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PART I

Introduction

In keeping with the ecosystemic perspective of this book, the first three chapters provide the reader with a broad context for understanding and practicing play therapy. Chapter One establishes a common vocabulary for all readers by defining play and play therapy. Next, the functions of the play behavior in human life are delineated. Finally, a brief history of play therapy is provided.

Chapter Two reviews the most widely used models of play therapy as well as several other theoretical models of psychotherapy that were used to develop the Ecosystemic Play Therapy model presented in Part II. The widely used models that are reviewed are psychoanalytic play therapy, humanistic play therapy, and behavioral play therapy. Each theory is presented somewhat uncritically by describing it from the perspective of its practitioners.

Chapter Three discusses the importance of play therapists' awareness and management of the interaction of their complete ecosystem, their personal philosophy, values, background, language, religion, family experience, and culture with the ecosystem of their child clients.

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CHAPTER ONE

Definition and History of Play Therapy

It is necessary to begin by defining the term *play therapy* as it is used in this text. It is logical to first define the term play by itself while examining the implications of these definitions for defining play therapy.

DEFINING PLAY

No single, comprehensive definition of the term *play* has been developed. The most often quoted definition was developed by Erikson (1950), who stated that "play is a function of the ego, an attempt to synchronize the bodily and social processes with the self" (p. 214). Play is generally thought to be the antithesis of work; it is fun. "It is free from compulsions of a conscience and from impulsions of irrationality" (p. 214). Play is also defined as (1) intrinsically motivated, (2) freely chosen, (3) nonliteral, (4) actively engaged in, and (5) pleasurable (Hughes, 1995). Many others agree that play is pleasurable (Beach, 1945; Csikszentmihalyi, 1976; Dohlinow & Bishop, 1970; Hutt, 1970; Plant, 1979; Weisler & McCall, 1976). However, if one considers the occurrence of play essential to the definition of play therapy, this way of defining play proves quite problematic. Much of what disturbed children do in play therapy is far from fun; it is compulsive, impulsive, and irrational—in other words, the opposite of everything Erikson said it should be. The traumatized child who replays a variation of the traumatizing event for the fortieth or fiftieth time in session can hardly be said to be having fun. Two questions arise: Is this child playing? And, is this play

This chapter was adapted from the Introduction to Part One of the *Handbook of Play Therapy* (Schaefer & O'Connor, 1983).

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therapy? The answer to the first question seems to be a tentative "No"; the answer to the second question appears to be "Yes."

A further review of the literature on play reveals that certain elements are generally considered as typifying play behavior. These elements are generally consistent with what children do in their play therapy sessions.

Play is intrinsically complete; it does not depend on external rewards or other people (Csikszentmihalyi, 1976; Plant, 1979). This element is consistent with most of the behavior in which children engage during play therapy. Most children's play behavior does not require external rewards; children continue to act whether or not the adult is present. This is not to minimize the impact of the therapist's presence, only to say that it is not needed for most children to engage in play behavior.

Probably because it is intrinsically motivated, play tends to be person-dominated rather than object-dominated; that is, it is aimed not at acquiring new information about an object but at making use of the object (Hutt, 1970; Weisler & McCall, 1976). Furthermore, intrinsic motivation and object independence tend to make play highly variable across both situations and children (Weisler & McCall, 1976). Again, this seems consistent with most children's behavior during play therapy. Once the child has initially explored an object, the child tends to switch her focus to the use of the object rather than continuing to explore it. However, one notable exception comes to mind: The in-session behavior of the autistic child tends to be object-focused. Is it therefore really play? Here one would probably have to answer "No." Can one then say they do play therapy with such an autistic child? If play therapy requires that the child be able to engage in play behavior, then the answer, it seems, is "No."

Play is noninstrumental: It has no goal, either intrapersonal or interpersonal, no purpose, and no task orientation (Berlyne, 1960; Bettelheim, 1972; Goldberg & Lewis, 1969; Huizinga, 1950; Hutt, 1970; Plant, 1979; Weisler & McCall, 1976). This element is also consistent with most children's play behavior in play therapy sessions. Rarely does the child engage in play with a conscious goal in mind. Even when the child says, "Let's build a castle out of blocks," rarely has the end point, or even the process, been consciously planned.

