PLAY THERAPY: Considerations and Applications for the Practitioner

by RITESH KOOL, MD, and TIMOTHY LAWVER, DO

Dr. Kool is from Wright State University, Psychiatry Department, Dayton, Ohio, and Dr. Lawver is from David Grant Medical Center, Travis, Air Force Base, California.

Psychiatry (Edgemont) 2010;7(10):19–24

ABSTRACT

Play therapy represents a unique form of treatment that is not only geared toward young children, but is translated into a language children can comprehend and utilize—the language of play. For the referring provider or practitioner, questions may remain regarding the nature, course, and efficacy of play therapy. This article reviews the theoretical underpinnings of play therapy, some practical considerations, and finally a summary of the current state of research in regard to play therapy. The authors present the practicing psychiatrist with a road map for referring a patient to play therapy or initiating it in appropriate cases.

THEORY

Piaget[1] observed that most children in their first decade of life had neither meaningful expression nor the ability to comprehend complex issues, motives, and feelings because they lacked the ability of abstract thinking. Piaget also noted that when a child is in his or her second period of intellectual development, called preoperational, the child begins assimilative play with the ability to form symbols. As the cognitive horizon expands, play becomes more complex with rules,

FUNDING: There was no funding for the development and writing of this article.

FINANCIAL DISCLOSURES: The authors report no conflicts of interest relevant to the content of this article.

ADDRESS CORRESPONDENCE TO: Timothy Lawver, DO, Staff Psychiatrist, David Grant Medical Center, 101 Bodin Circle, Travis, AFB, CA 94535; Phone: 937-474-3237; E-mail: timlawver@gmail.com

KEY WORDS: Play therapy, child, adolescent, therapy, piaget, play, axline, toys

TABLE 1. Criteria influencing play therapy effectiveness
• Therapeutic relationship
• Diagnostic opportunities
• Breaking down defense mechanisms
• Facilitating articulation
• Therapeutic release
• Anticipatory preparation

TABLE 2. Processes of change in play therapy
COGNITIVE DOMAIN 1. Schema transformation 2. Symbolic exchange 3. Insight 4. Skill development
AFFECTIVE DOMAIN 5. Abreaction 6. Emotional experiencing 7. Affective education 8. Emotional regulation
INTERPERSONAL DOMAIN 9. Support and validation 10. Corrective relationship 11. Supportive scaffolding

moral judgment, and language development.[2] Virginia Axline[3] saw meaningful expression in the process of play, which furthers our current understanding of how important language is to regulating emotions and bridging action to symbol and thought.[4] Play therapy seeks to balance symbolic play and language expression in an age-appropriate manner that can be most beneficial to the child.[5]

The capacity for symbolic play serves as the basis for the only significant inclusion, and conversely exclusion, criteria for play therapy. As long as the child has achieved the preoperational level of development, his or her inherent abilities to engage in symbolic play opens up his or her inner world to the keen observer. In practical terms, this means very small children and perhaps those with profound developmental delays would be excluded from play therapy. At the other end of the spectrum, there is a point when the adolescent no longer wishes to engage in play, desiring instead to be treated as an adult. This transition is highly variable and would require a case-by-case decision as to appropriateness for play therapy based on willingness to play versus ability to engage in more traditional talk therapy.

As detailed by Mulherin,[6] six criteria strongly influence the effectiveness of play therapy (Table 1). Despite sharing similarities between the adult therapeutic relationships, it is the fourth criteria that differs markedly in the child's therapeutic relationship. As play becomes a creative outlet that blends imagination and reality, it becomes fun and absorbing; the therapeutic relationship is deepened in play. The child is afforded the freedom to abreact and displace the unconscious ideas on the play event, allowing them to be observed by the therapist. If the accompanied emotion is beyond the child's coping mechanism, then that too can be displaced. In time, this can be experienced and acclimated. How a child expresses his or her morbid issues becomes a function of cognitive growth[7] and less about resistence. With the material now observed and articulated, catharsis and possible future scenarios can be explored through play.

To facilitate the overall process, O'Conner[4] states that 11 processes account for the lasting change in play therapy (Table 2). Based on Shirk and Russell's[8] work on child psychotherapy, these fit under the larger groupings of cognitive, affective, and interpersonal processes.

The cognitive domain deals with awarenes of and mastery over ideas and beliefs. Schema transformation is the process of remodeling the child's maladaptive value or belief into functionally adaptive value or belief. Symbolic exchange accomplishes this by making the dysfunctional adaptation more lucent; the problematic value takes form in emotion and language. This is followed by carefully restructuring the meaning of the patient's experience—insight. From insight comes skill development, where the child learns more protean cognitive means to handle future difficulties.

