

## Do You Have a Primary Play Therapy Theory or Approach You Use the Most and Why?

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A play therapist's theoretical orientation influences how the therapist understands child development, interprets play themes, engages caregivers, and makes moment-to-moment clinical decisions. The question, "*Do you have a primary play therapy theory or approach you use the most and why?*" invites clinicians to name the conceptual "home base" that organizes their work, and clarify the values and assumptions that guide their choices in the playroom. This matters because children present with diverse developmental profiles, cultural contexts, family systems, and presenting concerns; a therapist's orientation helps determine whether sessions lean more nondirective or directive, how safety and limits are established, and how meaning is co-constructed through metaphor, symbol, and relationship.

At the same time, many clinicians begin with one primary model (often shaped by early training and supervision) and later expand into integrative or prescriptive approaches as their caseload broadens, their expertise deepens, and the field evolves. This question also highlights the profession's ongoing balance: honoring fidelity to a coherent theory while remaining responsive to the child in front of us. Across contemporary play therapy, common threads include prioritizing the therapeutic relationship, attending to trauma and regulation, considering systemic and attachment influences, and practicing cultural humility; each offering a rationale for "why this approach" and "why now." As the field continues to adapt (including growth in telehealth and digital modalities), articulating one's theoretical anchors becomes an essential part of ethical practice, supervision, and professional identity development.

### Katie Bassiri

While I don't adhere to a single primary play therapy approach, one theory significantly impacted me as a young play therapist. As a graduate student, my internship site utilized experiential play therapy (EPT) as the primary play therapy approach to support clients. Developed by Dr. Byron Norton and Dr. Carol Norton (1997), EPT involves joining children as they recreate their experiences through fantasy play, symbols, and metaphors. Within a strong therapeutic relationship with a responsive therapist, the child can slowly approach their struggles and fears at their own pace, eventually expressing difficulties of the past through reenactment. With therapist support, children progress through five stages: exploratory, testing for protection, dependency, therapeutic growth, and termination.

My experience with this theory was, metaphorically, like a first love. Through my work using EPT, I experienced the power that play can have on healing the devastating impacts of trauma. Like many new therapists, my early play therapy training experience was filled with innocence, idealism, anxiety, and a forever connection with a theory I worked so hard to get “right.”

While I greatly appreciated getting such in-depth training in one theory, my singular experience left me with a minimal understanding of the breadth of play therapy and the seminal theories that have influenced so many approaches that followed them. As a supervisor, it’s essential to understand and appreciate the diverse forms of play therapy. When I began supervising as an RPT-S™, I wanted to support my supervisees in exploring the theories they were drawn to and to communicate that there are multiple valid ways to engage in the therapeutic process.

While I continue to appreciate the importance of metaphor, with time and training, I have grown to love many theories and now consider myself a prescriptive play therapist. Prescriptive play therapy is an approach to therapy where the clinician weaves together many theories that they’ve been trained in into one comprehensive, tailored approach for a particular client. I believe that prescriptive play therapy embodies many values that are essential to supporting dynamic disabilities like autism and ADHD. As our clients experience changes in their bodies, relationships, and environments, their therapeutic needs change. The humans I am sitting with will also continue to influence my work. Carl Jung reflected on this in 1928: “True art is creation, and creation is beyond all theories. That is why I say to any beginner: *Learn your theories as well as you can but put them aside when you touch the miracle of the living soul*” (p. 361).

My growth as a play therapist and supervisor has given me an appreciation for the many wonderful ways we can be with our clients. I am now able to observe young therapists discovering their first theoretical loves. Like me, they are filled with an anxious desire to “get it right.” While I greatly value knowing and mastering theories, I remind young clinicians of the value of one imperfect human building a relationship with another. That’s where we start.

## Alvin Bonds II

In my work as a play therapist, I draw from multiple evidence-based perspectives that allow me to provide the most effective, individualized therapeutic work to each child and family. My integrative approach blends Adlerian play therapy (AdPT) and child-centered play therapy (CCPT), both contributing fundamental elements to a flexible yet grounded process for therapeutic work with children. Viewing a child’s play through the lens of AdPT honors the humanistic and developmental understanding of children while offering a directive therapeutic approach to help reframe mistaken beliefs and facilitate constructive, playful change (Dickinson & Kottman, 2021). I come from a marriage and family therapy background, so I also draw from ecosystemic and attachment-based theories, bridging my work in the playroom with the child’s developmental needs and lived experiences.