Csikszentmihalyi (1975, 1976) talked about the concept of "flow" as it relates to play: Flow, among other things, involves a centering of attention in which action and awareness merge and a loss of self-consciousness occurs in the sense that the child is paying more attention to the task than to her own body state. These last two points are evidenced when an adult walks in on a child who is playing. Initially the child remains oblivious to the adult's presence, but when her attention is finally broken, she may seem suddenly embarrassed and then, just as suddenly and quite genuinely, realize that she has needed to go to the bathroom for quite some time. Flow is characteristic of children's play behavior in play therapy sessions.

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Several authors noted that play behavior does not occur in novel or frightening situations (Beach, 1945; Berlyne, 1960; Hutt, 1970; Mason, 1965; Piaget, 1962; Switsky, Haywood, & Isett, 1974; Weisler & McCall, 1976). Most play therapists find that children do very little that resembles play when they first enter treatment. In fact, much of a play therapist's training is geared toward the development of a style and techniques that will help the child feel safe and relaxed enough in the playroom so that play will ensue.

Many writers identify variations on the general concept of play behavior, including pretending, fantasy, and games with rules.

Pretend play is characterized by certain types of communication:

1. *Negation:* The means, often abrupt, by which the state is broken or terminated.
   a. "I stealed your cake."
   b. "I don't care. It's not cake any more."
2. *Enactment:* The gestures, tone, statements, or attitudes that the actor puts forth to establish or support the pretend situation or character, for example, crying like a baby, speaking sternly like a parent, making noises like a motor.
3. *Signals:* These support pretense by tipping off the partner and urging him to go along with the play. They include winking, grinning, and giggling.
4. The prepatory gestures set the stage, supply terms and conditions, and get the ball rolling at the beginning of the pretense: "That green telephone is the kind that policemen have in their cars." "Do you want to play with me?"
5. The final behavior is one that involves explicit mention of transformations in or out of the pretend situation or defines the terms or roles. "I'm a work lady at work." "Pretend you hated baby fish." "This is the train" (while pointing to the sofa) (Krasner, 1976, p. 20)

One type of pretend play, sometimes labeled fantasy play, is characterized by secret contents. It is the type of play that creates wish-fulfilling situations that allow instinctual discharge that would not be allowed within the framework of existing reality and that modify and correct that reality (Sandler & Nagera, 1963). Fantasy play also allows for the gratification of impulses that would not be allowed in reality, such as pretending to follow through on killing a hated sibling.

Games with rules do not generally fit within the standard definition of play, because there is some sense of implied task or goal. Games are, however, viewed as an intermediate phase between the unregulated play of young children and the often over-regulated play behavior of adults. In

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examining children's behavior in play therapy, one finds examples of all these play subtypes.

In spite of the consistency of this description of play, it is not entirely consistent with the types of play seen among children in play therapy. Their play includes:

1. *Connecting play,* where the child simply and literally makes contact with the toys, materials, environment, and the therapist.
2. *Safe play,* which is engaged in when the child is in control of either the toys or the therapist.
3. *Unsafe play,* involving the uncontrolled expression of emotions; this includes the child pretending actions that cannot be stopped by the characters in the play such as a tornado or an earthquake.
4. *Resolution play* where the child or the character in the child's play finds a way to cope with or contain unsafe play (Fall, 1997).

Again, a critical difference between the play behavior of normal children and those seen in a clinical context is that the play behavior of the latter is not always fun. In spite of this, it still seems to meet most of the other requirements of the definition and so it will continue to be included under the general heading of play for the purposes of this discussion.

