CHAPTER 1

Introduction

How Play Therapy Causes Therapeutic Change

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THERAPEUTIC FACTORS

Virgil (n.d.) once wrote "Fortunate the man who can understand the cause of things" and how true that is for child and play therapists with regard to conducting treatment and research. An accurate understanding of how play therapy works to cause change involves looking inside the black box to identify the therapeutic factors that operate to produce a treatment effect (Holmes & Kivlighan, 2000).

Therapeutic factors are the actual mechanisms that effect change in clients (Yalom, 1995). 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, for example, catharsis, counterconditioning, and contingency management, for obtaining 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, for example, sand play, role playing with puppets, and storytelling. Therapeutic factors have been given various names, for example, "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, that is, the overt and covert activities that various theoretical systems use to produce change in a client. A therapeutic power may be a thought, for example, insight; a feeling, for example, a positive affect; or a behavior, for example, role play. What they have in common is that they all act to produce 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.

Common factors, on the other hand, refer to change agents common to all theoretical orientations, for example, a supportive relationship, or the instillation of 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 change mechanisms and compiled a list of nine factors. Irving Yalom (1995) expanded the list to 11 factors that 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 "universality" (realization that 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, for example, individual, couples, and family therapy has also 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 change agents in which play initiates, facilitates, or strengthens their therapeutic effect. These play powers act as *mediators* that positively influence the desired change in the client (Barron & Kenny, 1986). In other words, the play actually helps produce the change and is not just a *medium* for applying other change agents nor does it just *moderate* the strength or direction of the therapeutic change. Based on a review of the literature and the clinical experiences of play therapists, we have identified 20 core therapeutic powers of play, which are the focus of the following chapters in this book. Among these powers are change agents that improve a client's attachment formation, self-expression, emotion regulation, resiliency, self-esteem, and stress management. In the following chapters, the contributors describe the nature of these powers and illustrate their therapeutic application to clinical cases.

TRANSTHEORETICAL MODEL 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). While some play therapists will be interested primarily in the narrow band of change agents underlying their preferred theory, for example, cognitive-behavioral play therapy, a growing number of play therapists will seek to understand and apply all of the multiple change agents in play therapy. By adopting a transtheoretical orientation (Prochaska, 1995), play

therapists avoid becoming locked into a single theory that 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 selecting and adding to your repertoire the best change agents from among all the major theories of play therapy. Among the underlying premises of this eclectic, transtheoretical approach to psychotherapy are:

- 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 your repertoire, the better able you will be to *eclectically* select the one(s) with the best empirical support for treating a particular disorder (Schaefer, 2011).
- With multiple change agents at your disposal, you can implement an evidence-based treatment plan that *prescriptively* tailors your play intervention to meet the individual needs and preferences of a client as well as your 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?" (Paul, 1967, p. 111).
- Therapists who possess multiple change agents 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 change agents in the belief that the resulting integration will surpass the effect of a single change mechanism. 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).

The editors of this volume personally believe that 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, for example, *prescriptive, prescriptive/eclectic*, and *integrative play therapy*, it is characterized by a 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.

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. Two main reasons a greater understanding of change agents is of vital importance to play therapists and other clinicians are:

1. It should improve clinical effectiveness by facilitating a more targeted and efficient treatment delivery through "prescriptive matching," that is, the matching of curative factor(s) in play to the underlying cause(s) of a disorder (Shirk & Russell, 1996).

   In this regard, Kazdin (2001) proposed that the first step in treatment planning is the identification of the core cognitive, affective, and behavioral forces involved in the development and maintenance of a particular clinical problem, for example, insecure attachment. Once the primary origin(s) of a disorder are uncovered through a comprehensive assessment, specific therapeutic powers can be applied that are designed 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-theory model (Goldfried & Wolfe, 1998).

In our opinion, we need the full arsenal of the therapeutic powers of play to effectively and efficiently overcome the many forces of psychopathology. In addition to expanded instruction and training on the importance and application of the causal mechanisms in play therapy, we need to substantially expand process research studies on play therapy so as 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 by play therapists and researchers.

We appreciate the efforts of the chapter contributors in this book to deepen our understanding and application of the therapeutic powers of play.