I integrate CCPT principles because it fosters a deeply empathic and accepting environment, which can be lacking or completely nonexistent in many children’s lives, precipitating their need for therapeutic services. When children experience unconditional positive regard and consistency, the playroom becomes a headquarters for serious therapeutic work in their lives, and I am honored to be instrumental in their therapeutic journey (Cochran et al., 2024). Given my focus on systemic frameworks and cultural humility, I often use play to explore how family dynamics and broader ecological influences impact the child’s world. It would not be uncommon for me to invite a child to create a sand tray of their family as an introductory rapport-building activity. This approach

resonates with my own personal experiences with the importance of family and attention to systemic relationships, and I have used my professional experiences to expand my perspectives to align with evidence-based play therapy approaches.

Cultural humility is not a static competency but is a lifelong relational stance, one that requires me to continuously examine how my own cultural lens (as an African-American male therapist in rural Tennessee) intersects with the child's worldview (Kress et al., 2025). For example, when working with a child from a collectivist cultural background, I might use AdPT to explore how family loyalty shapes their "mistaken belief" that they must suppress emotions to maintain harmony. In the playroom, this might look like inviting the child to participate in a directive expressive activity of painting a mask, directing the child to paint the outside of the mask how his/her family sees the child, and on the inside how the child actually feels (Dickinson & Kottman, 2021). This integration allows me to cocreate meaning with the child rather than imposing my individual framework, ensuring the therapeutic process is both intentional and culturally aware (Casey et al., 2022).

In practice, this integrative approach allows me to respond flexibly to the child's needs in the present, while honoring the developmental and relational foundations of play therapy. There are children whose emotional landscapes and presenting issues can be more effectively met with CCPT—a child who may have rarely been met with unconditional acceptance or even a child recovering from an intense traumatic experience. I intentionally suspend my need for questioning and direct exploration, and I intentionally allow the child to lead the session, tracking their play and reflecting feelings and content back to the child (Ray et al., 2022). Other children benefit more from the structure and direction offered through AdPT, especially when mistaken beliefs about self-worth, capability, or belonging drive maladaptive patterns in their relationships. For these children, directive metaphors, storytelling, or targeted experiential interventions provide opportunities to challenge unhelpful narratives while still maintaining a relationally safe environment (Dickinson & Kottman, 2021). For me, moving fluidly between these orientations ensures that the therapeutic process remains responsive, developmentally attuned, and grounded in evidence-based practice.

## **David A. Crenshaw, Ph.D., ABPP, RPT-S**

I draw on multiple theoretical frameworks that resonate with me in terms of meaning, philosophy, humanism, and emotional compatibility. These include CCPT, psychodynamic, gestalt, and family systems theories. My thinking is influenced by a strong belief, arising out of decades (55 years) of clinical practice as a board-certified clinical psychologist, that no single approach can adequately meet the complex and dynamically changing needs of the children we see clinically. Each of the theories mentioned, along with others, has their unique strengths that offer a rich repertoire of therapeutic responding.

I don't select my therapeutic approaches based on theory alone. Rather, I decide based on the particular child in front of me at this specific time and place. I do not want to impose a theoretical template that I prefer; rather, I want to understand what the child needs and what would be most helpful to them in this here-and-now moment. The therapist needs to spend sufficient time getting to know the child before deciding which approach or combination of approaches is indicated.

Play therapists vary greatly in how much time they devote to an initial assessment. The most comprehensive approach that I am familiar with is Eliana Gil's (2011) extended play-based

developmental assessment, which typically takes 12 sessions but yields an in-depth understanding of the child's developmental and emotional needs. Since the assessment is the foundation on which the treatment plan is built, it is important to take the time needed to gain a thorough appreciation of the child's strengths, resources, as well as current and past struggles.

The strengths of CCPT include therapeutic engagement, relationship building, and limit setting. These skills are essential for creating safety in the therapy setting and establishing a secure therapeutic relationship. A psychodynamic approach offers a clear rationale for exploring symbolization, as well as thoughts, feelings, and impulses outside of awareness. Gestalt approaches offer effective ways to make meaningful, emotional contact with the child and, along with the psychodynamic approach, provide effective ways of exploring affect and symbolic expression. I regard family systems as essential since, to understand a child, we must know their family. The influence of the family, both healthy and toxic, is one of the major contributors to child development.

