PART I

FUNDAMENTALS OF PLAY THERAPY PRACTICE

Chapter 1

PLAY THERAPY
Basic Concepts and Practices

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> *Oh, every child just once in their life should have this chance to spill themselves out all over without a "Don't you dare! Don't you dare! Don't you dare!"*
>
> *Jerry, age 7*

> *No. I don't have to break that window. I don't have to go on acting like I always have. I don't have to do everything just because I get the idea to do it. I don't have to hit people just because I feel like hittin' 'em. I guess it's because I didn't know before I could just feel mad and in a while it would go away—the bein' mad—and I would be happy again. I can change. I don't have to stay the same old way always because I can be different. Because now I can feel my feelings!*
>
> *Harold, age 8*

Jerry and Harold were clients of Virginia Axline, a leading figure in the world of play therapy (Axline, 1979, p. 520). These children entered therapy because of behavior problems and an inability to express their emotions in appropriate ways. Perhaps better than anyone, Jerry and Harold portray the true experience of play therapy as an opportunity to take control of the emotions that can sometimes run rampant. Their statements continue to ring true today, even as play therapy has evolved to include numerous theoretical orientations utilized around the world.

This chapter is intended to provide an overview of the basic concepts and practices of play therapy. Play therapy has a rich history dating back to Freud and the beginnings of psychoanalytic theory and is continually being developed and expanded. The following pages will define and describe play therapy, including the importance of using play in a therapeutic setting, the playroom and suggested materials, the stages of therapy, inclusion of caregivers, and the effectiveness of play interventions.

DEFINITION OF PLAY THERAPY

The Association for Play Therapy has defined *play therapy* as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve

psychosocial difficulties and achieve optimal growth and development" (Association for Play Therapy, n.d.). This indicates that play therapy is a therapeutic modality firmly grounded in theoretical models. The major theories of play therapy will be described in detail later in this book. Some examples include psychoanalytic, child-centered, cognitive-behavioral, prescriptive, and family play therapy.

The definition of play therapy also indicates that play therapists strive to recognize, acknowledge, and utilize the therapeutic powers of play. These therapeutic powers, also known as change mechanisms, are the active forces within play that help clients overcome their psychosocial difficulties and achieve positive development.

IMPORTANCE OF PLAY THERAPY

The therapeutic powers of play can be classified into eight broad categories: communication, emotional regulation, relationship enhancement, moral judgment, stress management, ego boosting, preparation for life, and self-actualization. Chapter 2 contains a detailed description of the specific healing agents inherent in play. These change mechanisms form the foundation for the theoretical models and, thus are the heart and soul of play therapy.

Play has many benefits in life, regardless of age. Play is fun, educational, creative, and stress relieving and encourages positive social interactions and communication. When playing, children learn to tolerate frustration, regulate their emotions, and excel at a task that is innate. Children can practice new skills in a way that makes sense to them, without the structured confines of "the real world" or the need to use verbal language. There are no mistakes too big to overcome through play, and no challenges too tricky to attempt. Play gives children a chance to master their worlds as they create, develop, and maintain their own senses of self. Children use play to communicate when they do not have the words to share their needs and look to adults to understand their language. As Landreth (2002a) aptly pointed out, play is a child's language and toys are the words.

A BRIEF HISTORY OF PLAY THERAPY

Sigmund Freud, through his work with Little Hans, first brought the idea of therapeutic play into the practice of psychotherapy (Freud, 1909). Freud wrote that play serves three main functions: promotion of freer self-expression (especially of instincts considered taboo), wish fulfillment, and mastery of traumatic events. To master traumatic events through play, a child reenacts the event with a sense of power and control of the situation. This allows the child to bring repressed memories to consciousness and relive them while appropriately releasing affect. Termed abreaction, this process is different from catharsis because abreaction includes the reliving and mastering of the experience itself rather than the simple release of affect (Freud, 1892, as cited in Erwin, 2001). While some theorists have described

catharsis in terms of a hydraulic theory of built-up negative energy that quickly discharges, more recent authors suggest that negative emotions are often brought out and released slowly as a child gradually assimilates the experience through repetitive play (Pulaski, 1974).