DEFINING PLAY THERAPY

Defining play therapy is not as simple as saying "It is a treatment modality in which the child engages primarily in play." Some of the behaviors in which children engage in the course of their treatment cannot be defined as play, yet that does not seem to obviate the rationale for labeling the treatment modality *play therapy.*

It is also not easy to define play therapy by focusing on its therapeutic aspects. Many individuals are capable of creating an environment that maximizes the naturally therapeutic aspects of play as they are described next; however, this situation seems best described as therapeutic play. Play therapy makes use of these therapeutic aspects of play, but it is distinct from therapeutic play in its reliance on a given theoretical orientation in directing the thinking and behavior of the play therapist. The play therapist has the training to work within a given theoretical model to help the child move systematically toward mental health. It is this incorporation of a system that qualifies what play therapists do as "therapy" comparable to any other clinical intervention.

In 1997, the board of directors of the International Association for Play Therapy developed a definition of play therapy that seems to address a number of issues in the field. The definition is inclusive of both a variety of

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definitions of play itself and of the wide variety of theoretical orientations represented by those who practice play therapy.

> 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 and achieve optimal growth and development. (Association for Play Therapy, 1997, p. 7).

For the purposes of this book, that definition has been expanded only slightly:

> Play therapy consists of a cluster of treatment modalities that involve 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 and the re-establishment of the child's ability to engage in play behavior as it is classically defined.

This means that the play therapist seeks to maximize the child's ability to engage in behavior that is fun, intrinsically complete, person-oriented, variable/flexible, noninstrumental, and characterized by a natural flow. High-quality play therapy as practiced by a given play therapist represents an integration of the therapist's specific theoretical orientation, personality, and background with the child's needs in working toward this goal. That both the child and the play therapist may engage in behavior that might be called anything but play along their way to this ultimate goal is irrelevant. Play therapists universally recognize that treatment has been successfully completed when the child demonstrates an ability to play with joyous abandon—this is what makes play therapy unique.

FUNCTIONS OF PLAY AND THEIR IMPLICATIONS FOR CONDUCTING PLAY THERAPY

Having accepted this compiled definition of play and, subsequently, the definition of play therapy, one may examine the various functions of play behavior in the lives of children and the possible value of these functions within the conduct of play therapy.

Biological

Play has several functions that can be loosely construed as biological. First, play is the medium through which the child learns many basic skills (Boll, 1957; Chateau, 1954; Dohlinow & Bishop, 1970; Druker, 1975; Frank, 1968;

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Slobin, 1964). An infant first learns to coordinate hand-and-eye movements by reaching for desired objects as she playfully explores her environment. In play therapy, most of the basic skills that the child learns are incidental to the overall focus of the treatment. However, one cannot ignore the therapeutic impact that learning to catch a ball might have on a child's self-esteem. Second, play allows the child to expend energy and relax (Schiller, 1875; Slobin, 1964). What pleasure children take in running themselves ragged in a game of tag, only to collapse in a giggling pile when it is over. Third, the process of playing is one of the ways in which children become aware of their own affect as well as the affect of others. Play itself stimulates a variety of internal sensations that children gradually learn to associate with a variety of positive and negative feelings. As they learn to differentiate these states in their own functioning, they also gradually learn to perceive and empathize with those feelings in others. Last, play gives the child kinesthetic stimulation (Plant, 1979; Slobin, 1964), another function that is especially important in infancy when the child is totally involved with her sensory intake. An infant lying in her crib wiggles and sets her mobile in motion. The mobile's movement causes the infant to wriggle more, and a cycle is created. Soon the infant is a wriggling, giggling ball of fire with every body part in motion. Play therapists rarely use the kinesthetic aspects of play, but they can be of great benefit in helping a child develop body awareness sufficient to allow for self-regulation.

Intrapersonal

Play serves three types of intrapersonal functions. First, play meets a need for "functionlust" (Slobin, 1964; Walder, 1933). That is, all human beings have a need to do something. Most of us find it almost painful, if not impossible, to do nothing. Even when kept perfectly still and sensorially deprived, we will do things in our minds. For children, play is something to do. When one takes this function of play into consideration, it is a little difficult for the play therapist to dismiss a session as a failure because "the child did not do anything." Barring the possibility that the child was comatose or catatonic, she did something, and whatever that was, it met at least this one intrapersonal function.

