110–111, 412
Kalff, D., 18, 28, 63, 68, 73–74, 241–244, 247
Kalra, N., 457
Kalsched, D., 64
Kamphaus, R. W., 255
Kaplan, N., 178
Karver, M., 47
Kasari, C., 358, 360
Kascsak-Miller, T. K., 604
Kasdorf, J., 110
Kassel, J., 343
Katz, L., 140
Kahn, K. B., 600
Kalander, H. G., 228, 328, 336, 337
Kaffman, A., 418, 420
Kagan, S., 114
Knell, S. M., 29, 120, 122, 126–127, 234, 328, 403, 491–492, 541
Knickmeyer, R. C., 586
Knoll, P., 277
Knoetze, J., 47
Ko, S. J., 419
Kobak, R., 381–383
Kogan, M. D., 376
Kohen, D., 260
Kohler, H., 197
Kohut, H., 49, 63, 75
Kokish, R., 614
Kolaitis, G., 445
Koller, T. J., 234
Kooper, G. P., 3, 9–10, 483, 512
Koo, R., 564, 567
Kopp, R., 260, 262
Korja, R., 190
Koslowkas, K., 178
Kor, S., 100, 110–111, 421, 430, 500
Kortler, J., 527
Kottman, T., 3, 18, 29, 244, 263, 281, 338, 343, 405, 492, 500, 572, 618, 654, 658
Kraemer, H. C., 635
Krankow, B., 574
Kratowchwill, T. M., 643
Kreimer, J. L., 447
Kringelbach, M. L., 587–588
Kronenberg, M. E., 457
Krueger, S., 511
Kupanoff, K., 140
LaBovitz-Bok, B., 244
Lacasse, J. R., 6
Ladany, N., 553
LaGreca, A. M., 456, 457, 458–459, 462, 466
LaGreca, A. M., 640
Lahad, M., 457, 559
Lahey, B. B., 343
Lahri, S., 144
Lambert, W. J., 228
Lamborn, S. D., 139–140
LaMotte, J., 572
Lamp, H., 175
Lamp, L., 190
Landgarten, H., 279
Landini, A. L., 178
Lanktree, C., 574
<table>
<thead>
<tr>
<th>Author Name</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lanyado, M.</td>
<td>65</td>
</tr>
<tr>
<td>Lapan, R.</td>
<td>486, 488</td>
</tr>
<tr>
<td>Larance, D. T.</td>
<td>141</td>
</tr>
<tr>
<td>Larman, C.</td>
<td>279</td>
</tr>
<tr>
<td>Lau, A.</td>
<td>351</td>
</tr>
<tr>
<td>Launchpad Toys</td>
<td>620</td>
</tr>
<tr>
<td>Lavelli, M.</td>
<td>382</td>
</tr>
<tr>
<td>Law, S.</td>
<td>200</td>
</tr>
<tr>
<td>Lawver, T.</td>
<td>564, 567</td>
</tr>
<tr>
<td>Leavy, P.</td>
<td>277</td>
</tr>
<tr>
<td>Lebby, K.</td>
<td>6</td>
</tr>
<tr>
<td>LeBlanc, M.</td>
<td>9, 12, 114, 129, 410, 411, 563, 568–569, 652, 663</td>
</tr>
<tr>
<td>Lebo, D.</td>
<td>18–19, 23</td>
</tr>
<tr>
<td>Lederberg, A. R.</td>
<td>138</td>
</tr>
<tr>
<td>Ledesma, M.</td>
<td>420</td>
</tr>
<tr>
<td>Lee, A.</td>
<td>27, 63, 197</td>
</tr>
<tr>
<td>Lee, E.</td>
<td>600</td>
</tr>
<tr>
<td>Lee, K.</td>
<td>637, 659</td>
</tr>
<tr>
<td>Lee, M.</td>
<td>110–111, 143, 663</td>
</tr>
<tr>
<td>Lee, M. K.</td>
<td>603</td>
</tr>
<tr>
<td>Lee, S.</td>
<td>189, 391–392, 576</td>
</tr>
<tr>
<td>Lefcourt, H. M.</td>
<td>46</td>
</tr>
<tr>
<td>Legrain, V.</td>
<td>479</td>
</tr>
<tr>
<td>Lehmkuhl, 437</td>
<td></td>
</tr>
<tr>
<td>Lehrer, J.</td>
<td>383</td>
</tr>
<tr>
<td>Leonardi, F.</td>
<td>261</td>
</tr>
<tr>
<td>Lesesne, C.</td>
<td>141</td>
</tr>
<tr>
<td>Lester, B. M.</td>
<td>352</td>
</tr>
<tr>
<td>Leung, C.</td>
<td>351–352</td>
</tr>
<tr>
<td>Levant, R. F.</td>
<td>8</td>
</tr>
<tr>
<td>Levenstein, P.</td>
<td>138</td>
</tr>
<tr>
<td>LeVieux, J.</td>
<td>479–480</td>
</tr>
<tr>
<td>Levin, S.</td>
<td>28</td>
</tr>
<tr>
<td>Levine, K.</td>
<td>45</td>
</tr>
<tr>
<td>Levy, D.</td>
<td>21–22, 26</td>
</tr>
<tr>
<td>Levy, L. M.</td>
<td>591</td>
</tr>
<tr>
<td>Levy, R.</td>
<td>36</td>
</tr>
<tr>
<td>Lewandowski, A. S.</td>
<td>480</td>
</tr>
<tr>
<td>Lewis, H.</td>
<td>574</td>
</tr>
<tr>
<td>Lewis, J. A.</td>
<td>600</td>
</tr>
<tr>
<td>Li, H. C. W.</td>
<td>572–573</td>
</tr>
<tr>
<td>Liang, J. C.</td>
<td>600</td>
</tr>
<tr>
<td>Lieberman, A.</td>
<td>663</td>
</tr>
<tr>
<td>Lieberman, A. E.</td>
<td>381, 565, 575</td>
</tr>
<tr>
<td>Lifter, K.</td>
<td>410</td>
</tr>
<tr>
<td>Lillas, C.</td>
<td>359</td>
</tr>
<tr>
<td>Lilly, J. P.</td>
<td>28, 430</td>
</tr>
<tr>
<td>Lin, 114</td>
<td></td>
</tr>
<tr>
<td>Lin, Y.</td>
<td>652</td>
</tr>
<tr>
<td>Lindaman, S.</td>
<td>166, 174, 178, 190, 217, 327, 339</td>
</tr>
<tr>
<td>Linden, J.</td>
<td>42, 260</td>
</tr>
<tr>
<td>Lindsey, E. W.</td>
<td>53</td>
</tr>
<tr>
<td>Lingnell, L.</td>
<td>479–480</td>
</tr>
<tr>
<td>Lisak, D.</td>
<td>419</td>
</tr>
<tr>
<td>Liss, M.</td>
<td>386</td>
</tr>
<tr>
<td>Liu, S.-I.</td>
<td>400</td>
</tr>
<tr>
<td>Liu, W. M. E.</td>
<td>599</td>
</tr>
<tr>
<td>Lloyd, S. A.</td>
<td>421</td>
</tr>
<tr>
<td>Lobato, D.</td>
<td>482</td>
</tr>
<tr>
<td>Lobaugh, A.</td>
<td>110–111, 144–145</td>
</tr>
<tr>
<td>Lobaugh, A. F.</td>
<td>431</td>
</tr>
<tr>
<td>Lobel, A.</td>
<td>615</td>
</tr>
<tr>
<td>Lochman, J. E.</td>
<td>234</td>
</tr>
<tr>
<td>Lochman, L. E.</td>
<td>640</td>
</tr>
<tr>
<td>Locke, John</td>
<td>41</td>
</tr>
<tr>
<td>Loeb, R.</td>
<td>343</td>
</tr>
<tr>
<td>Logan, J.</td>
<td>602</td>
</tr>
<tr>
<td>London, K.</td>
<td>420</td>
</tr>
<tr>
<td>Lopez, V.</td>
<td>572</td>
</tr>
<tr>
<td>Lori, A.</td>
<td>72</td>
</tr>
<tr>
<td>Lovett, J.</td>
<td>188</td>
</tr>
<tr>
<td>Lowenfeld, M.</td>
<td>18, 49, 66, 243–244, 246</td>
</tr>
<tr>
<td>Lowenstein, L.</td>
<td>278, 509</td>
</tr>
<tr>
<td>Luborsky, E.</td>
<td>228</td>
</tr>
<tr>
<td>Luborsky, L.</td>
<td>228</td>
</tr>
<tr>
<td>Luborsky, L.</td>
<td>663</td>
</tr>
<tr>
<td>Luborsky, L.</td>
<td>228</td>
</tr>
<tr>
<td>Luby, J. L.</td>
<td>352</td>
</tr>
<tr>
<td>Luke, M.</td>
<td>559</td>
</tr>
<tr>
<td>Luscz, M. A.</td>
<td>588</td>
</tr>
<tr>
<td>Lyman, C.</td>
<td>166</td>
</tr>
<tr>
<td>Lyneham, H.</td>
<td>127</td>
</tr>
<tr>
<td>Lyons, J. S.</td>
<td>343</td>
</tr>
<tr>
<td>Lyons-Ruth, K.</td>
<td>381</td>
</tr>
<tr>
<td>Lyubomirsky, S.</td>
<td>44</td>
</tr>
<tr>
<td>Macoby, E.</td>
<td>48</td>
</tr>
<tr>
<td>MacDonald, 277–278</td>
<td></td>
</tr>
<tr>
<td>MacLean, G.</td>
<td>66</td>
</tr>
<tr>
<td>MacMillan, H.</td>
<td>568</td>
</tr>
<tr>
<td>Maddux, C.</td>
<td>573</td>
</tr>
<tr>
<td>Mader, C.</td>
<td>422</td>
</tr>
<tr>
<td>Madsen, A. D.</td>
<td>645</td>
</tr>
<tr>
<td>Madsen, S.</td>
<td>382–383</td>
</tr>
<tr>
<td>Mahoney, G.</td>
<td>360</td>
</tr>
<tr>
<td>Maier, H.</td>
<td>4–5</td>
</tr>
<tr>
<td>Maier, P.</td>
<td>44–45</td>
</tr>
<tr>
<td>Main, M.</td>
<td>178, 383–384</td>
</tr>
<tr>
<td>Mäkelä, J.</td>
<td>189–190</td>
</tr>
<tr>
<td>Makkonen, C.</td>
<td>260, 278</td>
</tr>
<tr>
<td>Malliotra, S.</td>
<td>234</td>
</tr>
<tr>
<td>Mallory, G.</td>
<td>30, 297</td>
</tr>
<tr>
<td>Mandich, B.</td>
<td>4–5</td>
</tr>
<tr>
<td>Manly, J. T.</td>
<td>575</td>
</tr>
<tr>
<td>Mann, E.</td>
<td>422</td>
</tr>
<tr>
<td>Manno, A.</td>
<td>574</td>
</tr>
<tr>
<td>Mannaio, A. P.</td>
<td>121, 188, 223, 573</td>
</tr>
<tr>
<td>Manney, P.</td>
<td>50</td>
</tr>
<tr>
<td>Mannion, M.</td>
<td>18</td>
</tr>
<tr>
<td>Mapes, D. C.</td>
<td>527</td>
</tr>
<tr>
<td>March, J. S.</td>
<td>123, 234</td>
</tr>
<tr>
<td>Markell, K.</td>
<td>261</td>
</tr>
<tr>
<td>Markell, M.</td>
<td>261</td>
</tr>
<tr>
<td>Marlatt, G. A.</td>
<td>128</td>
</tr>
<tr>
<td>Marschak, M.</td>
<td>217</td>
</tr>
<tr>
<td>Martin, C.</td>
<td>140, 260</td>
</tr>
<tr>
<td>Martin, E. D.</td>
<td>499</td>
</tr>
<tr>
<td>Martin, E. M.</td>
<td>511</td>
</tr>
<tr>
<td>Martin, H.</td>
<td>419</td>
</tr>
<tr>
<td>Martinez, 604</td>
<td></td>
</tr>
<tr>
<td>Martini, R.</td>
<td>375</td>
</tr>
<tr>
<td>Martocchia, J.</td>
<td>41</td>
</tr>
<tr>
<td>Marvin, B.</td>
<td>139</td>
</tr>
<tr>
<td>Marvin, R.</td>
<td>384</td>
</tr>
<tr>
<td>Mase, J.</td>
<td>345–346</td>
</tr>
<tr>
<td>Masselos, C.</td>
<td>47</td>
</tr>
<tr>
<td>Masten, A.</td>
<td>51</td>
</tr>
<tr>
<td>Masters, J. C.</td>
<td>51</td>
</tr>
<tr>
<td>Mastrogiorgio, S.</td>
<td>358</td>
</tr>
<tr>
<td>Mathews, 616</td>
<td></td>
</tr>
<tr>
<td>Matos, M.</td>
<td>351</td>
</tr>
<tr>
<td>Mayer, M.</td>
<td>206–207</td>
</tr>
<tr>
<td>Mayr, S.</td>
<td>622</td>
</tr>
<tr>
<td>McAllister, M.</td>
<td>500</td>
</tr>
<tr>
<td>McBrien, J.</td>
<td>282–284</td>
</tr>
<tr>
<td>McCabe, K. M.</td>
<td>351</td>
</tr>
<tr>
<td>McCaffrey, D. E.</td>
<td>457</td>
</tr>
<tr>
<td>McCann, S.</td>
<td>149</td>
</tr>
<tr>
<td>McCool, B.</td>
<td>83–84</td>
</tr>
<tr>
<td>McGuire, K.</td>
<td>479</td>
</tr>
<tr>
<td>McDermott, J. F.</td>
<td>422</td>
</tr>
<tr>
<td>McFall, J.</td>
<td>36</td>
</tr>
<tr>
<td>McFarlane, A. C.</td>
<td>457</td>
</tr>
<tr>
<td>McFarlane, K.</td>
<td>419</td>
</tr>
<tr>
<td>McGilchrist, I.</td>
<td>234</td>
</tr>
<tr>
<td>McGoldrick, M.</td>
<td>600</td>
</tr>
<tr>
<td>McGrady, M. E.</td>
<td>481</td>
</tr>
<tr>
<td>McGrath, J. M.</td>
<td>352</td>
</tr>
<tr>
<td>McLean, G. A.</td>
<td>65</td>
</tr>
<tr>
<td>McMahon, L.</td>
<td>419</td>
</tr>
<tr>
<td>McNeil, C.</td>
<td>234</td>
</tr>
<tr>
<td>McWilliams, M.</td>
<td>189, 391–392, 576</td>
</tr>
<tr>
<td>Meaney-Walen, K.</td>
<td>144, 405, 487, 492, 658, 662</td>
</tr>
<tr>
<td>Meaney-Walen, K. M.</td>
<td>572–573</td>
</tr>
<tr>
<td>Meares, R.</td>
<td>261</td>
</tr>
<tr>
<td>Meichenbaum, D.</td>
<td>45, 126, 128, 234, 261</td>
</tr>
<tr>
<td>Meissler, K.</td>
<td>234</td>
</tr>
<tr>
<td>Melton, G. B.</td>
<td>510</td>
</tr>
<tr>
<td>Meltzer, H.</td>
<td>433</td>
</tr>
<tr>
<td>Mendel, E.</td>
<td>45, 234</td>
</tr>
<tr>
<td>Mendez, F.</td>
<td>576</td>
</tr>
<tr>
<td>Mental Health America</td>
<td>651</td>
</tr>
<tr>
<td>Mescia, N.</td>
<td>459</td>
</tr>
<tr>
<td>Messer, S. B.</td>
<td>229</td>
</tr>
<tr>
<td>Michael, L.</td>
<td>398</td>
</tr>
<tr>
<td>Middle, C.</td>
<td>419</td>
</tr>
<tr>
<td>Mikulas, W.</td>
<td>44–45</td>
</tr>
<tr>
<td>Mill, J. S.</td>
<td>200</td>
</tr>
<tr>
<td>Miller, C.</td>
<td>305</td>
</tr>
<tr>
<td>Miller, P.</td>
<td>486</td>
</tr>
</tbody>
</table>
Miller, P. A., 140
Miller, S. D., 4
Miller, T. L., 228
Miller, V. A., 129
Mills, 603
Mills, B., 592
Mills, J., 28, 260
Milne, 259
Milner, J. S., 141
Minagawa-Kawai, Y., 391
Minnix, G., 244
Mints, J., 574
Mirmiran-Webster, 314
Misurell, J., 234
Mitchell, S., 19, 24
Mitchell-Copeland, J., 140
Miyahara, M., 402
Mokkink, L. B., 437
Molloy, G., 45
Money, J., 197
Mongoven, L., 233
Montessori, M., 421
Montgomery, B., 568
Moore, D. J., 120, 122
Moore, M., 44, 438, 451
More, A., 558
Morgan, R. K., 641–642
More, A., 558
Morrison, M., 260, 262, 567
Morrison, M. O., 260, 262, 567
Morton, T., 568
Mounts, N. S., 139–140
Moustakas, C., 18, 23, 25, 99, 278, 403, 540–541
Moyle, J., 37
Mulherin, M., 566
Mulle, K., 123, 234
Mullen, J., 551
Mullen, J. A., 559
Munnis, E., 166, 230, 234, 330, 403, 575–576
Munro, N., 402
Murdock, S. A., 45
Muro, J., 411, 489, 572
Murphy, J. J., 555
Murphy-Jones, E., 447, 483
Musante, G., 45
Myers, C. E., 419, 421, 424, 424–425
Myrow, D., 174
Nabors, L., 437–438, 444
Naderi, E., 658, 662
Nagy, E., 383
Namka, L., 419
Nash, E., 234
Nash, M., 388
Nathan, E., 654, 664
Nathan, P., 633, 644
Nathan, P. E., 570
National Association of Social Workers, 651
National Center for Children in Poverty, 652
National Center for Clinical Infant Programs, 360
National Center for Education and Evaluation, 651
National Child Traumatic Stress Network, 223
National Dissemination Center for Children with Disabilities, 399
National Institute for Relationship Enhancement, 558
National Institute of Justice, 420
Navelski, L., 572, 656
Nebbergall, A. J., 554
Neeheles, J., 375
Neigh, G. N., 590
Nelson, A., 438
Nelson, C. A., III, 590
Nelson, J., 48
Nelson, K., 438
Nelson, M., 663
Nelson, M. M., 343, 347, 568
Nene, C. B., 590
Nemiroff, M. A., 123–124
Netel-Gilman, E., 234
Neubauer, P. M., 76
Neufeld, D., 234
Neumann, E., 63, 68, 72–73, 81–82
New, D., 27
Newberry, R., 51
Newcomb, K., 351
Newell, H., 21
Newman, D. S., 554–555
Nieu, A. M., 652–653, 664
Nieuw, C. M., 652–653, 664
Nichols, M., 43
Nickerson, E., 4–5
Niec, L., 651–652, 663
Niec, L. N., 565, 567
Nissen, H., 479
Nissim, S., 615
Nock, M., 36
Nock, M. K., 343, 640
Noelle, M., 553
Nopmaneejamruslers, K., 375
Norcross, J. C., 3–4, 8, 195, 227–230, 329, 512
Nordling, W. J., 11, 105–106
Norton, B., 28–29, 278
Norton, C., 28–29, 278
Norton, D., 450, 592
Novick, J., 540
Novotny, A., 480
Nutt, E. A., 553
Nylund, D., 260
Oaklander, V., 25, 244, 328, 403
O’Connell, M., 143
O’Connor, C., 565
O’Connor, T. G., 386
Oe, E. N., 5
Offringa, M., 437
Ogawa, Y., 114
O’Hanlon, B., 261
O’Hara, J., 138
Ojiambo, D., 654, 658, 662
Oldford, L., 261
Ollendick, T. H., 125–126, 228, 234
Olsmstead, J., 279
Otnes, K., 260
Olsen, J. A., 140
O’Malley, J. E., 483
Onland-van Nieuwenhuizen, A. M., 437
Ono, M., 352
Orlick, T., 234
Ormond, R., 420
Ormrod, R. K., 420
Ouats, R., 260
Ovens, R., 234
Oxford, L., 293
Oxman, L. K., 144
Packman, J., 100, 573, 659, 662
Paine, M. L., 420
Pajareya, K., 375
Palermo, T. M., 480
Panksepp, J., 54, 171, 587
Pao, T., 573
Paparella, T., 360
Paradise, L., 489
Pardeck, J. Y., 42
Parikh, S., 604
Parke, R. D., 140
Parker, J., 50, 231
Parker, L., 189, 391–392, 576
Parker, R., 643
Perry, G., 234–235
Pasek, J. L., 36
Pastis, 259
Pate, J. E., 253
Patton, S. C., 386
Paul, G., 227
Pearl, E., 351–352
Pearson, B., 129
Pedersen, P., 208
Pedro-Carroll, J., 234
Peery, J. C., 18, 28
Pellegrini, A., 51
Pelzer, D., 429
Penn, S. L., 603
Pthomegroup