Melanie Klein continued the idea of using play for child therapy in a psychoanalytic framework. In particular, she believed that play allowed unconscious material to surface, and the therapist could then interpret the repressed wishes and conflicts to help the child understand his or her problems and needs. Klein agreed with the gradual approach to understanding and assimilating negative experiences as well as the need to relive and master such experiences through play (Klein, 1955). Klein worked with younger children than traditional psychoanalysts would see.

One technique that Klein (1955) pioneered involved the use of miniatures. When children play with miniature toys, they often feel a sense of control over these objects as the representation of real-world objects or people. Margaret Lowenfeld took this idea further and developed the World Technique. This technique involves a sand tray and access to water and miniature objects that represent larger scale items. Sandplay therapists typically have a wide selection of miniatures available, for example, people, animals, buildings, landscape items, methods of transportation, archetypes, and supernatural beings. In the World Technique, children are given the opportunity to create an imaginary world in which they can express whatever they desire. Children may develop realistic or fantastic worlds, peaceful or aggressive worlds, orderly or chaotic worlds (Lowenfeld, 1939). These sand trays are considered to be expressions of predominantly unconscious material and utilized as such in therapy.

Another psychoanalyst who used play therapeutically was Anna Freud (1946). She helped to bring child therapy, particularly child analysis, into a more widely used arena. She believed play was important because it enabled the therapist to establish a therapeutic alliance with the child. Similarly, recent research has suggested that a strong therapeutic relationship is necessary for effective therapy.

In the middle of the 20th century, Virginia Axline brought a more humanistic, person-centered approach to child and play therapy. In particular, Axline (1947) espoused the belief that the necessary conditions for therapeutic change were unconditional positive regard, empathic understanding, and authenticity. She also stated that children are better able to express their thoughts, feelings, and wishes through play than with words.

The following chapters will provide more details about these classical theories of play therapy, together with more recent models, including cognitive-behavioral, prescriptive, solution-focused, narrative, and integrative play therapies.

WAYS OF IMPLEMENTING PLAY THERAPY

Like traditional talk therapy, play therapy can be implemented in a variety of formats. For example, child-centered play therapists tend to utilize individual sessions with the child and allow the child the freedom to express himself or herself with little direction from the therapist. The role of the therapist is to encourage the

child's appropriate expression of emotions and give the child a sense of control over the therapeutic relationship. Therapists who utilize other modalities, such as cognitive-behavioral play therapy, often structure the therapeutic process more, depending on the assessed needs of the child.

Filial therapists train parents to be cotherapists and implement the therapeutic process through parent–child interactions. Filial therapy sessions are similar to client-centered play therapy ones, but in the sessions the parents encourage positive interactions that will persevere beyond the constraints of the therapy room (Guerney, 2000). Family play therapy that utilizes other modalities (such as cognitive-behavioral or group approaches) to encourage involvement of caregivers has also been shown to be effective (Bratton, Ray, Rhine, & Jones, 2005).

Group play therapy has been applied to a number of presenting problems. Therapy groups may be either nondirective or directive in nature. In directive groups, sessions are typically psychosocial in nature and focus on a presenting issue that the children share in common, such as social skills deficits, acting out behaviors, or past trauma (e.g., Flahive & Ray, 2007; Spence, 2003; Sweeney & Homeyer, 1999).

APPLICATIONS OF PLAY THERAPY

Play therapy clients can be infants/toddlers (Schaefer, Kelly-Zion, McCormick, & Ohnogi, 2008), preschoolers (Schaefer, 2010), or elementary and high school students (Gallo-Lopez & Schaefer, 2005). Clients can come from many socioeconomic backgrounds, including those who are homeless (Baggerly & Jenkins, 2009). Play therapy can also be utilized with adult and elderly clients (Schaefer, 2003). While play therapy with adolescents and adults is continuing to gain popularity, most current therapeutic interactions are with children ages 3 to 12. Thus, *child* will be used throughout this chapter to designate the play therapy client.