Second, play allows a child to gain mastery of situations (Erikson, 1950; Slobin, 1964). Play lets the child explore her environment (Druker, 1975; Frank, 1955). In playing hide-and-seek, the child explores the environment in a somewhat novel way as she looks for places to hide. Play also allows the child to learn about the functions of the mind, body, and world (Cramer, 1975; Frank, 1955). A child running around the room pretending to be an airplane learns about the ability of her mind to create the sense of flying, the ability of her body to imitate the sounds of an airplane, and the fact that planes obviously do not fly by making noises and running around. In this sense, play fosters the child's overall cognitive development (Frank,

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1968; Piaget, 1962; Pulaski, 1974). It is through play that children learn to recognize, label, understand, and express emotions. In play therapy, these situational mastery aspects of play can be used to help the child develop competence relative to things with which she will never come in contact during the actual session. A play therapy session need not occur in the dentist's office for the child to learn not to fear the situation by playing it out in the playroom.

Finally, play lets the child master conflicts (Cramer, 1975; Druker, 1975; Erikson, 1950; Frank, 1955; Walder, 1933) through symbolism and wish fulfillment (Pulaski, 1974). This function of pretend play is probably the most widely used in the context of play therapy. A child may never actually experience her parents' remarriage after a long and bitter divorce, but she may play out just such an event over and over until she can eventually allow the bride and groom in the play not to marry but to be friends. Similarly, other traumatic events can be replayed until more satisfactory outcomes in terms of the child's thoughts and feelings can be effected.

Interpersonal

Play serves two primary interpersonal functions. Initially, play is one of the main vehicles through which the child practices and achieves separation/individuation from the primary caretaker. At home, the caretaker plays peek-a-boo, making a game of temporary separations from the infant. Later on, the toddler will delight in games of running away and being chased. These and many other games allow the child to experience separation, not as an overwhelming and terrifying thing but as a pleasurable and controllable game. In therapy, many of these same separation themes are played out relative to both the child's life outside the sessions and her experience of the sessions. After all, every session has a beginning and an ending, during which the child must learn first to engage and then to separate. Unfortunately, many play therapists do not make full use of the play rituals most children develop to contain these stressful realities. For example, some children will attempt to hide in the waiting room prior to the session. The therapist can either respond to this as an avoidant behavior or as a play behavior through which the child is attempting to initiate a game of hide-and-seek with the therapist. The child is beginning to play before even reaching the playroom. The therapist who makes an exaggerated effort to find the hidden child uses play to make the transition as well as communicating to the child that she is worth searching for.

Later in the child's development, play helps the child learn myriad social skills. Children learn how to share both toys and ideas in play. They learn to take turns and cooperate. They learn what is expected of them in school by playing with older peers. Essentially, they learn about human interactions simply by being with others. In individual play therapy, the child learns what it is like to be with an adult in a very special kind of interaction.

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Fortunately, or unfortunately, this interaction is not always very realistic, and the degree to which the child is able to generalize from it to the outside world varies considerably. On the other hand, in group or family play therapy this interpersonal function of play can be used to its full advantage.

Sociocultural

Finally, one must consider the sociocultural functions of play. It is the medium through which children learn about their culture and the roles of those around them. In play, children learn games that are culturally and, often, historically specific. These games may convey a great deal about society's values. Although ring-around-a-rosy has lost a lot of meaning over time, it once conveyed a powerful message to children. Originally, the game was ring, a ring, a rosey, first played during the Black Plague of the Middle Ages. It went as follows: Ring, A Ring, A Rosey; A pocketful of posies; Achoo, Achoo; We all fall down. The poem describes the round red blotches that first appeared on those stricken with the plague, then the practice of stuffing the victim's pocket's with flowers to cover the smell of both the illness and death because quick burial often was not possible, and finally the respiratory complications that caused the victim to fall down and die. One can imagine a group of children surrounded by the certainty of death playing a game that, if only in some bizarre way, helped to make death less frightening. In retrospect, one can certainly extract a sense of the social atmosphere of the time.