Author Index 677

Rogers, S., 574
Rogosch, F. A., 575
Rohrbeck, C. A., 141
Rolling, E., 144
Ronnestad, M. H., 557
Rosa-Olivares, J., 345–346
Rosen, G. M., 56
Rosen, S., 261
Rosenberg, B., 36
Rosenfeld, L. E., 457, 466
Ross, A., 144
Rothman, T., 573
Rubin, A., 3, 570, 633–634, 638–639, 652
Rubin, L. C., 621
Rubin, P. B., 166, 279
Ruma, C. D., 122, 419, 426
Runstein-McKean, O., 232
Rushton, S., 593
Russ, S., 565, 651–652, 663
Russ, S. W., 10, 44, 50, 289, 291, 438, 451
Russell, R. L., 55
Ryan, M., 190
Ryan, S., 190
Rycce-Menuhin, J., 63, 243–244
Safer, D., 30
Salmon, D., 554
Salo, S., 174, 189–190
Saltzman, N., 4
Samson, A., 377
Sanchez-Meca, J., 45, 576
Sandgrund, A., 410
Sandler, J., 66
Sanner, J. H., 345
Santucci, L., 352
Santiago, R., 351
Santacruz, I., 45, 576
Sanson, A., 377
Sawyers, J. K., 108, 110
Safer, D., 30
Sanchez-Meca, J., 45, 576
Sandgrund, A., 410
Sandler, J., 66
Sanner, J. H., 345
Santucci, L., 352
Sartre, J. P., 49
Saunders, B. E., 567
Sawyers, J. K., 108, 110
Saylor, C., 456–457
Scavelli, S., 260
Scheeringa, M. S., 456, 458
Schieffer, K., 166
Schore, D., 614
Scholkelkorb, A., 234
Schortelm, A., 100, 411, 501,