Play therapy is a modality that can be truly flexible in its location. The space can be an outpatient clinic or office setting, a school (e.g., Ray, Henson, Schottelkorb, Brown, & Muro, 2008), a home, the scene of a disaster (e.g., Dripchak, 2007), a hospital bed (e.g., Li & Lopez, 2008), or a playground. Play therapy can take place in a fully stocked playroom or with materials pulled out of a suitcase. Play therapy is limited only by the extent of the therapist's flexibility and creativity.

THE PLAYROOM AND SUGGESTED MATERIALS

Playrooms vary greatly, depending on the setting of therapy and the therapist's needs and style. Theoretical orientation and type of therapy also contribute to the design of the play space. For example, therapists using Theraplay or group play therapy require a good amount of clear, open floor space. Landreth (2002a) has described ideal features of a playroom to be used for individual therapy sessions. He suggests 150 to 200 square feet of space; easily cleaned materials, furniture, and floors; shelves for toys and cabinets for extra supplies; a sink with running

cold water; child- and adult-sized furniture; a desk or table for artwork; a marker or chalk board; and an attached bathroom.

In terms of play materials, the selection of toys and other items to be included certainly varies, depending on the therapist's theoretical orientation, personal ideas and values, and budget/space issues. There is a selection of basic items that are consistently useful. These include the following: animal families, baby doll (with bottle), dishes/plastic silverware, doll families, doll house or box with furniture, puppets, toy soldiers, blocks and other building materials, clay, art supplies (markers, crayons, large paper, tape, blunt scissors), small pounding hammer, two telephones or cell phones, doctor's kit, small soft ball, playing cards, small box with lid, and transportation toys (cars, airplane, ambulance, etc.). In addition to these items, such items as masks, mirrors, rope, dinosaurs, plastic tools, cardboard bricks, Lincoln logs, books, board games, a magic wand, dress-up clothes, and a sand tray and miniatures can also be beneficial.

Another useful feature of a playroom is separation of space. This might be achieved by variations in floor coverings, such as vinyl flooring near water or sand areas and carpets/area rugs in other spaces. Most play therapists like to separate materials by function to include a designated area for dollhouse play, another for sand trays, a third for puppets, and so on.

All other factors aside, predictability and consistency are perhaps the two most important features in a play space. Children should be able to know that the materials they need are available and easily located. If they keep encountering unfamiliar items, they will spend most of the therapy session exploring the items rather than playing with them (Kottman, 2001).

A general rule is that every item in the playroom should serve a therapeutic purpose. So, one should carefully select rather than haphazardly collect the play materials. Also, toys or games that are easily broken or expensive and games that are very complicated should be avoided (Kottman, 2001).

HOW TO BEGIN AND END A SESSION

While the process of play therapy is often intuitive to children, few parents know what to expect when they bring their child for individual play therapy. It is helpful to meet with parents without the child present to discuss presenting concerns as well as introduce parents to play therapy. An explanation to parents that children often cannot use words to express their feelings and problems and instead use play is usually well understood. Play therapy can then be described as a way to learn about the child's concerns and problems through play and to help the child find ways to overcome them.

For the child, initial sessions often include an introduction to the play space and therapeutic process. Both should be given at the child's developmental level and with appropriate amounts of information. Younger children are often happy to hear that the playroom is a space for them to play in many ways, while older children can understand more about the process. The amount of information given to a

child is also dependent on the theoretical orientation of the therapist. For example, Theraplay therapists would likely provide very little introduction for the child, while other therapists might explain the reason the child is being brought for therapy, what is going to happen in session, and meeting times.

Children use the initial session to explore not only the play space but the therapist as well. Play therapists should generally allow the child to explore at his or her own pace and not give suggestions about which materials to use. During the first session, therapists should focus on developing rapport by creating a warm, comforting, safe environment for the child.