It is important for the play therapist to remember that "the play of children tells us much about the values of the culture they live in" (Hughes, 1995, p. 15). Their spontaneous play is a reflection of their culture. For example, the more complex a culture the more complex the competitive games in which children engage. Games of physical skill are found in simple cultures. Games of chance are found more often in cultures whose fate is more dependent on chance such as agricultural or nomadic cultures. And, lastly, games that involve the use of strategy tend to be emphasized in technical and complex cultures (Hughes, 1995). An excellent resource for therapists interested in learning about children's play in other cultures is Roopnarine, Johnson, and Hooper (1994), *Children's Play in Diverse Cultures* (Albany, NY: State University of New York Press). The book presents detailed descriptions of the play behavior of East Indians, Taiwanese, Japanese, Polynesian, Puerto Rican, Italian, African, and Eskimo children in nonclinical contexts. The degree to which children's play is both a result and reflection of these very diverse cultures makes for very interesting reading and helps attune one to the cultural variability in what is considered normative behavior among children.

Children use the sociocultural aspects of play to rehearse desired adult roles. They pretend to be mommy and daddy. They pretend to be the teacher or a policeman. And in so doing they learn many of the thoughts,

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behaviors, and values associated with these roles. This is thought to be one of the primary ways in which children learn about and rehearse gender role behavior as it is manifested in their culture. That is, children learn and rehearse those behaviors typically associated with being a boy or a girl. In therapy, this process continues as children act out the roles of both desired and feared people in their lives.

HISTORY OF CHILD PSYCHOTHERAPY AND PLAY THERAPY*

Psychotherapy with children was first attempted by Freud (1909) in an attempt to alleviate the phobic reaction of his now historic patient Little Hans. Freud did not treat Hans directly but advised the child's father of ways to resolve Hans' underlying conflicts and fears. Although it was many years before therapists again attempted to work through a child patient's parents, it was this first therapeutic case that laid the necessary foundation for such interventions as filial therapy.

Play was not directly incorporated into the therapy of children until 1919, when Hug-Hellmuth (1919) used it, feeling it was an essential part of child analysis. However, Anna Freud and Melanie Klein wrote extensively on how they adapted traditional psychoanalytic technique for use with children by incorporating play into their sessions. Both theorists, as well as many who followed them in applying psychoanalysis to children, began to modify not only the techniques involved but the underlying theoretical model as well. Generally, all of these modified versions of psychoanalytic treatment are grouped under the heading of psychodynamic therapies. The primary goal of their approach was to help children work through difficulties or trauma by helping them gain insight. Although both women relied on play as part of treatment, they used it in very different ways.

In 1928, Anna Freud began using play as a way of luring children into therapy. The rationale behind this technique involved the concept of a therapeutic alliance. Traditional psychoanalysis held that the majority of the work of analysis was accomplished once the healthy aspects of the patient's personality joined forces with the analyst to work against the patient's unhealthy self. This joining of forces was termed the therapeutic alliance. Freud was aware that most children do not come to therapy voluntarily; they are brought by their parents, and it is the parents, not the child, who have the complaint. In addition, she realized that the therapeutic techniques of free association and dream analysis were foreign to most children's means of relating. Therefore, to maximize the child's ability to form an alliance with the therapist, Freud used play—the child's natural

* Portions of this section are direct extracts used with permission from the Introduction to Part One of the *Handbook of Play Therapy* (Schaefer & O'Connor, 1983).

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medium—with which to build a relationship with her child patients. She used games and toys to interest the child in therapy and the therapist. She made particular use of magic tricks as a way of engaging the child (A. Freud, 1928, 1965). Many therapists continue to find these very helpful in engaging even the most resistant child.

Dr. Diane Frey makes extensive use of magic tricks in her work with clients of all ages. She has plans to publish a compendium of these in an upcoming book. Gilroy (1997) writes about the value of using magic tricks to build rapport in play therapy. He indicates that magic tricks can be used to build the therapeutic alliance, as positive reinforcement, as diagnostic tools, as a way of enhancing the social skills of withdrawn children, and as a way of bypassing the defenses of resistant adolescents.