While I do not view any one theory as being able to meet the needs of all the children who seek play therapy, I do find it helpful for clinicians to have a primary theory or approach that provides them with a clear rationale for the therapy interventions they choose. Even if the therapy chosen is not their primary approach, developing one's thinking and rationale behind the therapeutic work will help select an alternative approach that is backed up with a solid rationale. My primary approach is psychoanalytic play therapy, rooted in the contemporary approach of culturalist psychoanalysis. Adler was the first of Freud's close followers to reject the extreme focus on psychosexual stages of development and to argue for attention to social, family, and cultural influences. This approach was further developed by Karen Horney, Harry Stack Sullivan, and Erich Fromm, among other seminal psychoanalysts.

In 1982, I sought out Walter Bonime, M.D., senior training psychoanalyst at New York Medical College, who, along with Erich Fromm, was a member of the first class of the Karen Horney Training Institute. I was drawn to Walter Bonime by his writings (1962, 1982, 1989) and lectures and initiated a private psychoanalytic supervision with him that lasted until the mid-1990s. Dr. Bonime passed away in 2001, I internalized his teaching and guidance to the point that to this very day, he accompanies me in all work I do in therapy and teaching.

## **Eliana M. Gil**

My primary theoretical foundation is humanistic approach, which centers on the individual's capacity to grow and self-repair. This theory involves striving for self-actualization via reaching individual potential (Bratton & Ray, 2002). When working with children, I trust their unique abilities to work through their thorny experiences, especially as they deploy a reparative mechanism that allows them to "play out" difficult or confusing experiences. In my professional career, I have seen traumatized children externalize their painful experiences through symbol, word, or behavior. Children may ask and/or respond to questions about their experiences in verbal and nonverbal ways and learn to manage their thoughts and feelings in a way that helps them make meaning and accomplish a sense of liberation from the power the trauma has held for them.

As children play out traumatic memories, they reclaim an active stance, restoring some personal power and control over the memory and visualizing different ways to understand the events and previous ideas about culpability or cooperation. Sometimes this trauma processing can be done exclusively through play (Gil, 2017); other times, there are collateral methods that enhance play, such as EMDR (Gomez, 2025; Beckley-Forest & Monaco, 2021), bilateral and

polyvagal stimulation, playful parts work (Jimenez-Pride, 2025), strengthening attachment, using playful cognitive behavioral therapy to change cognitive distortions and help children cope (Cavett, 2018), and allowing or introducing varied opportunities for mastery and renewed personal control.

My secondary theoretical orientation is systems theory, which prioritizes individual problems in the context that they occur (Rothbaum et al., 2004). Systems theory asserts that what affects one person in a family affects everyone, and thus it's critical to identify familial responses that can either grow or shrink the identified problem. It is simply ineffective and short-sighted to ignore or minimize the impact of the child's family, social group, and extended family when trying to provide assistance. A systems-focused therapist must keep one eye on the child, and the other on the various systems in which the child exists (Jason & Bobak, 2022). Thus, knowing the child's family, race and ethnicity, gender, neighborhood, school, religion, among other variabilities of intersectionality help us better design interventions that provide concrete help to children and their families. For example, when working with Hispanic families, I always inquire about their church, their pastor or priest, the relevance of their religion, and how much time they spend in church activities. At times, I have invited local priests to collaborate with therapy goals by making specific statements that alleviate client distress. One little eight-year-old girl felt that God was angry at her, and this kept her feeling low self-esteem and guilt. When I recruited her priest, he understood his task immediately. He listened to her, comforted her, and then told her that God was angry (and had already forgiven) the uncle who touched her inappropriately. Both the girl and her parents and grandparents felt greatly relieved to hear the official word from God. The priest was able to contribute greatly to the child's decrease in depression and guilt, and restoration of a sense of well-being.