When ending a session, play therapists must decide whether a child will help pick up the toys or not. This is a personal and theoretically oriented decision. Nondirective therapists such as Virginia Axline would not encourage children to pick up the playroom. Instead, they gave a warning 5 minutes before the end of session so that the child can mentally prepare to leave.

For most children, announcing when 5 minutes remain is sufficient. Some children require more time to put themselves back together mentally and would benefit from a 10-minute warning followed by a 5-minute warning. This is something that is often dependent on the child's age and level of functioning.

LIMIT SETTING IN PLAY THERAPY

Although limits on a child's behavior in the playroom are generally kept to a minimum, they are needed on occasion for two main reasons: (1) to ensure the physical safety of the child and the therapist and (2) to prevent the destruction of the play materials and the playroom. Typically, play therapists do not state the limits in advance but only as the need arises. Thus, a play therapist might begin a session by saying to the child: "You can play with whatever you like in here! If there is anything you can't do, I'll let you know."

In stating a limit, the noted play therapist Haim Ginott (1959) recommended the following four-step procedure. First, help the child express his or her feelings or wishes underlying the misbehavior ("You're angry at me because you can't take the toy home").

Next, clearly and firmly state the limit (I'm not for hitting!"). Third, try to point out an acceptable alternative to the inappropriate behavior ("You can pound this clay to get your anger out"). Finally, enforce the limit as needed ("We have to end the play now because you still want to hit"). This procedure avoids the extremes of being too harsh or too soft in teaching children responsible behavior.

Limits are most often set on acts of physical aggression (either to therapist or materials), unsafe behaviors, and socially unacceptable behaviors (including inappropriate displays of affection; Landreth, 2002b). Limits should also be set when a child tries to take a toy from the playroom, as well as when engaging in disruptive behaviors such as continuing to play past the end of session or trying to leave early (Landreth, 2002b). Limits are often initially uncomfortable for play therapists to apply, but one can become skilled at it with practice and patience.

INCLUDING PARENTS AND CAREGIVERS

There is growing evidence that including parents in the therapeutic process is beneficial (Bratton et al., 2005). Therapists utilizing family play therapy models such as filial, parent–child interaction therapy, and Theraplay train caregivers to be directly involved as cotherapists to their children. In the beginning stages of these therapies, play therapists teach caregivers how to use play interactions with their children to foster a more positive relationship. Webster-Stratton and colleagues have published numerous studies on social skills training groups for children who have conduct problems and their parents. In these studies, children received social skills training while their parents learned parenting skills and ways to promote their children's new skills. The involvement of caregivers in these studies led to maintained improvements in both the children's behaviors and the parents' skills (Webster-Stratton & Hammond, 1997).

STAGES OF PLAY THERAPY

There are three main stages to the therapy process. The first, *rapport building,* involves the initial sessions wherein the child and therapist begin to build a working relationship. The therapist is still gathering information about the child and his or her experiences, and the child is learning about the play space and process of therapy. Depending on the therapeutic orientation, these play sessions are typically supportive in nature and allow the child time to feel safe and comfortable in the play sessions.

The second stage is *working through.* This is the lengthiest of the three stages and is where much of the therapeutic change occurs. In this stage the therapist selects and applies the most appropriate change agent(s) inherent in play (e.g., abreaction, storytelling, a therapeutic relationship).

During the working-through stage, play themes often becoming apparent and offer a window into the child's inner world. Play themes are those topics that reappear across play sessions. They may stem from unmet needs/desires, unresolved conflicts, or difficulties the child is trying to master or is struggling to understand. Some examples of common play themes are aggression, attachment, competition, control, cooperation, traumatic events, death/grief, fears, fixing something that is broken/damaged, gender, good versus evil, identity, limit testing, mastery of developmental tasks, need for approval or nurturance, power, problem solving, regression, replay of real-life situations, school, sexuality, social rules, transitions, vulnerability, and win/lose situations. The therapeutic use of these themes will depend on the theoretical orientation of the therapist.