Schore, J. R., 169, 202, 385, 387,

Schottelkorb, A., 100, 411, 501,

Schottelkorb, A. A., 467, 572–573

Schuler, A. L., 234

Schultz, D., 460, 492

Schultz, S., 492

Schumann, B., 489, 660, 662

Scott, C., 419, 430

Scott, C. V., 574

Sedal, H., 67

Sekino, Y., 53

Sekelmann, M., 260

Senatore, N., 404

Sensue, M. E., 143

Setter, N. J., 123

Sevin, E., 466

Sevin, S., 466

Skadal, W. R., 232

Shahmoon-Shanok, R., 168

Shanker, S., 377

Shapiro, F., 188

Sharry, 616

Shattuck, A., 420

Shaw, J. A., 418, 420

Shaw, J. A., 418, 420

Sheler, J., 75

Sheely, A., 500

Sheely-Moore, A., 487, 660, 662

Sheely-Moore, A. I., 110–111, 144

Sheeringa, M. S., 129

Sheinbear, S. J., 352

Sheflary, J., 29, 459–460

Shen, Y., 114, 254, 500, 572–573, 604, 660, 662, 663

Shepard, L., 234

Shephard, C., 461

Shephard, L., 565

Sherer, M., 614

Sherman, E., 339

Shiner, S. K., 190

Shirk, S. R., 47, 55

Shircliff, E. A., 592

Shuman, D. W., 420, 430

Shumman, 572–573


Siegel, T., 47

Siegner, S., 234

Siev, J., 37

Sigelman, C. K., 382

Silk, J. S., 140

Silovsky, J., 573

Silverman, W., 233–234, 637, 659

Silverman, W. K., 458–459, 570, 640, 651, 653

Simeonsson, R., 398

Simpson, P., 78

Sin, T. C. S., 531–352

Sinacola, R. S., 591

Singer, D. G., 54, 228

Singer, J. L., 54

Singh, A., 644–645

Sink, 486

Sitarenios, G., 231

Siu, A. F. Y., 189, 576

Skagen, D., 615

Skinner, B. F., 201

Skovholt, T. M., 557

Slade, A., 10, 169

Slobogin, C., 510

Slote, M., 52–53

Smith, C., 141, 260

Smith, D., 400–401, 661, 662

Smith, M., 411

Smith, M. L., 228


Smith, S. K., 143, 445

Smith Micro Software, 620

Smuky, A. T., 589

Sniscak, C. C., 11, 24–25, 136, 149, 424

Snow, M. S., 260, 265–266, 511, 615–618, 645

Soares, J. C., 590

Society of Clinical Child and Adolescent Psychology, 651

Sodowsky, G. R., 600

Sohnmen, T., 457

Solomon, J., 21–22, 383–384

Solomon, M., 352

Solomon, R. S., 375–376

Solt, M., 483

Solt, M. D., 110–111

Sonuga-Barke, E. J. S., 590

Sorensen, G. P., 527

Sourkes, B., 473

Sousa, D. A., 409

Southern-Gerow, M. A., 570, 572

Spagnola, M. E., 398, 400, 402, 405, 412

Spanazola, J., 381

Speier, A., 457

Speligm, G., 36

Spinazola, J., 392, 419

Spinka, M., 51

Spitz, R. A., 75

Springer, C., 234

Straw, L. A., 75–76, 139

Stagnitti, K., 289–290, 565

Stahmmer, A. C., 574

Stallard, P., 616

Stam, H., 437

Stanley, B., 488

Starling, M., 430

State, T., 343

Staub de Laclav, V., 539

Steele, W., 254

Steen, L. S., 489

Steer, R. A., 178

Stein, D., 644

Stein, N., 227–228

Steinberg, A., 178

Steinberg, L., 139–140

Stern, D. N., 75, 138–139, 171, 290, 387

Stevens, B., 100

Stevens, S., 346

Stevens, S. E., 228

Stewart, A., 25

Stieben, J., 377

Stiles, K., 336

Stirling, J., 590

Stollbach, B., 381, 392, 419

Stolz, H. E., 140

Stone, J., 322

Stover, L., 143–145

Strachan, J., 404

Strandberg, K., 140

Strasburger, L. H., 430

Strauss, M. A., 421

Strayer, J., 50

Strayhorn, J., 53

Stroh, 486

Stubert, M., 178

Stulmaker, H., 637, 641, 659

Substance Abuse and Mental Health Services Administration, 651

Sue, D., 601

Sue, D. W., 600–604

Sue, S., 208

Sullivan, J., 572, 663

Sullivan, J. M., 144, 638

Sullivan, J. R., 438, 443, 445

Sullivan, M. A., 456–457

Sullivan, M. J., 514

Sultannot, S. M., 337

Sunderland, M., 171

Surgeon General of the United States of America, 487

Sutton-Smith, H., 10, 51

Svedin, C. G., 451

Swan, K., 644

Swanson, R. C., 100


Syrmik, C., 406

Swulak, A. E., 11, 24, 136, 143–144, 424

Szalavitz, M., 424, 428–429

Taffe, R. C., 600

Taft, J., 22, 26
Author Index

Wagner, M. M., 620
Wagner, S. M., 345
Wagner, W., 42
Walco, G. A., 451
Walk, R. D., 123
Walker, C. E., 567
Wall, S., 48, 139, 168–169, 383
Wallace, C., 50
Wallace, J. W., 512
Wallick, M., 45
Walls, R., 480
Walther, C., 568
Wampler, K. S., 144
Wampold, B. E., 4, 227–228
Wang, Q., 139–140
Wang Flahive, M., 351
Warington, H., 576
Warta, N. C., 65
Waters, E., 48, 139, 168–169, 290, 383
Watkins, A., 563
Watson, A., 386
Watson, D., 100
Watson, L., 563
Watson, Z. E., 600
Webster, J., 41
Webster-Stratton, C., 234, 663
Weems, C. F., 129
Weider, S., 593
Weiner, D., 293
Weinrib, E. L., 63, 244
Weir, K. N., 189, 386, 391–392, 576
Weiss, B., 568
Weisz, J. R., 128, 344
Welch, K., 572, 656
Welfel, E. R., 229, 527–528, 530–531
Wells, H. G., 20, 66
Wells, M., 385
Welsh, J., 410
Werb, B., 352
Werchel, F., 234
Westby, C., 410
Wettig, H. G., 189, 392, 576
Whelan, W., 25
Whidby, J. M., 234
Whitchurch, G. G., 602
White, D. R., 234
White, J., 419
White, P., 262, 272
Wickstrom, A., 404, 412
Wickstrom, M., 144
Wieder, S., 358, 360–361, 366, 375–376
Wignall, A., 127
Wilkes, S., 402
Williams, A. C., 480
Williamson, G. G., 170
Wilsie, C. C., 346
Wilson, K., 11, 98, 106, 129, 138
Wilt, L., 42, 260
Windburn, A., 615
Winnicott, D. W., 3, 24, 47, 75, 84, 277, 385
Winstead, M. L. R., 166, 174
Winters, A., 343
Wise, S. L., 600
Wunder-Fries, A. B., 382
Wypse, L., 52–53
Withbee, T., 105–106
Wohl, A., 419
Wohlteber, K., 479
Wolery, M., 386
Wolff, D. E., 10
Wolff, D., 55
Woll, L., 645
Wolheim, L., 197
Wolpe, J., 44
Woltmann, A. G., 122
Wong, C., 360

UNICEF
United Nations
Urofsky, R. I., 527–528
Urquiza, A., 567, 572
Urquiza, A. J., 9, 351–352
Urwin, C., 20, 66
Valdez, 604
Valentino, K., 386
### Author Index