When I meet with new clients, I describe myself as a *family play therapist* and explain that I will meet with the "identified child" individually to get to know them and help them feel comfortable and familiar with me and the office setting. I also tell parents that I will invite them and other family members (including siblings) to attend sessions. Most of the time parents seem to want therapists to "fix" their child and may show little interest in either seeing themselves as part of the problem or helping the child more directly. By the time many parents get to therapy, they are frustrated and out of ideas. It's important to me that my clients know that we will be working together, as the child's issues can be greatly helped or hindered by parental and family responses. Finally, I tell parents that when we meet together, I may invite them to do art, storytelling, puppet play, sand trays, arts and crafts, and a variety of other activities. If they make a fuss, I acknowledge how well they are expressing themselves and simply state, "Most people are a little hesitant at first, you'll have to trust me, you might actually find it valuable."

## Paris Goodyear-Brown

My primary play therapy approach is TraumaPlay, which is a flexibly sequential integrative play therapy model that I have been refining and disseminating for the last thirty years (Goodyear-Brown, 2010, 2019, 2022). TraumaPlay is grounded in attachment theory and interpersonal neurobiology, and it offers an umbrella framework of evidence-informed core components of trauma treatment with children and their caregivers. Each core component is a best practice treatment goal that provides the scaffolding for dozens of practical play-based interventions. These developmentally sensitive play therapy tools can be matched to the unique interests and needs of the client. Clinical decision-making is guided by the mantra, *follow the child's need* and requires

moment-to-moment attunement to the child in the playroom. Caregivers are an integral part of TraumaPlay treatment (Goodyear-Brown, 2021, 2026), and their importance is amplified through the training mantra *coregulation always precedes self-regulation*. TraumaPlay therapists seek to embody three roles—safe boss, nurturer, and storykeeper—for any parts of the client’s system they serve.

The safe boss makes sure everyone stays safe physically and emotionally, sets and maintains boundaries clearly and kindly, and seeks to empower those they serve. Embodiment of this role answers the question, *Am I safe?* with yes. The nurturer seeks to meet needs and provide nurture, delighting in the child and their caregiver throughout treatment. Embodiment of this role answers the question *am I loved?* with yes. The storykeeper role is defined as acknowledging the big behavior the therapist is currently seeing and threading the needle backwards to its origins in the child’s earliest experiences. Only after the questions *am I safe?* and *am I loved* have been answered with resounding yeses, can the thinking brain ask *what can I learn from this?* In these moments we become storykeepers for the child. A concept offered as the *cascade of care* supports clinicians in moving between the roles of safe boss, nurturer, and storykeeper first with the caregivers, so that they might expand their embodiment of these roles, and also with the child or teen client.

This integrative approach evolved as I faced iterative moments of cognitive dissonance in my direct clinical practice over several decades. As a clinical social worker, my graduate training was an immersion in systems theory with a strong focus on work with oppressed populations. In the first years of my clinical practice, I provided group therapy for 6–16-year-olds who were at risk of being expelled from school due to big behaviors. The clinical work was grounded in behavioral theory: we assigned points for positive behaviors, included a response-cost system, and relied heavily on praising the behavior we wanted to see more often and ignoring the behaviors we wanted to extinguish.

As I got to know the children, it became clear that they all had multiple adverse childhood experiences (ACEs), and it was even more apparent that this strictly behavioral approach fell woefully short of generating the sort of change these children needed. A foundational tenet of TraumaPlay was refined during this time: *relational trauma can only be healed relationally*.

My second job was as the first therapist for a therapeutic preschool program for children ages three to five who had been expelled from other childcare environments due to big behaviors. During this period, I pursued training in CCPT and honed the “being with” presence of a fully nondirective treatment stance. As I offered the language of play and worked to enter the child’s world, I found that some children eagerly employed the vocabulary of the symbols and metaphors to play through their trauma. From this season of work, the TraumaPlay core concept of *the continuum of disclosure* was born.

Defined as the glimpses and snapshots of trauma that children show us and “tell” us through their play, the continuum of disclosure captures how children reveal their stories in small, safe pieces. Therapists meet these disclosures with the validating communication: *I see what you are showing me and you can show me more*.

A second group of children entered treatment already feeling so dirty, shamed, humiliated, or weak that they could only begin approaching the hard things that had happened to them after they had engaged in experiential mastery play (EMP) in the playroom. TraumaPlay has articulated several therapeutic processes—supporting competency surges, containing or controlling perpetrator symbols, and taking care of self-objects—as forms of EMP. Children employ these processes to feel strong and able, to amplify their own sense of goodness, and these positive experiences in the playroom mitigate their approach to trauma content.