The final stage of play therapy is *termination.* The therapist and child have used the therapeutic process to ameliorate or resolve the presenting problem(s). The termination stage is intended to allow the child and family to take ownership of the changes that have occurred and to prepare the way to ongoing improvements.

CHARACTERISTICS OF EFFECTIVE PLAY THERAPISTS

A review of the play therapy training literature suggests that there are personal characteristics such as patience, flexibility, and love of children that all therapists need to work with children. In regard to the characteristics of a "good" play therapist, Nalavany and colleagues (2005) found in a sample of 28 experienced play therapists that they rated the personal qualities of empathy, warmth, and genuineness as most essential, while they considered theoretical knowledge and technical skills to be less important but easier to acquire.

Harris and Landreth (2001) outlined eight of the most essential characteristics of child-centered play therapists. This list includes genuine interest, unconditional acceptance, and sensitivity to the child. Their list also includes the ability to create a sense of safety, to trust a child to lead the course of therapy in a gradual and natural manner, and to honestly believe that a child is capable of solving his or her problems while setting the few necessary limits needed to help a child in this process.

THE EFFECTIVENESS OF PLAY THERAPY: A REVIEW OF META-ANALYTIC OUTCOME RESEARCH

While the clinical utility of play therapy has long been reported anecdotally in the field, more studies using rigorous research methods are definitely needed to firmly establish the effectiveness of play therapy. A compilation of previous, well-designed play therapy research is presented in the book *Empirically Based Play Interventions for Children* (Reddy, Files-Hall, & Schaefer, 2005). In addition, there are several promising meta-analytic studies on the effectiveness of play interventions. In a review of 42 published and unpublished studies, including dissertations, LeBlanc and Ritchie (2001) found the average effect size of play therapy outcomes to be 0.66 using a meta-analytic approach. This is a medium to large effect size (Cohen, 1977) and indicates statistically significant improvement in the children (LeBlanc & Ritchie). Previous meta-analytic studies of non-play-based therapeutic interactions with adults and children reported mean effect sizes of 0.68 (Smith & Glass, 1977) and 0.71 (Casey & Berman, 1985), respectively. In Casey and Berman's study, when play-based interventions were examined separate from non-play-based therapies, a mean effect size of 0.65 was found. These results suggest that interventions utilizing play therapy are as effective as talk-based therapies.

Bratton and colleagues (2005) recently performed a more comprehensive meta-analysis of play therapy interventions. Like LeBlanc and Ritchie (2001), Bratton and her colleagues analyzed only studies that included play therapy interventions as opposed to previous analyses that included traditional talk-based psychotherapies. These researchers identified 93 studies of play therapy by using the definition of play therapy that was determined by the Association for Play Therapy. They found a large mean effect size of 0.80 (Bratton et al., 2005).

These meta-analytic investigations also shed light on specific treatment and participant characteristics that led to improvements noted in the children. In particular,

these meta-analyses highlighted the importance of including parents in children's treatment. When parents were trained to act as cotherapists, higher effect sizes were seen across studies (Bratton et al., 2005; LeBlanc & Ritchie, 2001). Filial and parent–child interaction therapies often include parents in an effort to improve interactions between parents and children as well as teach parents skills that can be used after therapy has ended. Also, both studies suggested that having 30 to 35 sessions of play therapy was the optimal number for identifying positive changes on outcome measures (Bratton et al., 2005; LeBlanc & Ritchie, 2001).

SUMMARY

The goal of this chapter is to provide a basic introduction to the field of play therapy. From its psychoanalytic roots, the field of play therapy continues to expand its theoretical base and be applied to clients across the life cycle and throughout the world. The following chapters will introduce the reader to the diversity of theoretical approaches to play therapy, including psychoanalytic, child-centered, cognitive-behavioral, Gestalt, prescriptive, and integrative.

Play therapy is a powerful modality for working with children, adolescents, adults, groups, and families. Play therapists recognize the importance of play for normal development, as well as its many therapeutic powers or change mechanisms. The personal qualities of play therapists that facilitate a therapeutic relationship include empathy, warmth, genuineness, and unconditional acceptance of the child.

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