As the child developed a satisfactory relationship, the emphasis of the sessions was slowly shifted from a focus on play to a focus on more verbal interactions. Since most children were unable to make use of the technique of free association, Freud concentrated on the analysis of dreams and daydreams. She found that children were often as able and interested in the work of dream analysis as their adult counterparts; further, the children were often able to create mental images, and while visualizing their fantasies they were able to verbalize them.

Whereas Freud advocated using play mainly to build a strong, positive relationship between a child patient and the therapist, Klein (1932) proposed using it as a direct substitute for verbalizations. Klein considered play the child's natural medium of expression. She felt that children's verbal skills were insufficiently developed to express satisfactorily the complex thoughts and affects they were capable of experiencing. Kleinian play therapy has no introductory phase; the therapist simply starts out making direct interpretations of the child's play behavior. And, whereas A. Freud thought that analysis was most appropriate for neurotic children whose disorders were primarily anxiety-based, Klein thought that any child, from the most normal to the most disturbed, could benefit from her style of "play analysis."

The modifications of classic psychoanalytic theory and technique begun by A. Freud and Klein led to the development of a variety of theoretical models all loosely grouped under the heading of psychodynamic psychotherapies. One of the most important developments relative to work with children was an increasing emphasis on the role of the environment in the development of the child's personality and, related to this, the importance of attachment. The vast majority of psychoanalytically oriented play therapy practiced in the United States is based on psychodynamic rather than psychoanalytic theory and technique.

Between the 1930s and the 1950s, the number of child therapy theories and techniques grew rapidly. Not only were new theoretical models developed, existing models were modified to treat those children who were not suitable candidates for traditional psychoanalytic play therapy. In

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addition, a number of models and techniques were developed as reactions against various aspects of psychoanalysis.

In the late 1930s, a technique of play therapy, now known as structured therapy, was developed, using psychoanalytic theory as a basis for a more goal-oriented approach. Common to all the therapies in this category are (1) a psychoanalytic framework, (2) at least a partial belief in the cathartic value of play, and (3) the active role of the therapist in determining the course and focus of the therapy. Levy (1938) developed a technique called "release therapy" to treat children who had experienced a specific traumatic event. Levy provided the child with materials and toys aimed at helping the child recreate the traumatic event through play. The child was not forced into a set play pattern, but very few toys were made available to her other than those that the therapist thought might be best used to cathect the emotionally loaded event. The concept of this type of therapy was derived from Sigmund Freud's notion of the repetition compulsion. The idea here is that given security, support, and the right materials, a child could replay a traumatic event over and over until she was able to assimilate its associated negative thoughts and feelings.

Solomon (1938) developed a technique called active play therapy, that was to be used with impulsive/acting-out children. Solomon thought that helping a child express rage and fear through the medium of play would have an abreactive effect because a child could act out without experiencing the negative consequences she feared. Throughout interaction with the therapist, the child learns to redirect the energy previously used in acting out toward more socially appropriate play-oriented behaviors. Solomon also heavily emphasized building children's concept of time by helping them separate anxiety over past traumas and future consequences from the reality of their present life situations.

Hambridge (1955) set up play sessions in much the same way that Levy did, however, he was even more directive in setting up the specifics of the play situation. While Levy made available materials that would facilitate re-enactment of a traumatic event, Hambridge directly re-created the event or anxiety-producing life situation in play to aid the child's abreaction. This technique was not used in isolation but was introduced as a middle phase in an already established therapeutic relationship with a child; that is, when Hambridge was sure the child had sufficient ego resources to be able to manage such a direct and intrusive procedure. After the situation was played out, Hambridge let the child play freely for a time to recoup before leaving the safety of the playroom.