However, some of my child clients were not being helped with strictly nondirective play therapy. Children with entrenched post-traumatic avoidance symptoms needed more active alignment from the therapist. Providing more structured storykeeping through trauma narrative work became a third pathway for helping children create a more coherent story about the hard thing that happened. Naming these three pathways encourages clinicians to keep stretching themselves to hold hard stories in the many ways that children need us to hold them.

The core components of TraumaPlay serve as an umbrella framework for trauma-informed play therapy, but they require continual case conceptualization and decision-making as we follow the child's needs between components over the course of treatment. TraumaPlay is a “yes, and” model that celebrates the unique of each child in lieu of a “one-size-fits-all” approach to treatment.

## Tony Lai

For any field to continue to be relevant and effective long-term, it must be willing to evolve to meet the changing needs of the world around it. The field of play therapy is no different. Over the years, play therapy has experienced substantial international growth as play therapy associations across many countries have worked together to further the field. Interest in and recognition of the therapeutic powers of play continues to grow, expanding the field on a global scale.

In recent times, we have seen the modality of play therapy evolve to meet the needs that emerged during the COVID-19 pandemic in 2020 by moving online and finding creative ways to meet with youth via telemental health while keeping them healthy and safe. As I saw both clients and supervisees virtually, it was exciting to witness the development of many online resources in the field, including digital sand trays, dollhouses, online art activities, interactive playrooms, and more—all supporting practitioners' abilities to engage in therapeutic play with their clients from a distance.

In addition to making play therapy services via telemental health more accessible, it has been exciting to see play therapists' innovation as they have incorporated video gaming into play with clients. While some have hesitations about the benefits of video games and other online activities, gaming has undeniably become a major part of life for many of the children and teens who walk into the counseling room. Play therapists are beginning to explore the therapeutic potential of gaming and the benefits of using clients' existing interests in the current digital age. Common examples of games that play therapists are incorporating into play sessions include Roblox, Minecraft, Animal Crossing, and more. Reyna-Vasquez (2024) advocates for therapeutic gaming in play therapy when it is a good fit for a client, arguing it can aid in “facilitating communication, enhancing social relationships, increasing personal strength through problem-solving and resiliency, and developing self-representation.”

In addition to video gaming, play therapists will want to consider how the prevalence of AI can help them in their clinical work and their relationships with clients. Both technology-based play and AI are likely not going anywhere. They are a part of the world we live in, and I believe approaching this reality with openness and curiosity may benefit our therapeutic relationships and allow therapeutic goals to be met in a creative way.

As science continues to advance, play therapists have access to an increasing amount of valuable knowledge, allowing therapeutic work to be informed by research being done across many fields and locations. For example, new research in neuroscience now gives me a much better understanding of regulation and dysregulation, offering deeper insight into the nervous system and how it impacts a child's ability to engage in play and the therapeutic process. I am a much better play

therapist because of this knowledge. This type of information is invaluable to effective clinical work and, for this reason, play therapists must humbly hold an openness to other fields and professions, not taking themselves and the field too seriously. This willingness to collaborate with nonplay therapy professionals and be curious about how they might help support or inform work with children is necessary to ensure the most holistic care for clients.

If the field of play therapy is to continue growing, I firmly believe more must be done to promote the efficacy of play therapy and educate the public about its benefits. While play therapy is becoming increasingly accepted as an evidence-based modality, few insurances recognize it as a reimbursable treatment option, raising questions about the value or purpose of the registered play therapist (RPT) credential. The RPT credentialing process is not simple; it is a significant personal and financial investment, and one must inevitably consider what the professional advantages are before embarking on this journey. This is not meant to discourage people from pursuing the RPT title; however, for the sake of the longevity of the profession and the organization, these difficult questions must be asked.

Overall, the modality of play therapy has evolved and adapted in many ways to the changing needs of clients over time. To keep this forward movement, we must continue on with intentionality, openness, and curiosity, always considering ways we can better support each other and our clients. With these values at the forefront, the future of play therapy is bright.