<table>
<thead>
<tr>
<th>Name</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wood, D.</td>
<td>41, 213, 609</td>
</tr>
<tr>
<td>Woodcock, T.</td>
<td>243</td>
</tr>
<tr>
<td>Wormdal, A. K.</td>
<td>351</td>
</tr>
<tr>
<td>Wortham, S. S.</td>
<td>95</td>
</tr>
<tr>
<td>Wrightsman, L. S.</td>
<td>512</td>
</tr>
<tr>
<td>Wynne, L. S.</td>
<td>490</td>
</tr>
<tr>
<td>Xin, W. E. I.</td>
<td>402</td>
</tr>
<tr>
<td>Yalom, I.</td>
<td>36</td>
</tr>
<tr>
<td>Yapko, M.</td>
<td>260</td>
</tr>
<tr>
<td>Yeh, M.</td>
<td>351</td>
</tr>
<tr>
<td>Yu, I.</td>
<td>351–352</td>
</tr>
<tr>
<td>Yolton, K.</td>
<td>479</td>
</tr>
<tr>
<td>Yorbik, O.</td>
<td>457</td>
</tr>
<tr>
<td>Young, S.</td>
<td>618</td>
</tr>
<tr>
<td>Young-Bruehl, E.</td>
<td>67</td>
</tr>
<tr>
<td>Yu, J. W.</td>
<td>402</td>
</tr>
<tr>
<td>Yuen, T.</td>
<td>110–111, 143</td>
</tr>
<tr>
<td>Yuen, T. C.</td>
<td>661, 662</td>
</tr>
<tr>
<td>Zadra, A.</td>
<td>574</td>
</tr>
<tr>
<td>Zambelli, G.</td>
<td>234</td>
</tr>
<tr>
<td>Zeanah, C. H.</td>
<td>456, 589</td>
</tr>
<tr>
<td>Zeanah, C. H., Jr.</td>
<td>381, 383–384</td>
</tr>
<tr>
<td>Zebell, N.</td>
<td>352</td>
</tr>
<tr>
<td>Zeig, J.</td>
<td>259</td>
</tr>
<tr>
<td>Zera, M.</td>
<td>343</td>
</tr>
<tr>
<td>Zhou, A. J.</td>
<td>457</td>
</tr>
<tr>
<td>Ziegler, D.</td>
<td>427, 429</td>
</tr>
<tr>
<td>Zimmer-Gembeck, M. J.</td>
<td>575</td>
</tr>
<tr>
<td>Zimmerman, J. E.</td>
<td>450, 592</td>
</tr>
<tr>
<td>Zins, J. E.</td>
<td>555</td>
</tr>
<tr>
<td>Ziv, Y.</td>
<td>381</td>
</tr>
<tr>
<td>Subject</td>
<td>Page Numbers</td>
</tr>
<tr>
<td>---------</td>
<td>--------------</td>
</tr>
<tr>
<td>abreaction</td>
<td>43–44, 230</td>
</tr>
<tr>
<td>abuse. See child abuse; sexual abuse</td>
<td></td>
</tr>
<tr>
<td>ACA. See American Counseling Association</td>
<td></td>
</tr>
<tr>
<td>ACA Code of Ethics</td>
<td>529</td>
</tr>
<tr>
<td>academic achievement</td>
<td>100, 488, 501, 655, 662</td>
</tr>
<tr>
<td>accelerated psychological development</td>
<td>53</td>
</tr>
<tr>
<td>acceptance</td>
<td>98, 143–144, 215, 220–221</td>
</tr>
<tr>
<td>accessibility</td>
<td>488</td>
</tr>
<tr>
<td>acculturation</td>
<td>604</td>
</tr>
<tr>
<td>acting-out</td>
<td>102–103</td>
</tr>
<tr>
<td>action schemas</td>
<td>329</td>
</tr>
<tr>
<td>active competence</td>
<td>603</td>
</tr>
<tr>
<td>active imagination</td>
<td>69</td>
</tr>
<tr>
<td>active involvement</td>
<td>42</td>
</tr>
<tr>
<td>active play therapy</td>
<td>21–22</td>
</tr>
<tr>
<td>adaptive doll play, 47</td>
<td></td>
</tr>
<tr>
<td>ADHD. See attention-deficit hyperactivity disorder</td>
<td></td>
</tr>
<tr>
<td>adherence</td>
<td>446, 481–482</td>
</tr>
<tr>
<td>adjustment reaction</td>
<td>234</td>
</tr>
<tr>
<td>Adlerian play therapy</td>
<td>29, 492, 500, 658</td>
</tr>
<tr>
<td>admission length</td>
<td>474</td>
</tr>
<tr>
<td>adolescents</td>
<td>334–336</td>
</tr>
<tr>
<td>adult guidance</td>
<td>168</td>
</tr>
<tr>
<td>adults</td>
<td>168</td>
</tr>
<tr>
<td>expressive arts for</td>
<td>282–284, 286–287</td>
</tr>
<tr>
<td>in life span play therapy</td>
<td>328, 336–337</td>
</tr>
<tr>
<td>advocacy</td>
<td>199–200, 210, 515–516, 604</td>
</tr>
<tr>
<td>affect</td>
<td>360–361, 372, 376, 423, 424</td>
</tr>
<tr>
<td>affective domain</td>
<td>566</td>
</tr>
<tr>
<td>aggression</td>
<td>102–103, 105–106, 409, 497</td>
</tr>
<tr>
<td>in BGPT</td>
<td>319–320</td>
</tr>
<tr>
<td>in CCPT case example</td>
<td>111–112</td>
</tr>
<tr>
<td>limit-setting and</td>
<td>540, 545–546</td>
</tr>
<tr>
<td>research on</td>
<td>234, 660, 662</td>
</tr>
<tr>
<td>Allan, John</td>
<td>5, 28</td>
</tr>
<tr>
<td>Allen, Frederick</td>
<td>22</td>
</tr>
<tr>
<td>alliance</td>
<td>159–160</td>
</tr>
<tr>
<td>American Counseling Association (ACA)</td>
<td>529</td>
</tr>
<tr>
<td>American School Counseling Association (ASCA)</td>
<td>486, 490–491, 493</td>
</tr>
<tr>
<td>amygdala</td>
<td>585, 588</td>
</tr>
<tr>
<td>anal stage</td>
<td>65</td>
</tr>
<tr>
<td>analysis adequacy</td>
<td>574</td>
</tr>
<tr>
<td>analytical theory</td>
<td>68–75, 69, 88</td>
</tr>
<tr>
<td>analytic psychology</td>
<td></td>
</tr>
<tr>
<td>assessment in</td>
<td>78–79</td>
</tr>
<tr>
<td>client characteristics in</td>
<td>77–78</td>
</tr>
<tr>
<td>logistics and</td>
<td>78</td>
</tr>
<tr>
<td>therapists in</td>
<td>76–77</td>
</tr>
<tr>
<td>treatment in</td>
<td>79–80</td>
</tr>
<tr>
<td>analytic psychology case example</td>
<td>80, 88</td>
</tr>
<tr>
<td>archetype in</td>
<td>84</td>
</tr>
<tr>
<td>awakening in</td>
<td>83–84</td>
</tr>
<tr>
<td>communication in</td>
<td>86</td>
</tr>
<tr>
<td>dinosaurs in</td>
<td>85–87</td>
</tr>
<tr>
<td>ego development in</td>
<td>81–82</td>
</tr>
<tr>
<td>emptiness in</td>
<td>84</td>
</tr>
<tr>
<td>impressions in</td>
<td>81</td>
</tr>
<tr>
<td>mother and</td>
<td>82–86</td>
</tr>
<tr>
<td>symbolism in</td>
<td>83–87</td>
</tr>
<tr>
<td>unification in</td>
<td>87</td>
</tr>
<tr>
<td>anger</td>
<td>234, 268–269, 269</td>
</tr>
<tr>
<td>anger shield</td>
<td>336</td>
</tr>
<tr>
<td>anticipatory grief</td>
<td>447</td>
</tr>
<tr>
<td>antiepileptics</td>
<td>591</td>
</tr>
<tr>
<td>antipsychotics</td>
<td>590–591</td>
</tr>
<tr>
<td>anxiety</td>
<td>208, 254, 338, 450, 479–480</td>
</tr>
<tr>
<td>research on</td>
<td>657–658, 660, 662</td>
</tr>
<tr>
<td>apps development</td>
<td>622</td>
</tr>
<tr>
<td>APT. See Association for Play Therapy</td>
<td></td>
</tr>
<tr>
<td>archetype</td>
<td>71, 84</td>
</tr>
<tr>
<td>Aristotle</td>
<td>526–527</td>
</tr>
<tr>
<td>arousal levels</td>
<td>171, 461</td>
</tr>
<tr>
<td>ASCA. See American School Counseling Association</td>
<td></td>
</tr>
<tr>
<td>ASD. See autism spectrum disorder</td>
<td></td>
</tr>
<tr>
<td>Asian Americans</td>
<td>599, 626–628</td>
</tr>
<tr>
<td>ASK. See awareness, skills, and knowledge assessment</td>
<td>574, 617, 619</td>
</tr>
<tr>
<td>See also pretreatment assessment in analytic psychology</td>
<td>78–79</td>
</tr>
<tr>
<td>in BGPT</td>
<td>314–317</td>
</tr>
<tr>
<td>in CBPT</td>
<td>123–124</td>
</tr>
<tr>
<td>in CCPT</td>
<td>104–105</td>
</tr>
<tr>
<td>comprehensive</td>
<td>230–231</td>
</tr>
<tr>
<td>for drama</td>
<td>297–301</td>
</tr>
<tr>
<td>in FT case example</td>
<td>157–158</td>
</tr>
<tr>
<td>repetitions in</td>
<td>443, 444</td>
</tr>
<tr>
<td>in schools</td>
<td>493–494</td>
</tr>
<tr>
<td>assimilative integrative psychotherapy</td>
<td>229</td>
</tr>
<tr>
<td>Association for Play Therapy (APT)</td>
<td>245, 523–524</td>
</tr>
<tr>
<td>best practices from</td>
<td>8, 506–507</td>
</tr>
<tr>
<td>in play therapy emergence</td>
<td>4–6</td>
</tr>
<tr>
<td>schools and</td>
<td>490</td>
</tr>
<tr>
<td>assumptions</td>
<td>166–167</td>
</tr>
<tr>
<td>attachment</td>
<td>137, 293–295, 656, 662</td>
</tr>
<tr>
<td>brain and</td>
<td>586, 592</td>
</tr>
<tr>
<td>disorganized</td>
<td>383–384</td>
</tr>
</tbody>
</table>
attachment (continued)
  environmental, 205
  neuroscience and, 588–589
  in Theraplay® case example 1, 183
attachment-based goals, 219
attachment play, 48
attachment problems
  abandonment and, 391
  attachment stress in, 383
  attunement for, 385–387
  base relationship for, 390
  caregiver availability and, 382–383
  caregiver vulnerability in, 389
  case example on, 389–391
  creativity for, 388
  disorganized attachment in, 383–384
  hypervigilance in, 389
  matching for, 387
  motherese and, 382
  music for, 390
  negative self-view in, 389
  neurodevelopment and, 382, 384–385, 387–388
  population definition in, 381–384
  protoconversations and, 382
  research on, 75–76, 146, 391–392, 590
  safety for, 387
  strategies for, 386–388
  thematic play for, 388, 390–391
  theory and, 385
  therapist in, 380–388
  trauma and, 381–382, 387
attachment security, 139
attention, 41
attention-deficit hyperactivity disorder (ADHD), 100, 175, 229
  in disabilities, 409
  DRFT and, 463–466, 464–465
  research on, 234, 658–659
attrition rates, 352
attuned empathic reflective responsiveness, 168–169
attunement, 141–142, 385–387
auditory processing, 365–366
authenticity, 98
authorities, 604–605
autism spectrum disorder (ASD), 234, 292, 305–306, 358
  DIR®/Floortime strategies for, 369–374
  neurodevelopment and, 359–362, 376–377
autonomy, 526, 528, 530–531
autonomy support, 139–140, 143–144
avoidance, 451
avoidant play, 423, 424
awakening, 83–84
awareness, skills, and knowledge (ASK), 208
Axline, V., 22–23
baseline measures, 217
base relationship, 390
bathroom behaviors, 545–546
Baumrind, Diana, 344
bedside activities, 481
Beers, Clifford, 17
behavioral regulation, 139, 146, 402–403, 656–661
behavioral theory, 136, 201
CBT, 129, 223, 403, 458–459
belonging, 333
beneficence, 528
best practices
  from APT, 8, 506–507
  in prescriptive play therapy, 234, 234–235
BGPT. See board game play therapy
biologic hypersensitivity, 217–218
birth to 2 years, 329–330
birth to 18 months, 330
blind spot, 270
board game play therapy (BGPT), 309
  aggression in, 319–320
  assessment in, 314–317
  case example with muscular dystrophy in, 317–318
  case example with repetition in, 318–319
  case example with superiority in, 319–320
  choice in, 312, 318–319
  client characteristics in, 317
  competitiveness in, 315–316
  coping skills in, 315
  definition of, 313
  development in, 316
  documentation in, 322
  frustration tolerance in, 314–315
  how in, 314
  indications/contraindications in, 320
  logistics in, 320–321
  mastery in, 314
  norm compliance level in, 316
  patterns in, 317–318
  playroom for, 320–321
  pretreatment assessment in, 321
  procedure/technique in, 312–314
  rapport in, 316
  research on, 310–311
  rough IQ estimate in, 315
  social interaction abilities/style in, 315
  strategic abilities in, 315
  theory of, 311–312
  therapists in, 317, 322
  toys and materials for, 320–321
  treatment frequency and duration of, 321
  treatment planning for, 321
  treatment stages and strategies in, 321
  who in, 313
  why in, 313
  worksheet for, 322
bonding, 614, 616, 625
boundaries, 209–210, 335
in limit-setting, 539–541
Bowlby, John, 24–25
brain, 169–170
amygdala of, 585, 588
attachment and, 586, 592
development of, 586–587
emotional development and, 587–588
evolution of, 584–585, 585
integration of, 310
lateralisaton of, 585
neurotransmitters and, 587
play and, 587
reptilian, 584, 585
"states of mind" and, 586
subcortical regions of, 584, 585
brain-compatible classrooms, 593
breathing techniques, 479–480
Bridge Project 2009, 376
"broaden-and-build" theory, 50–51
Bromberg, Cynthia K., 7
bullying, 203–204, 206
C3 ARE model, 459–460
cancer, 210
caregiver availability, 382–383
caregiver responsiveness, 383
caregivers, 121, 374, 505, 662, 663
in CBPT, 127
cultural issues and, 602–603
in DIR®/Floortime, 367
in DRPT, 467
in medical illness and trauma, 440
in medical settings, 483
in Theraplay®, 166–167, 179–181
caregiver vulnerability, 389
case descriptions, 190
catharsis, 43
causal therapy, 230
CBPT. See cognitive-behavioral play therapy
CBT. See cognitive-behavioral theory; cognitive-behavioral therapy
CCPT. See child-centered play therapy
CCPT case example
agression in, 111–112
father in, 112–113
limits in, 111–113
mother in, 113
progress in, 113
responsibility in, 112
CCPT theory, 93
personality in, 94
person in, 94–95
phenomenal field in, 95
self in, 95–96
CD. See conduct disorder
CDC. See Centers for Disease Control and Prevention
CDI. See child-directed interaction
Center for Play Therapy, 7
Centers for Disease Control and Prevention (CDC), 100,
challenges, 173–174
of prescriptive play therapy, 235–236
change, 292–293
change ingredients, 292–293
change mechanisms, 232–233, 565, 566
The Child (Neumann), 73
child abuse, 234, 352
cultural issues and, 602
in interpersonal trauma, 419–420
metaphors and stories for, 266, 266–267, 267
perpetrators of, 420
reporting, 509
Child Abuse Prevention and Treatment Act, 420
A Child Called "It" (Pelzer), 429
child-centered imaginary play, 153
child-centered play therapy (CCPT), 115, 564
assessment in, 104–105
client characteristics in, 99
communication in, 109–110
CPRT for, 110–111
description of, 93
indication/contraindications in, 100
for interpersonal trauma, 424–425, 430
limit-setting in, 107–109
limits in, 100–101
logistics in, 100–104
objectives of, 105–106
parents in, 109–111
playroom for, 101–103
principles in, 96–97
problems and, 104
quasi-experimental group designs for, 572
reflection of content in, 107
reflection of feelings in, 107
research on, 100, 113–114, 467, 570, 572, 652–653,
655–660
in schools, 491, 499–501
therapists in, 97–99
toys and materials for, 101–103
tracking in, 107
treatment frequency and duration in, 103–104
treatment planning in, 104–105
treatment stages in, 105–106
trust in, 109
child-directed interaction (CDI), 344, 347–349, 348
child neglect, 419–420
Child-Parent Relationship Therapy (CPRT), 110–111,
499, 575
research on, 653, 655–657, 660–661
Child–Parent Relationship Therapy (Landreth, G.), 26
Child-Parent Relationship Training (CPRT), 425, 431–432
Child Parent Relationship Treatment (CPRT) Manual
(Bratton, S.), 411
Children’s Use of Board Games in Psychotherapy
(Bellinson), 310
choice, 312, 318–319
clean-up, 250, 347
classroom guidance, 486
client-centered play therapy, 22–23
client characteristics
in analytic psychology, 77–78
in BGPT, 317
in CBPT, 120–121
in CCPT, 99
in disabilities, 407
drama, 303–304
in EPT, 210
in FT, 147–148
in interpersonal trauma, 427
client characteristics (continued)
in medical illness and trauma, 441
in metaphors and stories, 271
in sandtray/sandplay therapy, 245–246
client-therapist matching, 230
“Climbing the Mountain” (Pernicano), 266, 266–267, 267
clinical considerations, 614–618
clinical experience, 632
clinical practice, 600–601
clinical review, 552–554
clinical supervision, 549–550. See also supervision

codes of ethics, 510–511, 527, 529
cognition accuracy, 461–462
cognitive-behavioral play therapy (CBPT), 29
assessment in, 123–124
caregiver in, 127
with CBT, 129
client characteristics, 120–121
delivery method in, 125–127
generalization and response prevention in, 127–128
for geriatrics, 339
indications/contraindications in, 121
in interpersonal trauma, 426
intervention in, 124–125, 125, 126
introductory/orientation in, 123–124
logistics in, 121–122
middle phase in, 124–128, 125, 126
playroom for, 121–122, 130
pretreatment intake and assessment in, 123
procedure/technique in, 120–128, 125
research on, 128–129
in schools, 491–492, 499–501
structured versus unstructured play in, 127
termination in, 128
therapists in, 120
toys and materials for, 121–122, 130
treatment frequency and duration in, 122
treatment planning in, 123
treatment stages and strategies in, 123–128, 125, 126
cognitive-behavioral theory (CBT), 129, 223
disabilities and, 403
in DRPT, 458–459
cognitive-behavioral therapy (CBT), 119–120
cognitive distortions, 124
cognitive domain, 366
cognitive restructuring, 124, 125
cognitive theory, 137. See also cognitive-behavioral theory
Color-Your-Life Technique, 27
common disabilities, 398–401
common factors, 36
communication, 86, 339, 399, 533
in CCPT, 109–110
in DIR®/Floortime, 362–363
in medical settings, 473–476
as power of play, 232
in schools, 494
communication disabilities, 399
comorbidity, 401, 656, 657, 662, 662
in EST current research status, 664
in medical settings, 475
competence, 429, 507, 534, 603
competitiveness, 315–316
compliant children, 546
comprehensive assessment, 230–231
counterconditioning of fears, 44–45
court order, 511
courts, family, 209
court testimony, 512–513
CPRT. See Child-Parent Relationship Therapy;
Child-Parent Relationship Training
“The Cracked Glass Bowl” (Pernicano), 268
Creative Family Therapy Techniques: Play, Art, and
Expressive Activities to Engage Children in Family
Sessions, 278–279
critical thinking, 103, 278, 388, 616, 623
credentialing, 8
credibility, 512–513
CTRT. See teacher-adapted CPRT
cultural competency, 12
critical thinking, 103, 278, 388, 616, 623
credentialing, 8
credibility, 512–513
CTRT. See teacher-adapted CPRT
cultural competency, 12
active competence in, 603
case example in, 208
ethnicity and, 603–604
social advocacy in, 604
for therapists, 208–209, 608–609
training for, 604
cultural differences, 400–401
cultural issues