"Adler (1927), one of Freud's early students and colleagues, was the first to rebel against orthodox psychoanalytic thought. He was followed by Karen Horney (1937), Eric Fromm (1947), and Harry Stack Sullivan (1953). These four theorists often are grouped together because of their mutual concern for the role of the self and the importance of interpersonal and social dynamics in the development of personality and psychopathology. Each

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theorist, however, placed a different emphasis on the self (Adler, Horney), the role of the individual in society and culture (Fromm), and interpersonal dynamics (Sullivan). Although these theorists provided the basis for variations in psychoanalytic treatment, many common elements remained. In general, though, their treatment methods involved more active interaction with the patient, less interest in unconscious processes, more concern with the patient's present than past situation, and interpretation based on their particular theoretical focus" (Johnson et al., 1986, p. 127). As was previously mentioned, those treatment models that use traditional psychoanalysis as their base while modifying either the theory or technique are referred to as *psychodynamic*.

Also in the 1930s, a number of play techniques generally grouped together under the heading of *relationship therapies* developed. The original philosophical basis for relationship therapy came from the work of Rank (1936), who stressed the importance of the birth trauma in development. He believed that the stress of birth causes persons to fear individuation and thus leads them to cling to their past. He de-emphasized the importance of transference and the examination of past events in therapy and instead focused on the realities of the patient/therapist relationship and the patient's life in the here and now.

Taft (1933), Allen (1942), and Moustakas (1959) adapted Rank's ideas to work with children in play therapy. These theorists emphasized the negative role of the birth trauma on the child's ability to form deep positive relationships. Because of this trauma, susceptible children may have difficulty separating from their primary caretaker by becoming either clinging and dependent or isolated and unable to relate sufficiently to others. Through therapy, the child is given a chance to establish a deep, concerned relationship with a therapist in a setting that, simply because of the basic therapeutic agreement, is safer than any he or she will ever experience again. Taft adopted an existential approach and focused on the interaction between the child and therapist and the child's ability to learn to use that relationship effectively. Moustakas focused on helping the child to individuate, to explore interpersonal situations while using the secure relationship with the therapist as a safe base. Despite the tendency to emphasize the child/therapist relationship and to de-emphasize the significance of past events, the relationship therapists still maintain a strong tie to psychoanalytic theory. Rather than completely discarding this theoretical framework, they seem to have relaxed the "rules" of analysis while retaining the essential element, the therapeutic relationship.

In the 1940s, Carl Rogers (1942, 1951, 1957, 1959, 1961) developed the client-centered approach to therapy with adults; Axline (1947) modified it into a play therapy technique. This approach is based on the philosophy that children naturally strive for growth and that this natural striving has been subverted in the emotionally disturbed child. Client-centered play therapy aims to resolve the imbalance between the child and her environment so as

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to facilitate natural, self-improving growth. The therapist and child develop a warm and accepting relationship in which the therapist reflects back the child's feelings so that the child gains insight that allows her to solve her own problems and institute change as she desires.

In 1949, Bixler wrote an article titled "Limits Are Therapy" and, in a sense, ushered in a movement in which the development and enforcement of limits were considered the primary vehicles of change in therapy sessions. Bixler suggested that the therapist set limits with which she is comfortable, including:

1. The child should not be allowed to destroy any property or facilities in the room other than play equipment.
2. The child should not be allowed to physically attack the therapist.
3. The child should not be allowed to stay beyond the time limit of the interview.
4. The child should not be allowed to remove toys from the playroom.
5. The child should not be allowed to throw toys or other material out of the window. (Bixler, 1949, p. 2)

Ginott (1959, 1961) felt that the therapist, by properly enforcing limits, can re-establish the child's view of herself as a child who is protected by adults. To say that this technique stresses limits is not to say that other techniques do not use limits. Many other therapists and therapy techniques use limits explicitly, but they are not seen as the major effective element of the therapy. The rationale in limit-setting therapy is that children who manifest specific acting-out behavior can no longer trust adults to react in consistent ways and therefore must constantly test their relation to adults. Limits allow the child to express negative feelings without hurting others and subsequently fearing retaliation. Further, limits allow the therapist to maintain a positive attitude toward the child because she does not feel compelled to tolerate the child's aggressive acting out.