## Heidi G. Kaduson

When I began practicing play therapy, I was trained in the nondirective, child-centered approach—mainly because that’s what my mentor, Dr. Charles Schaefer, emphasized. My very first client was a four-year-old girl who, by today’s standards, would probably be diagnosed with autism spectrum disorder. I remember sitting with her for 45 minutes as she focused intently on four pennies she found on the playroom floor. I tried to follow her lead, as the child-centered model suggested, but I couldn’t help wondering if we were making progress. That session taught me something crucial: while the approach was valuable, it didn’t quite fit my natural therapeutic style.

Afterward, I told Dr. Schaefer that I wasn’t sure the child-centered method was right for me. He smiled and said simply, “Then do it your own way.” That sentence changed everything. It gave me permission to think critically about what worked and what didn’t—and to create a version of play therapy that felt more authentic and effective for the kinds of children I was working with.

At that time, I was not only a graduate student but also a mother of three young children, two of whom had been diagnosed with ADHD. Surrounded by their energy, distractions, and creativity, I was eager to find a therapeutic approach suitable for children who didn’t always fit the “typical” mold. Having seen how powerful play can be in helping kids express themselves and grow, I was determined to adapt play therapy to meet those unique needs.

I was lucky to serve as the on-site director for The Play Therapy Training Institute, which met every July for a month-long intensive training program. Each summer, specialists from various theoretical backgrounds shared their ideas, and I filled notebook after notebook with detailed handwritten notes. Over time, I began integrating these ideas into what I eventually called “Play Therapy for Children with Attention-Deficit Hyperactivity Disorder” (Kaduson, 2020).

Initially, I followed the nondirective model closely. However, as I gained more experience, I began exploring other frameworks that better suited my clients’ needs. This exploration led me toward a prescriptive model of play therapy, one that combines various theories and techniques

rather than sticking strictly to one. This flexibility allowed me to meet each child where they were and adjust my approach based on their temperament, developmental level, and emotional needs.

In 1997, I coauthored *The Playing Cure: Individualized Play Therapy for Specific Childhood Problems* (Kaduson et al., 1997), which formalized this prescriptive approach. The idea was simple but powerful: no single method works for every child. Instead, therapists should draw from multiple approaches to design interventions that truly fit each child's unique situation. At the heart of this philosophy is the belief that children don't "talk out" their problems the way adults do; they *play* them out. Play is their natural language for healing. Dr. Schaefer's taxonomy of the 14 "therapeutic powers of play" (Schaefer, 1993) became a foundation for my work. These therapeutic powers can be activated through different methods such as cognitive-behavioral play therapy (Knell, 2011), psychodynamic play therapy, or nondirective approaches, depending on what best helps the child.

Today, I continue to practice a prescriptive, eclectic, and integrative form of play therapy. I consider each child's cultural background, family involvement, and resources before designing an individualized plan. Just as importantly, I consider my own skills and comfort level with various interventions. One of the greatest lessons Dr. Schaefer taught me was to stay open and to use whatever approach best serves the child in front of me.

Looking back, I realize that "doing it my own way" was never about abandoning theory. It was about bringing myself fully into the work. And in doing so, I discovered that the most powerful healing often begins with play.

## Terry Kottman

My primary play therapy approach is AdPT (Kottman & Meany-Walen, 2016), which I developed in the late 1980s by integrating Adlerian principles with play therapy practices. At the time, I was applying Adlerian conceptualization and interventions with adults and teens when I was assigned a child client and was expected to use CCPT with her.

I initially attempted a nondirective approach, but after several sessions, the child client confronted me for not being my "real self" in the playroom. That moment prompted me to find a way to integrate my theory of personality (Adlerian) with the play therapy methods I had studied. Since that time, I have taught thousands of other play therapists how to do AdPT. I am a learning junkie, and as I encounter new concepts and tools (dance, movement, storytelling, temperament, video games, attunement, attachment, multicultural counseling, and beyond), I integrate my learning into AdPT.

The "why" is a little more complicated than the "what." While I don't believe AdPT is the "best" approach for everyone, it is the best approach for me. It aligns with my personality and beliefs about how people develop their ways of thinking, feeling, and behaving, and how those patterns can shift if given the right support. I love being myself in the playroom: goofy, nerdy, wiggly, and playful.