caregivers and, 602–603
child abuse and, 602

Pthomegroup
in clinical practice, 600–601
corporation of, 601
racism in, 599, 606–608
systemic theory and, 601–602
culturally inclusive space
   acting-out/aggression-release in, 102–103
   creative expression in, 103
   emotional release in, 103
   furnishings in, 103
   real-life toys in, 102
cultural perspective, 401
cultural sensitivity, 599–600
cultural systems context, 604–605
culture-inclusive office, 605–606
cultures, 208, 600–601, 645–646
   DRPT and, 466
   research and, 114, 351–352, 662
in schools, 488
curative elements, 205–207
curiosity, 187–188, 264
custody issues, 513–515
cutting, 186, 268
death, 67–68
   suicide, 295, 301–302, 660
deficit perspective, 400–401
deintegrative state, 72
delivery method, 125–127
denial, 264
deontology, 526
despair stage, 338–339
The Developing Mind (Siegel), 262
development, 619–620
   in BGPT, 316
   of brain, 586–587
   in EPT, 202–203
   of metaphors and stories, 263–265
developmental/attachment theory, 137
developmental delays, 358. See also DIR®/Floortime
developmental framework, 359, 375
developmental goals, 219
Developmental Play Assessment (DPA), 410
developmental theory, 403
diabetes, 448–450, 483, 657, 662
diagnosis, 269–270, 593–594, 617, 619
Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5), 59, 196, 418
diagnostic clarification, 269–270
Dibs: In Search of Self (Axline), 22, 115
differential therapeutics, 228
differentiation, 72
dinosaurs, 85–87
direct here-and-now interaction, 168
direction, 55
   in EPT, 198
   nondirective play therapy, 22–23, 278, 439, 444, 564, 568
   PDI, 347, 349, 349–350
   self-direction, 105
direct observation supervision, 554
direct supervision of play sessions phase, 154
direct teaching, 41–42
DIR®/Floortime, 593
   application and integration of, 363, 376–377
   ASD strategies in, 369–374
   beginning case example in, 369
   beginning with, 369
caregivers in, 367
   communication in, 362–363
diagnostic framework in, 359, 375
   EBP in, 374–377
   escape artist in, 367–368
   Floortime model in, 361–369
   following child’s lead case example in, 362
   following child’s lead in, 361–362
   individual in, 359–360, 375
   joining child’s world case example in, 363
   mastery case examples in, 364–367
   mastery in, 364–367
   pacing in, 370–371
   playfully obstructive strategies in, 364–365
   playful obstruction in, 368
   play partner case example in, 370
   problematic behaviors in, 371–374
   regression in, 373–374
   relationship and affect in, 360–361, 376
   review on, 358
   spin master in, 372–373
   theory in, 358–361
   therapist in, 363–365
   toss champ in, 373
   train engineer in, 371–372
   validation in, 366–367
disabilities
   ADHD in, 409
   behavioral regulation in, 402–403
   CBT and, 403
   client characteristics in, 407
   cognitive-behavioral theory and, 403
   common, 398–401
   communication, 399
   cultural differences and, 400–401
   developmental theory and, 403
   DPA for, 410
   emotional regulation in, 402–403
   EPT and, 403–404
   FT for, 404, 411
   group therapy for, 404–405
   hearing, 399, 661
   indications/contraindications in, 407
   individual play therapy theories and, 403–404
   interpersonal relationship theory and, 403
   learning, 400
   limited success experience in, 402
   modalities for, 403–405
   motor, 398
   multiple, 400
   playroom for, 407–408
   population definition in, 397–403
   pretreatment assessment for, 410–411
disabilities (continued) research on, 411–412
self-esteem in, 402 social-emotional issues in, 401–403 social skills in, 402 therapists in, 403–407, 412–413 toys and materials for, 408–409 treatment frequency and duration for, 410 treatment planning for, 410–411
visual, 399

response set and, 205–206
termination in, 215–216
treatment in, 215–216
theory of, 195–200
therapists in, 199–200, 207–210
treatment in, 215–216
Thouret's Disorder case example in, 200
toys and materials in, 199, 211–212, 220–221

education, 7–8, 460
IDEA, 397–398, 404–405, 524–525
psychoaeducation, 124, 125, 480
educational systems, 200, 209
ego, 67, 70–71
superego, 19, 64–65
ego development, 81–82
E-Learning Center, 8
11–18 years, 334–336
embodied play, 285
Embodiment-Projection-Role (EPR), 291–292
emotional development, 587–588
emotional participation, 101
emotional regulation, 144, 146, 401
in disabilities, 402–403
neuroscience and, 589
in parenting practices and attitudes, 140
emotional release, 103
emotional wellness, 232–233, 362, 620
emotions, 44, 51–52, 429, 446–447
empathic listening, 142, 146, 153
empathy, 73, 168–169
in FT case example, 159
powers of play, 49–50
research on, 145, 146

empirically supported treatment (EST), 222–223, 651.
See also EST current research status
history of, 652–653
emotional support, 138–145, 232. See also research
effectiveness, 84
entitlement, 265–266, 270
ending sessions, 547
engagement, 98, 172, 278
engrossment, 40
environmental attachment, 205
EPR. See Embodiment-Projection-Role
EPT. See Ecosystemic Play Therapy
EPT complete case example
attachment-based goals in, 219
baseline measures in, 217
developmental goals in, 219
ecosystemic case conceptualization in, 217–218
growing and trusting in, 221
hypervigilance in, 216–218
initial treatment goals and contract in, 218–219
introduction and exploration in, 219–220
need-based goals in, 218
negative reaction in, 221
occupational therapy in, 217
pretreatment intake and assessment in, 216–217
tentative acceptance in, 220–221
termination in, 221–222
toys and materials in, 220–221
treatment phases in, 219–222
Escalate artist, 367–368
EST. See empirically supported treatment
EST current research status
comorbidity in, 664
conclusions in, 654, 655–662, 662–663
controls in, 664
culture in, 662
intervention identification in, 654
omissions in, 663
original studies in, 654
protocols in, 664–665
randomization in, 653–654, 655–662
RCTs in, 664–665
replications in, 664
strengths and limitations in, 663–665
ethical absolutism, 526
ethical altruism, 526
ethical decision-making models, 516–517
of ACA, 529
of Kitchener, 527–528
of Welfel, 529–531
ethical dichotomies, 525–527
ethical egoism, 526
ethical models, 533
ethical principles and theories, 530–531
ethical professional readiness
dilemmas in, 532–533
ethical models in, 533
guidelines in, 531–532
organizational memberships in, 532
ethical relativism, 526
ethical standards, 530
ethics
consultations for, 535–536
ethical decision-making models, 527–531
ethical dichotomies in, 525–527
guidelines about, 523–524
laws compared to, 524
legal considerations and, 524–525
states and, 525
terminology for, 533–534
ethics literature, 530
ethnicity, 114, 603–604
etiology and maintenance, 204–205
evidence-based practice (EBP), 222, 230, 570. See also
research evidence
in DIR®/Floortime, 374–377
evidence-informed matching, 230
evidentary base, 572–573
mental health, 632–633
variation, 584–585, 585
Existential Child Therapy: The Child's Discovery of Himself
(Moustakas), 23
expanded definition play therapies, 574–575
experiential continuum, 198
experiential play therapy, 28–29
equivalent designs, 570, 572. See also
quasi-experimental group designs; single-case
equivalent designs
RCTs in, 573, 575–577, 647, 653, 663
expressive arts
for adults, 282–284, 286–287
learning environment in, 281
logistics in, 280–283
nondirective play therapy in, 278
open play/art studio in, 282
playroom for, 281–282
“portable” playroom, 281–282
pretreatment assessment in, 283
research on, 278–279
technique of, 279–287
theory of, 277–278
therapists in, 279–280
Ugandan girls and, 282–287
expressive language, 656

face-to-face supervision, 551
facts, context, stakeholders, 530
Fairy Tale Model (Greenwald), 263
false self, 385
family courts, 209
Family Education Rights and Privacy Act (FERPA), 524–525
family involvement, 12
family loyalty, 604–605
family play observation, 157–158
family play therapy, 12, 30, 252, 391–392
Family Play Therapy: Assessment and Treatment Ideas (Gil), 30, 263
family scenes, 298
family systems, 137
family therapy, 252, 391–392
fantasy compensation, 41, 47, 624
fantasy escape, 47
father, 112–113, See also caregivers
fears, 44–45, 122, 234. See also hypervigilance
mastery play for, 206–207
in medical illness and trauma, 448–449
technology and, 623–624
feedback, 536
Ferenczi, Sandor, 19
FERPA. See Family Education Rights and Privacy Act
ferility, 528
Filial Therapy (FT), 26–27, 110. See also FT case example
case example of, 156–161
client characteristics in, 147–148
direct supervision of play sessions phase in, 154
for disabilities, 404, 411
discharge planning in, 156
empirical support of, 138–145
features of, 137–138
generalization in, 155
indications/contraindications in, 148–149
limit-setting in, 153–154
logistics in, 149–150
in medical illness and trauma, 445
of parental skills and attitudes, 141–142
of parent-child play, 138
of parenting practices and attitudes, 139–141
playroom for, 149–150
pretreatment intake and assessment in, 150
procedure in, 145, 147–156, 152
progress in, 156
research on, 143–145, 412, 575
theory and, 135–137
therapists in, 145, 147
tools and materials for, 149–150
training in, 153–154, 158
transfer to home play sessions in, 155
treatment frequency and duration for, 149–150
treatment planning in, 151–156, 152
treatment stages and strategies in, 152, 152–156
“First Things First” (Pernicano), 265
Floor Games (Wells, H. G.), 20
Floortime model, 361–369
focus time, 253
following child’s lead, 361–362
following child’s lead case example, 362
Fordham, Michael, 18, 72
formal operations stage, 333–336
foster/adoptive, 234
foster care, 606–608
founding building, 6–7
Foundation for Play Therapy, 5, 9
freedom, 49, 74
Freud, Anna, 20, 66–68
Freud, Sigmund, 18, 40, 201
treaties of, 64–65, 69
frustration tolerance, 314–315
FT. See Filial Therapy
FT case example
alliance in, 159–160
assessment in, 157–158
background in, 156–157
empathy in, 159
family play observation in, 157–158
home play sessions in, 160–161
limit-setting in, 159
nurturance in, 160–161
parental training in, 158
play session demonstration in, 158
reflecting in, 158–159
functional emotional capacities, 362
functional play, 330
furnishings, 103
future, 12, 55, 451–452, 621–622

game play, 52, 54. See also board game play therapy; technology
Game Play (Schaefer, C. and Reid, S. E.), 310
Subject Index 689

games, with rules, 333–334
games development, 622
generalization, 127–128, 155, 160
genertivity, 336
geriatrics, 338–339
gift-giving, 546
Ginott, H., 23, 540
good enough mothering, 385
graduate education development, 7–8
graduation, 181, 186, 189, 350
Greenspan, Dr., 358, 360
grief, 234, 447
grounded theory, 645
group design, 573. See also quasi-experimental group designs
Group Psychotherapy with Children: The Theory and Practice of Play Therapy (Ginott), 23, 29
group supervision, 556
group therapy, 252, 279
in CCPT, 108–109, 658
for disabilities, 404–405
in life span play therapy, 337, 339
in schools, 498
technology and, 617, 621
growing, and trusting, 215
growth, and development, 584–588, 585
with technology, 619–620
Guernsey, Bernard, 12, 24
Guernsey, Louise, 4, 24, 27
Guerrero, Carol Munoz, 6
guidelines, 8, 234, 234–235
in ethical professional readiness, 531–532
about ethics, 523–524
about legal systems, 517–518
guilt, 95, 206

Hall, G. Stanley, 18
Handbook of Play Therapy (Schaefer, C. & O’Connor, K.), 7, 651
hard science philosophy, 200–201
Healing with Stories: Your Casebook Collection for Using Therapeutic Metaphors (Burns), 259
Health Insurance Portability and Accountability Act (HIPAA), 508, 524–525
hearing disabilities, 399, 661
auditory processing, 365–366
hierarchical linear modeling (HLM), 652
HIPAA. See Health Insurance Portability and Accountability Act
Hispanics, 606–608
history, 17, 26–27
in America, 21–22
of EST, 652–653
pioneers of, 19–20
rise and fall of, 23–25
systematic reviews in, 653
theoretical and conceptual roots in, 18–19
of therapeuic powers, 36
HLM. See hierarchical linear modeling
holding environment, 385
home play sessions, 160–161
hope, 462–463
hospitals, 439–440, 445–446. See also medical settings
Hug-Hellmuth, Hermine, 19, 65–66
humanistic model, 200, 568
humanistic theory, 136
humor, 52
humor therapy, 46
Hurricane Katrina, 422–423
hyperarousal, 461
hypersensitivity, biologic, 217–218
hypervigilance, 206, 216–217, 389
IDEA. See Individuals With Disabilities Education Act
identification, 654
in metaphors and stories, 261, 264, 285
identified personal theory, 311
identity, 334–335
identity crisis, 335
imagery, 447–448, 451
imagination, 49, 69, 277, 616–617
implementation of PCIT, 350–351
of SCED, 641–642
in schools, 493–494
impressions, 81
impulse control, 613–614, 619
in-between space, 277
incarceration, 431
incest, 69
independent variable definition, 573
indications/contraindications in BGPT, 320
in CBPT, 121
in CCPT, 100
in disabilities, 407
in EPT, 210–211
in FT, 148–149
in medical illness and trauma, 441–442
for metaphors and stories, 271
in sandtray/sandplay therapy, 246
indirect teaching, 42
individual, 359–360, 375
individual play therapy theories, 403–404
individual supervision, 554
Individuals With Disabilities Education Act (IDEA), 397–398, 404–405, 524–525
individual treatment, 227–228
individualization, 70, 625
industry, 333
infection control, 476, 478
inferiority stage, 333
informed consent, 506–507, 534
initial play sessions, 158–160
initial treatment goals and contract, 218–219
initiative, 95
inoculation, 45–46
Institute for Child Guidance, 21
Institute of Child Psychology, 20
intake, 346–348. See also pretreatment intake and assessment
integration, 11, 136, 310, 363, 376–377
integrative models, 195–196
integrative psychotherapy, 229
integrative state, 72
integrity, 338–339
intense play, 422–423, 424
interactive relationship based experiences, 167–168
interactive scenes, 299–300
International Journal of Play Therapy, 7, 9, 592, 647
interpersonal neurobiology, 10
interpersonal process, 588–591
interpersonal relationship theory, 403
interpersonal theory, 136
interpersonal trauma, 417
CBPT in, 426
CCPT for, 424–425, 430
child abuse in, 419–420
childhood development and, 421
client characteristics in, 427
competence and, 429
confidence and, 429
CPRT for, 425, 431–432
description of, 418
domestic violence in, 419–421
effects of, 419, 422
emotions and, 429
EPT in, 426
love and, 429
play healing properties for, 422
playroom for, 428
play therapy for, 421–424, 424
population definition in, 418–424, 424
posttraumatic play behaviors in, 422–424, 424
procedure in, 427–428
relational trauma in, 418
research on, 430–432
security and, 429
sense of self in, 429
social hunger and, 418
techniques and strategies for, 428–430
TF-IPT for, 431
therapists in, 427, 429–430
toys and materials in, 428
TPS and, 423–424, 424
treatment frequency and duration for, 428
trust and, 419–420, 428–429
intervention identification, 654
interventions, 139, 631, 663
strategies and, 330, 332, 334, 336–337
intimacy, 336
introduction, and exploration, 214, 219–220
introductory/orientation, 123–124
intrusive behavior, 545
investigator, 509–511
iPad, 613–615
isolation stage, 336
issue illumination, 268–269, 269
James, William, 17
joining child’s world, 362–364
joining child’s world case example, 363
Freud, Anna, 18
Jung, Carl, 18, 68–72, 75, 539
Jungian play therapies, 28
justice, 528
Kalff, Dora, 18, 73–74
kidnapping, 422. See also Ugandan girls
kitchen-sink eclecticism, 228
Klein, Melanie, 19–20, 67–68
Knell, Susan, 29
knowledge. See awareness, skills, and knowledge
Kottman, Terry, 29
Landreth, Garry, 5, 7, 12, 26–27
language, 60, 260, 400, 533–534, 656
natural, 39
schools and, 486–487
latency period, 313–314
lateralization, 585
laughter, 47, 48
laws, 524
learning, by example, 42
learning disabilities, 400
learning environment, 281
Lebby, Kathryn, 6
legal advocacy, 515–516
legal considerations, 524–525
legal guardians, 506–507
legalities, 492–493
legal systems, 209
best practices and, 506
caregivers and, 505
child abuse reporting and, 509
codes of ethics and, 510–511
competence in, 507
confidentiality and, 514
counseling and, 506–507
counselors and, 516
court testimony and, 512–513
credibility and, 512–513
custody issues and, 513–515
ethics and, 506–507
guidelines about, 517–518
legal advocacy and, 515–516
legal and ethical decision-making model and, 516–517
recordings and, 508–509
recordkeeping and, 507–509, 515, 517
risk management and, 514–515
role confusion and, 510, 514, 516
security and, 507–508
sexual abuse and, 515–516
subpoenas and, 511–512
therapist or investigator and, 509–511
Leon, Diane, 6
Levy, David, 21
libido, 69
life cycle, 12
life span play therapy, 12, 327
3–7 years, 330–332
6–11 years, 333–334
Subject Index 691