Under the affective umbrella, a similar process occurs where abreaction and emotional experiencing allow for discharge, mastery, and integration of the child's emotions into the affective self. With the aide of the therapist, the child is able to catalog his or her emotions with words in affective education. Via these processes, emotional regulation results in new and more flexible defense mechanisms and coping strategies—alternatives to unhealthy behavior patterns.[4,8]

The interpersonal process accomplishes this via validation and support from the therapist. Validation and support nurture the child's psychosocial expression and development within the relatively safe context of play. Through a series of content-specific observations and the more complex, motive reflections, the therapist shows his or her interest in the child's problems and shows a blue print for future therapy sessions. A key ingredient that is unique to the therapeutic relationship is a corrective relationship, a relationship made accessible to the child via the engagement of play. If a child is to alter his or her core belief, then the therapist must respond to the child's cognitive and affective expression differently from the anticipated reaction. With this repeated incongruence between the therapist's response and the child's anticipation, the child's core beliefs are disrupted. This allows for restructuring, but with many children who do not have the cognitive or affective abilities, it falls on the therapist to act as supportive scaffolding as progress is made.[4,8]

PRACTICE

These processes and layers of interaction differentiate play therapy from simply spending time playing with a child. As with most forms of

therapy, time is focused toward a therapeutic goal. This starts with assessment, a clinical interview, and appropriate objective measures. With the child patient, the key measures will likely be parent- and teacher-report questionnaires, such as the Conners Teachers Rating Scale or the Vineland Adaptive Behavior Scales.

Assessment allows for a careful selection of a target behavior or symptom. Reassessment can be both informal and formal. During the course of therapy, the therapist can monitor for changes in themes, appropriateness, and flexibility. At predetermined intervals, the more formal measures can be repeated.

The specifics of the interaction and strategy employed by the therapist vary with the style of play therapy employed. From Axline's original work,[3] the field has diversified with approaches, such as child-centered, psychoanalytic, Jungian, and Gestalt, among others.[9] There is also nondirective play therapy, a label and philosophy intended to return the practice to what Axline originally proposed.[10] Innovation continues with such variants as Lego therapy being studied, particularly with autism spectrum disorders.[11] An exhaustive review of all the different types and intricacies of each are outside the scope of this paper. They still all maintain the centrality of play as a medium of discourse for the child patient.

Many factors come into play that help define effective play therapy, including session length, frequency, and number of sessions. Of the many skills a therapist may exercise in setting the frame for therapy, the hardest, least researched, and possibly most important is limit setting.[12] Limit setting is a vital factor in the therapeutic process, requiring a delicate balance.[13–15] Too many limits can prevent the child from displacing and constructively experiencing feelings on the play event. Insufficient limits may allow bad behavior to continue at the expense of the cognitive and affective processes.[12,16] In order to reach an acceptable balance, the therapist needs to know necessary limits and their purpose. Limits in play therapy serve the following purposes:

1. Define therapeutic boundaries
2. Provide physical and emotional safety and security for the therapist and child
3. Foster a positive attitude in the therapist toward the child
4. Anchor the session in reality
5. Safely express negative feelings without fear or retaliation
6. Promote responsibility and control on the part of the child resulting in stability and consistency in the relationship
7. Provide a cathartic experience for the child
8. Protect the room and all its contents
9. Maintain legal, moral and professional standards.[17–19]

Landreth[12] reminds us that when setting limits, the therapist should deliver them in a developmentally appropriate language with as much specificity as possible (e.g., do not leave it up to the child to determine how hard is "hard" when acting out his or her aggression in the play of hitting). Simply state the behavior is not appropriate or, if appropriate, say nothing. In order to effectively set the limits, the therapist may reference the acronym ACT: Acknowledge (the wants, feelings, and wishes of the child), Communicate (the limit), and Target (reasonable alternatives). Acknowledging the child's unwanted behavior defuses the situation by acknowledging the child's feeling and accepting the motives of the child. Communicating the limit in specific and exact terms makes clear what is unacceptable in the playroom and, therefore, outside of the office. Targeting a reasonable alternative redirects the child's abreaction to more productive and cathartic expression.