AdPT doesn't require a specific formulaic way of interacting with my clients. There are a few "Dos"—like building a caring relationship and sharing power with the client—and just a couple of "Don'ts," such as avoiding the phrase "makes you feel" when reflecting feelings and steering clear of evaluative words/praise. Beyond that, I get to engage with clients in ways that are authentic to me (well, maybe not "normal," but congruent with my playful and fun personality).

One thing I love about AdPT is that it is “technically eclectic.” When I conceptualize and treatment plan through an Adlerian ideas, I can use whatever interventions suit a particular client. I can work with children, teens, and adults; I can work with individual clients, groups, and families; I can also consult with parents and teachers to help them learn to be more encouraging and supportive to the children with whom I work. The structured process of AdPT, has four phases (Kottman & Meany-Walen, 2016).

- a. building an egalitarian relationship with the client,
- b. exploring the client’s lifestyle,
- c. helping the client gain insight into their lifestyle, and
- d. reorienting and reeducating the client.

The four phases make sense to me as way of unfolding the therapeutic process. I love having the freedom to be directive and to be nondirective, depending on the needs of the client, the setting, and the presenting problem. Being intentional and strategic with my interventions helps me to custom-design what I do with clients based on their developmental level, their culture, their natural inclination to express themselves in the playroom and their outside interests. I further create a prioritization of their treatment goals, the phase of therapy, and my conceptualization of what they need to understand and learn. Encouragement is very important to me and a cornerstone of Adlerian practice. I also believe in working with parents, families, and teachers—family play therapy and parent/teacher consultation are integral components of AdPT. Not surprisingly, since I created it, AdPT just fits me.

## Anne L. Stewart

My theoretical orientation reflects how I see and experience the world—through a deeply contextual and relational frame. It follows that I have adopted an integrative approach that incorporates constructs from systems and attachment theories.

Systemic approaches recognize that we are shaped by our individual attributes as expressed in a complex interplay of our family’s historical and current context, external events, and the broader social and cultural environment. In clinical work, this perspective helps me consider how biopsychosocial and cultural factors intersecting at individual, family, community, and societal levels influence my client’s life and development. The systemic model I have found most useful is the multicontextual life cycle framework for clinical assessment (McGoldrick & Hardy, 2011). The model names and asks the clinician to account for the impact of systemic oppression, racism, poverty, sexism, homo/bi/transphobia, classism, and violence in the client’s experience. The client’s development is viewed in the context of impactful historical and unpredictable events such as illness, natural disasters, trauma, or migration. The result is a comprehensive, culturally responsive, and dynamic view of the client. I see the client as embedded in multiple systems with varying levels of supportive and harmful influence, including the system of care that includes me.

Attachment theory is a developmental theory with a robust evidence base for its relevance to positive outcomes in clinical work (Ainsworth et al., 1978; Cassidy & Shaver, 2016). The constructs of safe haven and secure base illustrate important processes for understanding how psychologically safe and secure our clients may perceive relationships and the world to be. A person (caregiver or

therapist) who provides protection and coregulation of internal and external experience is serving as a safe haven. Persons who encourage us to explore the world of people, objects, nature, and ideas; who make it safe to do so; and then welcome our return are acting as a secure base. I believe we grow well in such caring relationships, ... and when some kind of stress disrupts us, attachment-informed interventions are relevant and therapeutic (Whelan & Stewart, 2014).

So how is play part of the scene? Dr. Stuart Brown theorizes that in typical child development, play creates the cornerstone for building all interpersonal relationships. Brown (2009) states that the unplanned and mutual delight between a child and caregiver creates a state of play. Brown and others further argue that the need to connect is evolutionarily wired to occur and is a pathway to healing across the age span (Cozolino, 2024; Siegel, 2012). From this perspective, creating a safe and secure relationship and being engaged in play are intricately interwoven (Stewart & Echterling, 2014).

Translating my integrated, theoretically based case conceptualization into treatment, I incorporate findings from neuroscience research. This body of knowledge has demonstrated the physiologically dysregulating impact of discrete and chronic adverse events and relational trauma, as well as the regulating impact of positive, attuned interpersonal interactions on well-being. I apply Perry's trauma-informed 3 R's model (Perry, 2009) to support the client's capacity to regulate, relate, and reason. I engage with the child, the caregiver, and, importantly, the caregiver-child relationship in playful, meaningful, and engaging ways, often using nature-based interventions.