11–18 years, 334–336
19–64 years, 336–338
65 and older, 338–339
daught er in, 328, 336–337
appropriateness of, 328
birth to 2 years, 329–330
birth to 18 months, 330
case example 22-year-old, 337–338
group therapy in, 337, 339
strategies and interventions of, 330, 332, 334, 336–337
theories in, 328–337
limited success experience, 402
limits, 100–101, 111–113
limit-setting
aggression and, 540, 545–546
bathroom behaviors in, 545–546
boundaries in, 539–541
in CCPT, 107–109
compliant children in, 546
des co nctions and, 547
in FT, 153–154
gift-giving in, 546
intrusive behavior in, 545
in medical settings, 481–482
in parental skills and attitudes, 141–142
in playroom, 541
research on, 146
resistant children and, 542–543
in sandtray/sandplay therapy, 251–252
self-destructive behavior and, 543
shy children in, 545
strategies on, 541
with technology, 618
touch in, 545
“Little Butterfly and the Bad Thing” (Pericano), 265
live supervision, 554
logistics, 78
in BGPT, 320–321
in CBPT, 121–122
in CCPT, 100–104
in EPT, 211–213, 212
in expressive arts, 280–283
in FT, 149–150
in medical illness and trauma, 442
in metaphors and stories, 271–272
in sandtray/sandplay therapy, 247–250
in Theraplay®, 176–177
long-term recovery phase, 463–466, 464–465
long-term therapies, 74–76
love, 429, 449–450
Lowenberg, Margaret, 18, 20, 66

Mahler, Margaret, 20
make-believe, 39, 94–95, 438–439. See also imagination
Mancala, 311–312, 319–320
mandated reporting, 533–534
Marshak Interaction Method (MIM), 175, 183, 217
Maslow’s hierarchy of needs, 202, 335–337
MasterMind, 318–319
mastery, 314, 364–367
mastery play, 206–207
matching, 229–230, 387
materials, 78. See also toys and materials
maturation, 639
MEACI. See Measurement of Empathy in Parent–Child
Interaction
Measurement of Empathy in Parent–Child Interaction
Mediators outcome designs, 640–641
medical illness, and trauma
adherence in, 446
anticipatory grief in, 447
appropriateness in, 438–439
avoidance in, 451
caregivers in, 440
case study in, 448–450
characteristics in, 437–438
client characteristics in, 441
control in, 446–447
divorce and, 448–450
emotions after procedures in, 446–447
fears in, 448–449
FT in, 445
future research on, 451–452
hospitalization and medical procedure preparation in, 445–446
imagery for, 447–448, 451
indications/contraindications in, 441–442
logistics in, 442
love in, 449–450
pain management in, 448, 451
playroom for, 442
population definition in, 437
pretreatment intake and assessment in, 443, 443–444
procedure in, 439–445, 443
research on, 450–452
special needs in, 437–438
techniques and strategies in, 445–448
theory and, 439
therapists in, 440–441
and treatment, 442, 446
treatment frequency and duration in, 442–443
treatment stages and strategies in, 444–445
medical play, 479
medical settings
adherence and, 481–482
admission length in, 474
anxiety- and pain-management in, 479–480
appropriateness in, 474–475
bedside activities in, 481
breathing techniques in, 479–480
caregivers in, 482
characteristics of, 473–474
communication in, 475–476
comorbidities in, 475
definition of, 473–477
distraction techniques in, 479
infection control in, 476, 478
limit-setting in, 481–482
medical play in, 479
obstacles in, 475–477
medical settings (continued)  
- population definition in, 477  
- procedure in, 478  
- psychoeducation in, 480  
- rapport in, 481  
- research on, 482  
- sensitivity in, 474–475  
- siblings in, 482  
- techniques and strategies in, 478–482  
- theory and, 477–478  
- time in, 476–477  
- toys and materials in, 476, 478–479  
- medicated children, 590–591, 594–595  
- memories, 262  
- mental health evidentiary base, 632–633  
- meta-analyses, 411, 444, 568–569  
- on CBPT, 129  
- on CCPT, 114  
- in history, 652–653  
- metaphors, 616, 619  
- metaphors, and stories, 259  
- blind spot and, 270  
- for child abuse, 266–267  
- client characteristics in, 271  
- client construction of, 265–266, 266, 267  
- development of, 263–265  
- diagnostic clarification in, 269–270  
- enactment of, 265–266, 270  
- identification in, 261, 264, 285  
- indications/contraindications for, 271  
- issue illumination in, 268–269, 269  
- as language of play, 260  
- logistics in, 271–272  
- memories in, 262  
- modeling in, 270–271  
- neurodevelopment and, 261–262  
- orientations for, 260  
- procedure/technique in, 262–272, 266, 267, 269  
- reality related to, 261  
- research and, 262  
- specific techniques for, 270–271  
- theory on, 260–262  
- therapists in, 271  
- toys and materials for, 271–272  
- for trauma, 263–265  
- treatment planning for, 272  
- metatheories, 196  
- Meyer, Adolf, 17  
- MIM. See Marschak Interaction Method  
- mind-body interactions, 202  
- The Mindful Therapist (Siegel), 262  
- MineCraft, 621, 623–625  
- mixed profile, 365  
- modeling, 270–271, 652  
- model reviews, 189  
- models, 3–4, 10, 195–199, 533. See also ethical decision-making models  
- C³ARE, 459–460  
- Floortime, 361–369  
- humanistic, 200, 568  
- service delivery, 345–346  
- therapeutic, 593–594  
- transtheoretical, 36–37  
- models expansion  
- Adlerian play therapy in, 29  
- cognitive behavioral play therapy in, 29  
- experiential play therapy in, 28–29  
- family play therapy in, 30  
- Jungian play therapies in, 28  
- psychoanalytic and psychodynamic play therapies in, 27–30  
- moderators outcome designs, 640–641  
- monster, 299  
- mood stabilizers, 590  
- moral development, 52–53  
- moratorium, 335  
- mother, 73, 82–86, 113, 385. See also caregivers  
- motherese, 382  
- motives, 202  
- motor disabilities, 398  
- Moustakas, Clark, 23  
- Mr./Ms. Opposite, 298–299  
- multiple disabilities, 400  
- multisensory experiences, 170  
- muscular dystrophy, 317–318  
- music, 390, 480  
- My Voice Will Go With You (Rosen, S.), 261  
- narrative play therapy, 300, 620–621  
- National Committee for Mental Hygiene (NCMH), 17  
- National Institute of Mental Health, 376  
- natural language, 39  
- natural play, 10  
- NCMH. See National Committee for Mental Hygiene  
- necessary resources  
  for quasi-experimental group designs, 639  
  for RCTs, 636–637  
- need-based goals, 218  
- negative affect, 423, 424  
- negative reactions, 215, 221  
- negative self-view, 389  
- Neumann, Erich, 72–73  
- neurobiology, 10, 253–254, 583  
- neurodevelopment, 487  
  ASD and, 359–360, 376–377  
  attachment problems and, 382, 384–385, 387–388  
  metaphors and stories and, 261–262  
- neuroscience. See also brain  
  attachment and, 588–589  
  attachment disturbances and, 589–590  
  emotional regulation and, 589  
  interpersonal process and, 588–591  
  medicated children and, 590–591  
  of optimal growth and development, 584–588, 585  
  principles of, 593  
- research application of, 594–595  
- therapeutic models and diagnostics of, 593–594  
- therapeutic powers of play and, 591–592  
- Neurosequential Model of Therapeutics, 10  
- neurosis, 67, 69  
- neurotransmitters, 587
Subject Index