Choice of play material presents the next juncture within play therapy. The child's choice of toy or game can give insight into the child's ability to self express and the type and degree of play in which the therapist is about to engage with the child. While there is no list of approved toys, therapists must find a commonality in selected toys that facilitate a positive alliance with the child, a broad range of expression, testing limits, positive self-image, and insight and self control.[12] The following three categories of toys are suggested to broaden the range of expression in the child: 1) real-life toys, 2) aggressive toys, and 3) creative-expression toys (Table 3).

Real-life toys target withdrawn children that may be timid, shy, or introverted. Play is noncommittal and feelings are not drawn out right away. These "ice-breaker" toys (e.g., car, boat, airplane, dolls, doll house furniture, cash register, utensils, and telephones) come with their own set of rules and require little limit setting. Aggressive toys facilitate the release of anger, irritability, hostility, and other emotions that can be released through destruction. These toys (e.g., handcuffs, rope, projectiles, and toy soldiers) will require more limit setting than the other two categories. The limits set on smashing, throwing, and knocking down these toys will largely depend on the therapist's judgment. Creative-expression toys afford a wide range of expressive emotions that foster creativity and allow kids to be messy. These toys (e.g., crayons, scissors, other craft material, puppets, Play-Doh, Legos) will also need limit setting to avoid damage to the room or other items in the play area.[20] The therapist, the child, and creativity combine with available elements to allow myriad possibilities for play, both along the classical use of the toys and novel ones.[21]

In the midst of play will come opportunities for interpretation. The process of efficient interpretation can shorten treatment and effectively connect therapy behavior to outside behavior. To effectively interpret, the therapist must develop a comprehensive initial formulation

TABLE 3. Toy suggestions

REAL LIFE	AGGRESSIVE	CREATIVE EXPRESSION
Matchbox cars	Handcuffs	Play-Doh
Generic dolls	Ropes	Scissors
Dollhouse	G.I. Joes	Paper
Cash register	Toy guns	Crayons
Play money	Nerf darts	Blocks
Boats	Toy swords	Puppets
Planes	Super hero figures	Legos
Toy kitchen	Plastic armor	Felt board

TABLE 4. Indications for play therapy

STRONG	GOOD	PRELIMINARY
• Preoperative anxiety • Attention deficit hyperactivity disorder	• Problem classroom behaviors • Anxiety • Fear • Self efficacy	• Posttraumatic stress disorder • Maltreatment • Natural disaster • Palliative care • Chronic illness • Cultural issues • Aggressive behavior

detailing the maladaptive behavior and the sustaining factors perpetuating this behavior. In order to test these interpretations, the child must be appropriately informed of the therapeutic process and be reassured that any transient discomfort during the session will be outweighed by greater gains in the future. These interpretations are then used to guide play and deliver it in a calculated way so as not to overwhelm the child. When delivered, the child's reaction is gauged, and interpretations are strengthened or rejected based on the child's reaction. The correct interpretations will help the child and the therapist through the cognitive, affective, and interpersonal processes mentioned previously.[4]

Amidst the technical aspects of play therapy, the therapist must keep in mind cultural considerations. In the melting pot of American culture, the therapist must respect and affirm diversity without assimilating the child into dominant culture. Culture can embody sexual orientation, gender role, sex, race, religion, age, physical or mental disability, ethnicity, or social class. Before one can start to respect the boundaries of another culture, the therapist must understand his or her own. Based on Pedersen's work,[22] the therapist must not only take inventory of the culture with which he or she identifies, but also how the patient population may identify him or her. This may include profession, perceived nationality, gender, religion, or any of the other categories mentioned previously. This is a necessary step in avoiding erroneous assumptions across culture and better defining limits placed on the self.[23]

RESEARCH

Two recent meta-analyses have lent credit to play therapy as an effective treatment that is on par with other available modalities. There is some debate surrounding the strength of this claim and the overall quality of the research data used to arrive at this conclusion. One is a review by Phillips[24] and the other is a response paper by Baggerly and Bratton.[25] Both articles speak more directly to the nature and particulars of current and future research than to the practitioner selecting a treatment for his or her patient. A review of the same studies cited by these two reviews yields three categories in terms of indications for which play therapy has some evidence: 1) strong evidence, 2) good evidence, and 3) preliminary evidence. Here, strong evidence refers to indications for which there are multiple studies with significant results gained from studies with sufficient power. Good evidence refers to indications with a small number of studies with number of subjects being greater than 30, representing solid clinical evidence. Preliminary evidence refers to indications that as of yet have studies with number of subjects less than 30, including case studies.