This theoretical approach aligns with my values and beliefs about people, organizations, and the importance of place (National Scientific Council on the Developing Child, 2023). I characterize my approach of using systemic and attachment conceptualizations as *responsive therapy*—responsive to the needs of the child in context, at that time, and in relationship with me. It is important to note that even as I use a variety of techniques and strategies with my clients, my conceptualization remains consistently held in an integrated systemic and attachment frame.

## LaKaavia Taylor

My early theoretical journey connects to CCPT, which is grounded in person-centered theory (Rogers, 1951). I valued the emphasis on the therapeutic relationship and the core conditions of change (Landreth, 2023). In my own life, these characteristics allowed me to feel seen, validated, and empowered, making CCPT a perfect therapeutic fit. As I gained experience in play therapy, I realized that while the core conditions and relationships are vital for every child, some children required additional intervention. AdPT (Kottman, 2011) appeared to share many of CCPT's foundational values, particularly the focus on relationship development and honoring the whole child. Over time, my approach has evolved to align more closely with AdPT, continuing to honor my CCPT roots.

Adlerian theory forms the foundation of AdPT, developed by Dr. Terry Kottman (2011). It is grounded in the belief that people are creative beings who interpret their experiences subjectively (Adler, 1998). Adlerians hold that individuals have an innate desire to belong and are best understood holistically. As Kottman emphasizes, to be an effective AdPT therapist, one's beliefs about people, personality development, and human motivation must align with Adlerian principles (Kottman & Meany-Walen, 2016). My personal values of respect, compassion, community, and self-realization align with these principles and positively influence the way I build therapeutic relationships, connect with children, and create environments that promote belonging.

As an Adlerian play therapist, I strive to explore and affirm all aspects of a child's experience. Creating a supportive and self-enhancing therapeutic environment that fosters change is of utmost importance. I do this by engaging in the four phases of AdPT: 1) building the relationship, 2) exploring the child's lifestyle, 3) helping the child gain insight, and 4) reorientation and reeducation (Kottman & Ashby, 2025). These phases are consistent with my understanding of how change occurs, as they allow creativity and flexibility to meet each child's unique needs (Kottman & Ashby, 2019).

Through AdPT, I build a collaborative connection to facilitate trust and respect with children. Based on this approach, the therapist is a model of social interest. Social interest is essential to fostering prosocial and relational behaviors needed to engage successfully in many environments (Kottman & Meany-Walen, 2016). From the beginning of the therapeutic process, I find it vital to communicate the value and importance of the child's role in creating a relationship. Therefore, I convey genuine interest in the child's play, preferences, and expressions. I do this by acknowledging and reflecting on the child's interests, abilities, and strengths. In my work with children, I notice this gives them courage to connect and show up authentically in play sessions, which impacts their sense of belonging. Belonging is a factor in AdPT that enhances feelings of adequacy, self-worth, and resilience (Kottman & Ashby, 2019). This process is powerful considering children can feel discouraged and inferior as they navigate developmental tasks and challenges (Kottman & Ashby, 2025).

I observe and actively listen to the different ways the children respond to experiences in the playroom. Through this process, I can understand how children view themselves, others, and the world. Furthermore, it builds cultural understanding because the focus is on seeing things from the child's perspective rather than biases or assumptions (Hook et al., 2025). I am able to conceptualize the child's presenting problems and the resulting behaviors, thoughts, and emotions in a holistic manner. These are the key aspects of connecting and building a collaborative partnership with the child.

Once I have a better understanding of children and their presenting problems, my goal is to help them transform unhelpful feelings, beliefs, and behaviors as they navigate their life experiences and seek belonging within their sociocultural contexts (Kottman & Meany-Walen, 2016). This goal is addressed intentionally through strategies such as metacommunicating to the child about how they are thinking, expressive arts for them to nonverbally communicate their feelings, and role-playing practical alternative and adaptive behaviors. Instead of putting the focus on the child's behavior, the child is encouraged to view the aspects of their current feelings, thoughts, or behaviors that are not serving them. As a result, they begin to engage in more socially useful behaviors in and outside of therapy.

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