19–64 years, 336–338
nondirective play therapy, 444, 564, 568.
See also child-centered play therapy
Axline and, 22–23, 96, 439
in expressive arts, 278
nonmaleficence, 526, 528, 530–531
nonverbal connection, 187
norm compliance level, 316
numbers, 83–84
numinous, 69
nurture
in FT case example, 160–161
in Theraplay®, 172–173, 183
Oaklander, Violet, 25
obesity, 234
objectives, 105–106
object relations theories, 385
obscene compulsive disorders, 207
obstacles, 639
in medical settings, 475–477
for SCED, 643–644
in schools, 489–491
obstinate attachment, 385
occupational therapy, 217
O'Connor, Kevin, 4–5, 7, 27
ODD. See oppositional defiant disorder
Oedipal phase, 65, 67, 69
omissions, 663
"On the Technique of Child Analysis" (Hug-Hellmuth), 19
101 Healing Stories for Kids and Teen: Using Metaphors in Therapy (Burns, G.), 259
opening, 188
open play/art studio, 282
oppositional defiant disorder (ODD), 234, 343
optimal growth and development, 584–588, 585
oral stage, 65
organizations, 5–6
memberships in, 532
orientations, 123–124, 260
original studies, 654
outcomes assessment, 574
pacing, 370–371
pain management, 448, 451, 479–480
parent acceptance, 143–144
parental sensitivity, 143
parental skills and attitudes
attunement in, 141–142
empathic listening in, 142
limit-setting in, 141–142
reflecting in, 142, 144, 158–159
structuring in, 141–142
parental training, 147, 158, 350–351
CPRT for, 425, 431–432
in research evidence, 574–576
parent–child dyad, 138, 251–252, 347
parent-child interaction therapy (PCIT), 353
attrition rates in, 352
case example in, 346–347
CDI in, 344, 347–349, 348
child abuse and, 352
clean-up in, 347
components of, 346–350, 348, 349
description of, 343–344
graduation in, 350
implementation of, 350–351
intake in, 346–348
PDI in, 347, 349, 349–350
playroom for, 345
research on, 351–352, 575
service delivery model of, 345–346
theory of, 344–345
therapists in, 345–346, 348, 350–351
toys and materials in, 345
training in, 350–351
parent-directed interaction (PDI), 347, 349, 349–350
parenting genograms, 253
parenting practices, and attitudes
attachment security in, 139
behavioral regulation in, 139
emotional regulation in, 140
reflective functioning in, 140–141
socialization-as-intervention approach in, 139
structuring in, 139–140
training for, 147
parents, 78
in CCPT, 109–111
divorce of, 182–183, 209, 234, 448–450
incarceration of, 431
participation, 98, 101
“Partnership for Research Based Evaluation” (PRBE), 488
pathology, 203–205
patience, 99
patterns, 317–318
Patterson's coercive cycle, 344
PCIT. See parent–child interaction therapy
PDL. See parent-directed interaction
peek-a-boo, 48
peer-reviewed journals, 189–190
peer supervision, 555–556
permission, 534
Ferry, Leslee, 5
person, 39, 94–95
personality, 94, 201–203
personal strengths, 232–233
PFA. See psychological first aid
phallic stage, 65
phenomenal field, 95
phenomenology, 200–201, 644–645
philosophy, 200–201
phone supervision, 552
physical assault, 419–420
Poupel, Jean, 39, 52
pivotal moments of change, 292
play, 357
play analysis, 19
play disruptions, 423, 424
playful attitude, 170–171
playfully obstructive strategies, 364–365
playful obstruction, 368
playful supervision, 555, 559
play genograms, 253
play healing properties, 422
Play in Family Therapy (Gil), 30, 265
play partner case example, 370
playroom, 618
for BGPT, 320–321
for CBPT, 121–122, 130
for CCPT, 101–103
for disabilities, 407–408
for drama, 304
for EPT, 199, 211–212, 212
for expressive arts, 281–282
for FT, 149–150
for interpersonal trauma, 428
limit-setting in, 541
for medical illness and trauma, 442
for PCIT, 345
for sandtray/sandplay therapy, 247–249
for schools, 494–495
play session demonstration, 158
play therapy. See also specific topics
cultural competency in, 12
definitions of, 7, 327, 507, 564–565
emergence of, 4–9
family involvement in, 12
through life cycle, 12
origins of, 3
psychotherapy and, 3–4
research and, 9–12
special populations and, 11
Play Therapy Best Practices (APT), 8, 506–507
Play Therapy: Dynamics of the Process of Counseling with Children (Landreth, G.), 26
play therapy emergence
APT in, 4–6
credentialing in, 8
foundation building in, 6–7
graduate education development in, 7–8
organizations in, 5–6
publications in, 7
research base in, 8–9
standards of practice in, 7–8
The Play Therapy Primer (O’Connor, K.), 202–203
Play Therapy: The Art of the Relationship (Landreth, G.), 278
Play Therapy: The Inner Dynamics of Childhood (Axline), 22–23, 439
Play Therapy Treatment Planning and Interventions: The Ecosystemic Model and Workbook (O’Connor, K. & Ammen), 195, 410
population definition
in attachment problems, 381–384
in disabilities, 397–403
in DRPT, 455–458
in interpersonal trauma, 418–424, 424
in medical illness and trauma, 437
in medical settings, 477
in research evidence, 573–574
Porter Parental Acceptance Scale (PPAS), 143
positive emotions, 44, 51–52, 96
positive self-statements, 124, 125
postcreation, 249–250
posttraumatic play behaviors, 422–424, 424
Posttraumatic Stress Disorder (PTSD), 175, 234, 338, 418, 659, 662
powers of play, 56. See also therapeutic powers of play
abreaction, 43–44
accelerated psychological development, 53
attachment, 48
catharsis, 43
communication, 232
counterconditioning of fears, 44–45
creative problem solving, 50–51
direct teaching, 41–42
emotional wellness, 232–233
empathy, 49–50
indirect teaching, 42
moral development, 52–53
personal strengths, 232–233
positive emotions, 44
resiliency, 51–52
self-esteem, 54–55
self-expression, 38–40
self-regulation, 53–54
sense of self, 49, 429
social relationships as, 232–233
stress inoculation, 45–46
stress management, 46–47
therapeutic relationship, 47–48
unconscious access, 40–41
PPAS. See Porter Parental Acceptance Scale
PPRA. See Protection of Pupil Rights Amendment practitioners, 646–647
pragmatic approach, 233–234
PRBE. See “Partnership for Research Based Evaluation”
preintervention assessment, 304–305
preoperational stage, 94
prescriptive matching, 229–230
prescriptive play therapy, 618
best practices in, 234, 234–235
challenges of, 235–236
comprehensive assessment in, 230–231
core practices of, 232–236, 234
description of, 227
differential therapeutics in, 228
eclecticism and, 228–229
empirical support of, 232
individual treatment in, 227–228
integrative psychotherapy in, 229
pragmatic approach of, 233–234
prescriptive matching in, 229–230
tenets of, 227–231
therapeutic change mechanisms in, 232–233
therapist in, 235
transtheoretical approach of, 228–229
presentations, 494
pretend play, 54, 438–439
pretend play development, 290–291
pretreatment assessment
  in BGPT, 321
  for disabilities, 410–411
  in expressive arts, 283
pretreatment intake and assessment
  in CBPT, 123
  in EPT, 213–214, 216–217
  in FT, 150
  in medical illness and trauma, 443, 443–444
preverbal level, 73
preverbal social right-brain focus, 169–170
primary process thinking, 49
principle ethics, 526
principles, 530–531
  in CCPT, 96–97
  of neuroscience, 593
privileged communication, 533
problematic behaviors, 371–374
problems, 104, 620. See also attachment problems
  problem solving, 50–51, 124, 125
procedures, 446–447, 478, 638
  in DRPT, 459–466, 464–465
  in EPT, 207–208
  in FT, 145, 147–156, 152
  in interpersonal trauma, 427–428
  in medical illness and trauma, 439–445, 443
  for RCTs, 634–636
  in sandtray/sandplay therapy, 244–246
  for SCED, 642–643
  in schools, 492–498
procedure/technique
  in BGPT, 312–314
  in CBPT, 120–128, 125
  in drama, 293–296
  in metaphors and stories, 262–272, 266, 267, 269
processing delay, 366
professional boundaries, 209–210
professional competence, 534
professional disclosure statement, 534
professional readiness, 531–533
program descriptions, 190
progress, 113, 156
projection, 40, 69–70, 291–292
protection, 73
Protection of Pupil Rights Amendment (PPRA), 524
protocols, 664–665
protocconversations, 382
psyche, 73
psychic system, 70
The Psychoanalysis of Children (Klein), 19–20
psychoanalytic play technique, 19
psychoanalytic play therapies, 27–30
psychoanalytic theory, 64–68, 69
psychodynamic play therapies, 27–30
psychodynamic theory, 136
psychoduducation, 124, 125, 480
psychological first aid (PFA), 458–459, 467
“The Psychology of the Unconscious” (Jung, C.), 68
psychosis, 247
psychosocial dwarfism, 197
psychostimulants, 591
psychotherapy, 3–4, 29, 229
Psychotherapy with Children (Allen, F.), 22
PTSD. See Posttraumatic Stress Disorder
publication bias, 569, 572
publications, 7
puppet interview, 30, 297–298
puppets, 122, 408
qualitative research designs, 645–646
quantification, 569
quantitative research designs
  mediators and moderators outcome designs in, 640–641
  quasi-experimental group designs, 572, 633, 637–639
  RCTs in, 634–637
  SCED in, 641–644
  single group pre/post designs, 639–640
  small trial pilot designs, 637
  quasi-experimental group designs, 633, 637
  for CCPT, 572
  examples of, 638–639
  necessary resources for, 639
  obstacles in, 639
  procedures for, 638
  publication bias and, 572
  quasi-experimental studies, 570
race, 283
racism, 599, 606–608
randomization, 653–654, 655–662
randomized controlled trials (RCTs), 633
  for CCPT, 570
  in EST current research status, 664–665
  examples of, 636
  in experimental studies, 573, 575–577, 647, 653, 663
  modification of, 637
  necessary resources for, 636–637
  obstacles of, 637
  procedures for, 634–636
Rank, Otto, 18
rapport, 316, 481
reality, 261, 292
Reality Therapy, 11
REATs. See Registered Expressive Arts Therapists
reciprocity, 360, 372–373
recordings, 553
  legal systems and, 508–509
  recordkeeping, 507–509, 515, 517, 536
The Red Book (Jung, C.), 68–69
  reflecting, 168–169
  in FT case example, 158–159
  in parental skills and attitudes, 142, 144, 158–159
  reflection, of content, 107
  reflection, of feelings, 107
  reflective functioning, 140–141
Registered Expressive Arts Therapists (REATs), 280
Registered Play Therapist (RPT), 8, 278–279, 523–524
Registered Play Therapist-Supervisor (RPT-S), 8, 535–536
regression, 105–106
in DIR®/Floortime, 373–374
relational trauma, 418
relationship and affect, 360–361, 376
release therapy, 21
religious fundamentalism, 208
repetition, 44, 318–319
in assessment, 443, 444
repetition compulsion, 44
repetitive play, 423, 424
replications, 664
reptilian brain, 584, 585
research, 5, 8–12, 53, 594–595. See also EST current research status on ADHD, 234, 658–659
on aggression, 234, 660, 662
on anxiety, 657–658, 660, 662
on attachment problems, 75–76, 146, 391–392, 590
on BGPT, 310–311
on CBPT, 128–129
on CCPT, 100, 113–114, 467, 570, 572, 652–653, 655–660
on CPRT, 653, 655–657, 660–661
cultures and, 114, 351–352, 662
on disabilities, 411–412
on divorce, 234
on domestic violence, 432
on drama, 305–306
on DRPT, 467
on empathy, 145, 146
on EPT, 222–223
on expressive arts, 278–279
foundation for, 6–7
on Freud, S., 64
on FT, 143–145, 412, 575
interpersonal neurobiology and, 10
on interpersonal trauma, 430–432
on limit-setting, 146
on long-term therapies, 74–76
on medical illness and trauma, 450–452
on medical settings, 482
metaphors and stories and, 262
on PCIT, 351–352, 575
on sandtray/sandplay therapy, 254–255, 657
on schools, 500–501, 665
on sexual abuse, 431
technology and, 614–616, 621–622
on Theraplay®, 189–190, 575–576, 593
research application, 594–595
researchers, 632
traditional, 646–647
research evidence, 567
analysis adequacy in, 574
EBT criteria in, 570, 571–572, 572
evidentiary base in, 572–573
expanded definition play therapies in, 574–575
experimental studies as, 572
group design in, 573
intrasubject definition in, 573
meta-analyses in, 568–569
outcomes assessment in, 574
parental training in, 574–576
population definition in, 573–574
quantification in, 569
research issues
efficacy as, 563–565, 566, 567
key ingredients as, 565, 566, 567
perspectives on, 567
therapeutic factors as, 564–565
research methodologies, 631
clinical experience in, 632
levels of, 633
practitioners and, 646–647
qualitative research designs in, 644–646
quantitative research designs in, 634–644
statistical analyses in, 632
theoretical constructs in, 632
traditional researchers and, 646–647
resiliency, 51–52
resistance, 69
resistant children, 542–543
response set, 205–206
responsibility, 112
responsive services, 486
retrospection, 339
risk management, 514–515
Roesler, C., 75
Rogers, Carl, 18, 22–23, 93–94
role confusion, 334–335
role-play, 50, 52–53
roles/characters, 298–299
rough-and-tumble play, 54
rough IQ estimate, 315
Rousseau, J., 421
RPT. See Registered Play Therapist
RPT-S. See Registered Play Therapist-Supervisor
safe environment, 42
safety, 387, 623–624
sandtray/sandplay therapy, 28, 73–74, 337
client characteristics in, 245–246
documentation in, 250
focus time in, 253
group and family therapy in, 252
indications/contraindications in, 246
limit-setting in, 251–252
logistics in, 247–250
neurobiology and, 253–254
parent–child dyad in, 251–252
parenting genograms in, 253
playgenograms in, 253
playroom for, 247–249
play therapy, 247–249
procedure in, 244–246
research on, 254–255, 657
theory of, 243–244
therapists in, 244–245
Toys and materials in, 247–249, 605–606
treatment frequency and duration in, 249–250
treatment stages and strategies in, 250–253
Subject Index 697