HOW BEST TO USE THE MATERIAL IN THIS BOOK

Ideally the reader would benefit from reading the entire book in order to gain the most benefits. However, each chapter stands alone and can be read separately from the other chapters to address a specific issue or area of interest. There are also sections and chapters that flow together that can be read as a cluster depending on the treatment being done and the client being served. As mentioned earlier, a prescriptive approach is best utilized, thinking about your client's needs, where they currently are, and what symptoms and goals you are addressing in your treatment plan. Are your clients dealing with *cognitive processes*, *emotional processes*, or *interpersonal processes* (O'Connor, 2010; Shirk & Russell, 1996)? Or perhaps all of these at one time or at various stages in the treatment?

Cognitive processes involve learning adaptive or compensatory cognitive skills such as social skills; the reorganization of the meaning of experiences; and the gaining of an increased self-awareness (O'Connor, 2010; Shirk & Russell, 1996). Examples would be those of children struggling with a trauma that has impacted their worldview, thus creating cognitive distortions and misconceptions, or children with Asperger's disorder who lack the knowledge of friendship skills and how to respond in socially acceptable ways, or children with executive functioning difficulties due to an attention deficit disorder.

In these types of cases the therapist might focus on change agents involving the direct and indirect teaching of skills such as social and problem-solving skills or teaching compensatory or adaptive skills, along with ways to increase a client's cognitive development, self-esteem, and resiliency (O'Connor, 2010).

Chapters That Best Help With Cognitive Processes Include:

Direct Teaching (Chapter 3)
Indirect Teaching (Chapter 4)
Creative Problem Solving (Chapter 16)
Resiliency (Chapter 17)
Accelerated Psychological Development (Chapter 19)
Self-Esteem (Chapter 21)

If the client does not seem to display an ability to develop insight and needs help in reorganizing the meaning of their experiences (cognitive distortions and misattributions) and modifying assumptions and expectations that might be brought to the session, which might be seen in the content of the play (symbolically) or from direct verbalizations, the reader might want to also focus on the chapters on:

Self-Expression (Chapter 2)
Access to the Unconscious (Chapter 3)

Clients may display difficulty in the area of *emotional processes* (O'Connor, 2010; Shirk & Russell, 1996). More specifically, they may show deficits in feelings identification, emotional expression, discharge of negative emotions, and integration of emotions. This may be due to a variety of causes ranging from trauma (sexual abuse, physical abuse, domestic violence) to systemic and biological issues. In these cases, the therapist would want to look at chapters that focus on helping with affect regulation through the cathartic release of feelings that results in mastery or control; teaching the client how to recognize, as well as be aware of, name and talk about their own feelings and those of others; the integration of their feelings and personal emotional experience; and the development of coping strategies or psychological defenses that would avoid emotional dysregulation (O'Connor, 2010).

Chapters That Assist in Treatment of Maladaptive Emotional Processes Include:

Catharsis (Chapter 6)
Abreaction (Chapter 7)
Positive Emotions (Chapter 8)
Stress Inoculation (Chapter 10)
Stress Management (Chapter 11)
Empathy (Chapter 15)

If the client, perhaps as a result of trauma or other developmental issues, develops specific fears and phobias, the reader would want to be sure to also look at Chapter 9, Counterconditioning Fears.

Clients may show deficits in *interpersonal processes* (O'Connor, 2010; Shirk & Russell, 1996) and need treatment designed to foster positive relationships. Attachment difficulties may be present due to prolonged separations from parents due to hospitalizations/placements or due to parental neglect, abuse, disengagement, or loss. Through the therapeutic relationship the client is able to utilize the play therapist as a secondary attachment figure to work through past negative experiences and to develop an alternative relationship of trust and connection. Difficulties with peer relationships and forming friendships might necessitate treatment that offers social-emotional support as well as supportive scaffolding in bolstering the client's functioning with the environment (school, after-school activities, engaging parents) (O'Connor, 2010).

Chapters That Help in Focusing on Such Social Difficulties Include:

Direct Teaching (Chapter 4)
Therapeutic Relationship (Chapter 12)
Attachment (Chapter 13)
Positive Peer Relationships (Chapter 13)
Creative Problem Solving (Chapter 16)
Moral Development (Chapter 18)

It is our hope that the reader will frequently utilize this book as a guide and resource in creating treatment plans that are tailor-made to overcome an individual client's problems. We are confident that a greater understanding of the therapeutic powers of play will not only result in more effective treatment gains for clients, but also in better formulated and focused research. To further move the field of play therapy into the mainstream, we need studies designed to show how play is the active ingredient that leads to therapeutic change.

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