Both reviews agree on the strong evidence for children facing medical procedures, though Phillips[24] maintains some critiques of the methodology. This is likely due to the relative ease in patient selection, as the indication is based on a planned procedure and not meeting diagnostic criteria. Further, the nature of the treatment, therapy done as a scheduled portion of a treatment plan, allows for easier research design and application. The two reviews then differ on the status of problem sexual behaviors as a focus of play therapy, with Phillips[24] downplaying the state of research at present. Baggerly and Bratton,[25] however, cite the 2000 study by Bonner, Walker, and Berliner[37] as definitive regarding the validity of this indication.

Numerous studies included in Baggerly and Bratton's review focus on academic issues and attention deficit hyperactivity disorder (ADHD). Taken as a whole, these studies with pre-test and post-test evaluation of groups, ranging in size from 5 to 60, show strong evidence for the effectiveness of play therapy in the group. The targeted symptoms for this group included both academic performance and untoward behaviors in the classroom setting.

For example, one study showed significant gains among children with ADHD after 16 sessions of play therapy, with benefits seen in the areas of anxiety, withdrawal, emotional lability, and learning difficulty.[38]

Several other areas also yielded good evidence. Phillips[24] discussed anxiety and fear components themselves as indications for play therapy, finally landing on the evidence as being conflicted, despite a fair number of studies, including some randomly controlled trials. Aside from ADHD itself, children with problem classroom behaviors have been shown to respond to play therapy, both in the setting of learning disabilities[26] and from the point of view of improving beliefs of self efficacy.[27]

Several other indications fall into the category of having preliminary evidence based on small-scale studies, case reports, and nonrandomized trials. Cited in the review by Baggerly and Bratton are studies that suggest the viability of play therapy for aggressive behavior, learning disabilities, chronic illness, victims of natural disaster, and cultural issues. A review of available literature yields a variety of exemplar studies for autism spectrum disorders,[28] effects of maltreatment,[29,30] victims of natural disaster,[31–33] and cross-cultural issues of adjustment.[34] Jones and Landreth[35] presented a small study with 15 children that showed positive results for play therapy in the setting of chronic illness. In a similar vein, van Breeman[36] has done work using play therapy in palliative care. See Table 4 for a list of indications for play therapy.

CONCLUSION

Though there is a great deal of research available, it remains the clinical judgment of the individual provider as to the role of play therapy in the treatment of a given patient. A sound understanding of the underlying theory and principles educates the decision in terms of compatibility with the patient's developmental level and ability to engage. The knowledge of what to expect on a functional level within the confines of play therapy allows for an appropriate discussion on informed consent and setting the stage for both parents and children of what to expect. Finally, available evidence supports the use of play therapy as a valid approach to treating children.

Further research remains a vital need in the field of play therapy. This, however, should not hamper the prompt and appropriate referral of patients to this modality. As the field and study advance, play therapy represents a vibrant and viable resource in the present tense to reduce suffering in the child population.

REFERENCES

1. Piaget J. *Play, Dreams and Imitation in Childhood*. C Gattengo, FM Hodgson, trans. New York: Norton; 1962.
2. Schaefer CE. *The Therapeutic Power of Play*. Northvale, New Jersey:Jason Aronson, Inc.;1993.
3. Axline V. *Play Therapy*. New York: Ballantine Books; 1947.
4. O'Conner K. The value and use of interpretation in play therapy. *Prof Psychol Res Pr*. 2002:33(6):523–528.
5. Schaefer, CE, O'Connor K. *Handbook of Play Therapy*. New York: John Wiley and Sons; 1983:193–199.
6. Mulherin M. The Masterson Approach with play therapy: a parallel process between mother and child. *Am J Psychother*. 2001;55(2):251–272.
7. Mumford S. *Play therapy*. In: Kay J, Klykylo W, eds. *Clinical Child Psychiatry*. London: Wiley and Son; 2005:119–128.
8. Shirk S, Russell R. *Change Process in Child Psychotherapy; Revitalizing Treatment and Research*. New York: Guilford Press; 1996.
9. O'Conner KJ, Braverman LJ. *Play Therapy Theory and Practice: A Comparative Presentation*. San Francisco, CA: John Wiley and Sons, Inc.; 1997.
10. Wilson K, Ryan V. *Play Therapy: A Non-directive Approach for Children and Adolescents*. Burlington, MA: Bailliere Tindall; 1992.
11. Legoff DB, Sherman M. Long term outcome of social skills intervention based on Lego interactive play. *Autism*. 2006;10(4):317–329.
12. Landreth Garry L. Therapeutic Limit setting in the Play Therapy Relationship. *Prof Psychol Res Pr*. 2002;33(6):529–535.
13. Axline V. *Play Therapy: The inner Dynamics of Childhood*. Boston: Houghton Mifflin;1969.
14. Bixler RH. Limits are therapy. *TJ Consult Psychol.* 1949;13(1):1–11.
15. Guerney L. Client-centered (nondirective) play therapy. Schaefer CE, O'Connor K, eds. *Handbook of Play Therapy*. New York: Wiley; 1983:21–64.
16. Landreth G, Wright C. Limit setting practices of play therapist in training and experienced play therapist. *Int J Play Ther*. 1997;6:41–62.
17. Ginott H. *Group Psychotherapy with Children: The Theory and Practice of Play Therapy*. Northvale, NJ: Aronson;1994.
18. Landreth G, Sweeny D. Child-centered play therapy. In: O'Connor K, Braverman LJ, eds. *Play Therapy: Theory and Practice*. New York: Wiley; 1997:17–45.
19. Moustakas C. *Children and Play Theapy: A Key to Understanding Normal and Disturbed Emotions*. New York: McGraw-Hill; 1953.
20. Landreth GL. Facilitative dimensions in play in the play therapy process. Landreth G, ed. *Innovations in Play Therpy: Issues, Proces, and Special Poplulations*. Philidephia: Brunner-Routledge; 2001:3–22.
21. Hall TM, Kaduson HG, Schaefer CE. Fifteen effective play therapy techniques. *Prof Psychol Res Pr*. 2002;33(6):515–522
22. Pedersen P. *A Handbook for Developing Multicultural Awareness*. Alexandria, VA:

American Association of Counseling and Development; 1988.
23. O'Conner K. Addressing diversity issues in play therapy. *Prof Psychol Res Pr*. 2005;36(5):566–573.
24. Philips RD. How firm is our foundation? Current play therapy research. *Int J Play Ther*. 2010;19:13–25.
25. Baggerly J, Bratton S. Building a firm foundation in play therapy research: response to Philips. *Int J Play Ther*. 2010;19:26–38.
26. Packman J, Bratton S. A school-based group play/activity therapy intervention with learning disabled preadolescents exhibiting behavior problems. *Int J Play Ther*. 2003;12:7–29.
27. Fall M, Balvanz J, Johnson L, Nelson L. A play therapy intervention and its relationship to self-efficacy and learning behaviors. *Professional School Counseling*. 1999;2:194–204.
28. Kasari C, Freeman S, Paparella T. Joint attention and symbolic play in young children with autism: a randomized controlled intervention study. *J Child Psychol Psychiatry*. 2006;47(6):611–620.
29. Fantuzzo J, Sutton-Smith B, Atkins M, et al. Community-based resilient peer treatment of withdrawn maltreated preschool children. *J Consult Clin Psychol.* 1996;64:1377–1386.
30. Kot S, Landreth GL, Giordano M. Intensive child-centered play therapy with child witnesses of domestic violence. *Int J Play Ther*. 1998;7:17–36.
31. Dugan EM. Working with children affected by Hurricane Katrina: two case studies in play therapy. *Child Adolesc Ment Health*. 2010;15:52–55.
32. Ohnogi AJ. Using play to support children traumatized by natural disaster: Chuetsu earthquake series in Japan. In: Kalayjian A, Eugene D (eds). *Mass Trauma and Emotional Healting Around the World: Rituals and Practices for Resilience and Meaning-Making*. Santa Barbara, CA: Praeger; 2010;1:37–54.
33. Shen Y. Short-term group play therapy with Chinese earthquake victims: effects on anxiety, depression and adjustment. *Int J Play Ther*. 2002;11:43–63.
34. Garza Y, Bratton S. School-based child-centered play therapy with hispanic children: outcomes and cultural consideration. *International Journal of Play Therapy*. 2005;14:51–80.
35. Jones EM, Landreth G. The efficacy of intensive individual play therapy for chronically ill children. *Int J Play Ther*. 2002;11:117–140.
36. Van Breeman C. Using play therapy in paediatric palliative care: listening to the story and caring for the body. *Int J Palliat Nurs*. 2009;15:510–514.
37. Bonner B, Walker CE, Berliner L. 2000 Final report. Children with sexual behavior problems: assessment and treatment. Grant No. 90-CA-1469. Washington, DC: National Clearinghouse on Child Abuse and Neglect.
38. Ray S, Schottelkorb A, Tsai M. Play therapy with children exhibiting symptoms of attention deficit hyperactivity disorder. *Int J Play Ther.* 2007;16(2):95–111.