Sandtray Therapy: A Practical Manual (Homeyer & Sweeney), 28
scarf story, 300
SCED. See single-case experimental designs
Schaefer, Charles, 4–5, 26
schizophrenia, 100
school counselors, 485–486
schools
   accessibility in, 488
   Adlerian Play Therapy in, 492, 500
   aggressive toys in, 497
   appropriateness in, 486–489
   APT and, 490
   ASCA and, 492–491, 493
   assessment in, 493–494
   CBPT in, 491–492, 499–501
   CCPT in, 491, 499–501
   classroom guidance in, 486
   communication in, 494
   confidentiality in, 495
   CPRIT in, 499
   culture in, 488
   disruptive behavior in, 487
   effectiveness in, 488
   group therapy in, 498
   implementation in, 493–494
   lack of support in, 489
   lack of training in, 490
   language and, 486–487
   legalities in, 492–493
   neurodevelopment and, 487
   obstacles in, 489–491
   playroom for, 494–495
   PRBEs in, 488
   presentations in, 494
   procedure in, 492–498
   refusal of, 233
   research on, 500–501, 665
   responsive services in, 486
   space in, 490
   techniques and strategies in, 499–500
   theory in, 491–492
   time in, 489
   toys and materials in, 495–498
   treatment frequency and duration in, 498
scientific mindedness, 208
scope of practice, 534
security, 139, 535
   interpersonal trauma and, 429
   legal systems and, 507–508
self, 71–72, 124, 125, 385, 389
   in CCPT theory, 95–96
   sense of, 49, 429
self-awareness, 527
self-blame, 302
self-consciousness, 333
self-control, 53
self-destructive behavior, 186, 268, 543
self-determination, 99
self-direction, 105
self-esteem, 175–176, 255, 335, 655
   in disabilities, 402
   powers of, 54–55
self-expression, 38–40
self-regulation, 53–54
self-report supervision, 553
self-respect, 335
self-soothing play, 47, 54
sense of self, 49, 429
sensitivity, 143, 217–218
   cultural, 599–600
   in medical settings, 474–475
   in Welfel’s ethical decision-making model, 529–530
sensory input, 41, 170
sessions, 177.
   See also medical settings; space
sexual abuse, 234, 302
   incest, 69
   as interpersonal trauma, 419–420
   legal systems and, 515–516
   research on, 431
sexuality, 71
shadow, 70–71
Shedler, J., 75
Shelby, Janine, 29
short-term intervention, 663
short-term recovery phase, 461–463
shy children, 186–187, 543
siblings, 482
The Sims, 615, 622
single-case experimental designs (SCED), 633
   case studies compared to, 641
   examples of, 644
   features of, 642
   implementation of, 641–642
   obstacles for, 643–644
   procedures for, 642–643
   single group pre/post designs, 639–640
   6–11 years, 333–334
   65 and older, 338–339
   skills, 42, 208, 315, 402, 620.
   See also parental skills and attitudes
Slaying the Dragon (Greenwald), 263–264
small trial pilot designs, 637
social advocacy, 604
social context, 466
social-emotional issues, 401–403
social hunger, 418
social interaction abilities/style, 315
socialization-as-intervention approach, 139
social neuroscience, 592
social referencing, 372
social relationships, 232–233
social right-brain focus, preverbal, 169–170
social skills, 402, 620, 656, 658
social support, 462, 466
social workers, 405–406
sociodramatic play, 54
socioeconomics, 400
sociological perspective, 401
“soft souls,” 367
Solomon, Joseph, 21–22
Solomon, Richard, 376
space, 102–103, 277, 366
in schools, 490
for Theraplay®, 176–177
SPARX, 622
spatial processing, 366
special needs, 437–438
special populations, 11, 616–617
specific factors, 35–36
spin master, 372–373
Sri Lanka tsunami, 461
stagnation, 336
stakeholders, 530
standards, ethical, 530
standards of practice, 7–8
states, 72, 525
"states of mind," 586
statistical analyses, 632
storytelling, 30, 263. See also metaphors and stories
strategic abilities, 315
strategic family play therapy, 30
strategies, 287, 364–365, 369–374. See also techniques
and strategies; treatment stages and strategies
for attachment problems, 386–388
interventions and, 330, 332, 334, 336–337
on limit-setting, 541
strengths, and limitations, 663–665
strengths, personal, 232–233
stress, 383. See also Posttraumatic Stress Disorder
stress inoculation, 45–46
stress management, 46–47
structure, 171–172, 183
structured activity play therapy, 658
structured play, 127
structured play therapy, 21
structuring, 139–142, 146, 153
subcortical regions, 584, 585
sublimation, 41
subpoenas, 511–512
suicide, 295, 301–302, 660
superego, 19, 64–65
superheroes, 299
supervision, 8, 154, 535–536
clinical review and, 552–554
consent in, 550–551
direct observation, 554
face-to-face, 551
foundation of, 550
group, 556
individual, 554
introduction to, 549–550
live, 554
peer, 555–556
phone, 552
playful, 555, 559
recordings for, 553
role variety in, 557–558
self-report, 553
supervisee in, 556–557
supervision of, 558–559
supervisor in, 557
training for, 557–558
video conferencing, 552
supervisor, 557
support, 489
surplus reality, 292
symbolism, 83–87, 645
symbolization, 40, 71
symptom normalization, 460–461
synchronicity, 71
synthetic eclecticism, 228, 329
systematic reviews, 653
systemic theory, 601–602
syzygy, 71
Taft, Jessie, 22
talking
doing while, 40
in third person, 39
teacher-adapted CPRT (CTRT), 658, 661
techniques, 19, 270–271, 479–480. See also procedure/technique
of expressive arts, 279–287
World Technique, 20, 66
techniques, and strategies
of DRPT, 466
for interpersonal trauma, 428–430
in medical illness and trauma, 445–448
in medical settings, 478–482
in schools, 499–500
technology
benefits and uses of, 619–621
bonding through, 614, 616, 625
case example about, 622–625
characters in, 621
clinical considerations about, 614–618
diagnosis, assessment, insight with, 617, 619
economic problems and, 620
fears and, 623–624
future of, 621–622
games and apps development in, 622
group therapy and, 617, 621
growth and development with, 619–620
imagination for, 617
impulse control and, 613–614, 619
iPad, 613–615
limit-setting with, 618
MineCraft, 621, 623–625
narrative play therapy and, 620–621
prescriptive play with, 618
rationale for, 616–617
research and, 614–616, 621–622
review of, 614–616
themes and metaphors with, 619
therapists and, 617–618, 622
trust and, 624–625
video/computer games, 615–616, 623–625
virtual playroom with, 618
willingness for, 617–618
tentative acceptance, 215, 220–221
termination
  in CBPT, 128
  in EPT, 215–216
  in EPT complete case example, 221–222
terminology, 533–534
TF-CBT. See Trauma Focused Cognitive Behavioral Therapy
TF-IPT. See Trauma-Focused Integrated Play Therapy
thematic play, 388, 390–391
themes, and metaphors, 619
theoretical constructs, 632
theoretical integration, 136
theoretical roots, 18–19
theories, 63, 201, 439, 530–531, 645
  analytical, 68–75, 69, 88
  attachment problems and, 385
  behavioral, 129, 136, 201, 212, 403, 458–459
  of BGPT, 311–312
  “broaden-and-build,” 50–51
  CBT, 129, 223, 403, 458–459
  CCPT, 93–96
  developmental, 403
  developmental/attachment, 137
  in DIR®/Floortime, 358–361
  drama and, 289–293
  of DRPT, 458–463
  of EPT, 195–200
  of expressive arts, 277–278
  of Freud, S., 64–65, 69
  FT and, 135–137
  interpersonal, 136
  interpersonal relationship, 403
  in life span play therapy, 328–337
  medical illness and trauma and, 439
  medical settings and, 477–478
  on metaphors and stories, 260–262
  of PCIT, 344–345
  psychoanalytic, 64–68, 69
  psychodynamic, 136
  of sandtray/sandplay therapy, 243–244
  in schools, 491–492
  systemic, 601–602
  of zone of proximal development, 53
therapeutic change mechanisms, 232–233
therapeutic factors, 35–36, 564–565
Therapeutic Metaphors for Child and the Child Within (Mills & Crowley), 28
therapeutic models, and diagnostics, 593–594
therapeutic powers of play, 11, 35, 565, 566
  definition of, 36
  neuroscience and, 591–592
transcendental models in, 36–37
The Therapeutic Powers of Play (Schafer, C.), 11
The Therapeutic Powers of Play: 20 Core Agents of Change (Schafer, C. & Drewes), 11
therapeutic relationship, 47–48
therapeutics, 10
  differential, 228
The Therapeutic Use of Child’s Play (Schafer, C.), 26
therapists, 5
  in analytic psychology, 76–77
  in attachment problems, 386–388
  in BGPT, 317, 322
  in CBPT, 120
  in CCPT, 97–99
  cultural competency for, 208–209, 608–609
  in DIR®/Floortime, 363–365
  in drama, 296–297, 303
  in DRPT, 459–460, 464–465
  educational systems and, 200, 209
  in EPT, 199–200, 207–210
  in expressive arts, 279–280
  in FT, 145, 147
  in interpersonal trauma, 427, 429–430
  legal systems and, 509–511
  in medical illness and trauma, 440–441
  in metaphors and stories, 271
  in PCIT, 345–346, 348, 350–351
  in prescriptive play therapy, 235
  professional boundaries for, 209–210
  racism and, 599, 606–608
  RPT, 8, 278–279, 523–524
  RPT-S, 8, 535–536
  in sandtray/sandplay therapy, 244–245
  technology and, 617–618, 622
  in Theraplay®, 177–178
Theraplay®, 11, 230
caregiver session in, 179
caregivers in, 166–167, 179–181
challenge in, 173–174
contraindications in, 176
description of, 165–166, 190–191
equipment in, 172
for geriatrics, 339
graduation in, 181
logistics in, 176–177
nurture in, 172–173, 183
procedure/technique in, 174–181
research on, 189–190, 575–576, 593
session sequence in, 180
settings for, 177
space for, 176–177
structure in, 171–172
therapists in, 177–178
toys and materials for, 176–177
treatment in, 178–181
treatment stages and strategies in, 179–181
validation in, 173
Theraplay® case example 1
  attachment in, 183
caregiving in, 183
caregivers in, 184
cooperation in, 184
divorce in, 182–183
graduation in, 186
nurture in, 183
structure in, 183
touch in, 185
transition in, 185–186
Theraplay® case example 2
  curiosity in, 187–188
Theraplay® case example 2 (continued)
graduation in, 189
nonverbal connection in, 187
opening in, 188
shy child in, 186–187
trauma in, 186
verbal connection in, 187–188
Theraplay® theory, 165
adult guidance in, 168
arousal levels in, 171
assumptions of, 166–167
attuned empathic reflective responsiveness in, 168–169
core concepts of, 167–171
dimensions of, 171–174
direct here-and-now interaction in, 168
interactive relationship based experiences in, 167–168
multisensory experiences in, 170
origins of, 166
playful attitude in, 170–171
preverbal social right-brain focus in, 169–170
Theraplay® case example 1, 185
TPS. See Trauma Play Scale
tracking, 107
traditional researchers, 646–647
train engineer, 371–372
training, 490. See also parental training
tree, 87
for supervision, 557–558
for unexpected, 51
transference, 69, 69
transference neurosis, 67
transference relationship, 197–198
transfer to home play sessions, 155
transition, 185–186
transstheoretical approach, 228–229
transstheoretical models, 36–37
trauma, 121, 186, 254, 265, 352. See also interpersonal trauma; medical illness and trauma
attachment problems and, 381–382, 387
metaphors and stories for, 263–265
PTSD, 175, 234, 338, 418, 659, 662
Trauma Focused Cognitive Behavioral Therapy (TF-CBT), 129, 223
Trauma-Focused Integrated Play Therapy (TF-IPT), 431
The Trauma of Birth (Rank), 18
Trauma Play Scale (TPS), 423–424, 424
Treating Problem Behavior: A Trauma-Informed Approach (Greenwald), 264
treatment
in analytic psychology, 79–80
in EPT, 214
treatment contract, 199, 218–219
treatment frequency, and duration, 219–222
of BGPT, 321
in CBPT, 122
in CCPT, 103–104
for disabilities, 410
in EPT, 213
in expressive arts, 282–283
for FT, 149–150
for interpersonal trauma, 428
in medical illness and trauma, 442–443
in sandtray/sandplay therapy, 249–250
in schools, 498
for Ugandan girls, 282–283
treatment planning
for BGPT, 321
in CBPT, 123
in CCPT, 104–105
for disabilities, 410–411
in expressive arts, 284
in FT, 151–156, 152
for metaphors and stories, 272
for Ugandan girls, 284
treatment stages
in CCPT, 105–106
for drama, 297
in EPT, 214–216
in expressive arts, 284–286
treatment stages, and strategies
in BGPT, 321
in CBPT, 123–128, 125, 126
in expressive arts, 284–287
in FT, 152, 152–156
in medical illness and trauma, 444–445
in sandtray/sandplay therapy, 250–253
in Theraplay®, 179–181
tree, 87
trust, 73, 215, 221, 225
  in CCPT, 109
  interpersonal trauma and, 419–420, 428–429
  technology and, 624–625
tsunami, Sri Lanka, 461
TV show storyboard, 300
Ugandan girls, 286, 658
  embodied play for, 285
  race and, 283
  strategies for, 287
  treatment frequency and duration for, 282–283
  treatment planning for, 284
Uncommon Therapy (Haley), 261
unconscious, 69, 70, 261
unconscious access, 40–41
unification, 87
unstructured play, 127
Using Trauma-Focused Metaphor and Stories (Pernicano), 260
utilitarianism, 526
utilitarian model, 200
validation, 173
  in DIR®/Floortime, 366–367
  verbal connection, 187–188
video/computer games, 615–616, 623–625
video conferencing supervision, 552
Vienna Psychoanalytic Society, 18
virtual playroom, 618
virtue ethics, 526–527
visual disabilities, 399
visual learners, 366–367
Voluntary Play Therapy Practice Guidelines, 8
Vygotsky, Lev, 53

Weltel’s ethical decision-making model
  consultations in, 531
  ethical principles and theories in, 530–531
  ethical standards in, 530
  ethics literature in, 530
  facts, context, stakeholders in, 530
  issues in, 530
  sensitivity in, 529–530
Wells, H. G., 20
whole family Theraplay (WFT), 391–392
Wieder, Dr., 358, 360
willingness, 617–618
Winnicott, Donald, 24
worksheet, 322
World Technique, 20, 66
World Wrestling Federation, 299–300
zone of proximal development, 53, 264
WILEY END USER LICENSE AGREEMENT

Go to www.wiley.com/go/eula to access Wiley’s ebook EULA.