The role of parents or caretakers has been emphasized from early in the play therapy movement. As was mentioned, Freud's treatment of Little Hans (1909) was the first example of what later came to be known as Filial Therapy, in which parents act as the primary therapeutic agents with their own children. As early as 1949, Baruch was advocating planned play sessions to enhance parent-child relationships. In 1959, Moustakas talked about play therapy sessions conducted in the child's home by the parents. The term, *Filial Therapy,* was applied to the technique by Bernard Guerney in 1964. While the method has been around for some time its use has become a growing trend over the past 10 years (Landreth, 1991). Other strategies for involving parents in play therapy can be clustered under the heading of developmental play therapy. Brody (1978) developed a technique she specifically called *Developmental Play Therapy,* that emphasizes the use of physical contact and somewhat structured sessions. Deriving from

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her work and the earlier work of Des Lauriers (1962), Jernberg (1979) developed one of the most succinct theoretical and technical models of developmentally oriented play therapy, *Theraplay*®. The technique is based on the notion that normal caretaker/child interactions in the first few years of life are essential to establishing the basis for the child's future mental health and that these types of interaction may be instituted later in the child's life with the same health-producing effects. Each of these is important for the degree to which they include parents. The developmentally based therapies are important for the degree to which they advocate for a high level of therapist-child interaction in session.

The last four decades have witnessed a burgeoning number of new theories and techniques of child psychotherapy in general and play therapy in particular, some of which are described in such texts as:

Johnson, J., Rasbury, W., & Siegel, L. (1986). *Approaches to child treatment.* New York: Pergamon Press.

Kazdin, A. (1988). *Child psychotherapy: Developing and identifying effective treatments.* New York: Pergamon Press.

Morris, R., & Kratochwill, T. (Eds.). (1983). *The practice of child therapy.* New York: Pergamon Press.

O'Connor, K. & Braverman, L. (1997). *Play therapy theory and practice: A comparative presentation.* New York: Wiley.

O'Connor, K. & Schaefer, C. (1994). *The handbook of play therapy* (Vol. 2.) New York: Wiley.

Schaefer, C. (1979). *Therapeutic use of child's play.* New York: Aronson.

Schaefer, C. & O'Connor K. (Eds.). (1983). *Handbook of play therapy.* New York: Wiley.

Schaefer, C. & Kottman, T. (Eds.). (1993). *Play therapy in action a casebook for practitioners.* Northvale, NJ: Aronson.

A great deal of the credit for the growth of the field of play therapy over the past decade or more must go to the International Association for Play Therapy (IAPT). This association was founded in 1982 by Dr. Charles Schaefer and Dr. Kevin O'Connor. The IAPT began with approximately 50 members and, as of this writing, has over 3600. Besides the parent organization, branches now exist in 33 out of the 50 United States as well as Canada and South Africa. The IAPT promotes theoretical development, research, and clinical work through its annual conference and its publication of the *International Journal of Play Therapy.* Additionally, the IAPT developed standards for registering individuals as play therapists (Registered Play Therapist; RPT) and as play therapy supervisors (Registered Play

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Therapist—Supervisor; RPT-S). The work of the association has led to a steady increase in both the quantity and quality of work done in the field of play therapy. You may contact the International Association for Play Therapy at 2050 N. Winery, Suite 101, Fresno, CA, 93703.

As discussed in the Preface to this volume, the first edition of this text focused on the need to integrate ideas from a number of different theoretical models of play therapy in order to provide optimal treatment to the widest range of child clients. In this edition that integration is taken to the next level and elaborated into a freestanding model called *Ecosystemic Play Therapy.* In spite of this shift in emphasis, the effective practice of play therapy requires the practitioner to understand a broad range of theoretical and technical models of play therapy. To this end Chapter Two of this edition presents the major existing theories of play therapy as well as some additional theories that contributed significantly to the development of Ecosystemic Play Therapy. In Part II, Chapters Four to Fifteen current information on the theory and practice of Ecosystemic Play Therapy is presented.