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Abstract

Play therapy techniques are valuable tools for a variety of professionals who work with children. One need not be a registered play therapist to implement play techniques when working with child clients. There are many types of clients that would benefit from play therapy. There are several different theoretical approaches, but the researcher chose to focus on Adlerian Play Therapy, Client-Centered Play Therapy, Cognitive-Behavioral Play Therapy, and Psychodynamic Play Therapy. The paper considers the best location to implement play techniques, by urging the counselor to be aware of the setting's location within the building, ease of cleaning, available space, and what play mediums are available to the child.

PLAY THERAPY

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by

Melissa A. Hardman

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Play therapy techniques are valuable tools for a variety of professionals who work with children. One need not be a registered play therapist to implement play techniques when working with child clients. There are many types of clients that would benefit from play therapy. There are several different theoretical approaches, but the researcher chose to focus on Adlerian Play Therapy, Client-Centered Play Therapy, Cognitive-Behavioral Play Therapy, and Psychodynamic Play Therapy. The paper considers the best location to implement play techniques, by urging the counselor to be aware of the setting's location within the building, ease of cleaning, available space, and what play mediums are available to the child.

Play has been viewed as a critical aspect of working with children by researchers dating as far back as the 1930's and 1940's (Gitelson, 1938; Watson, 1940). Many (if not, most) children struggle with verbalizing their emotions to adults because of their limited developmental capabilities (Kottman, 2001). Kottman (2001, p. 4) described play therapy as "an approach to counseling young children in which counselors use toys, art supplies, games, and other play media to communicate with clients using the language of children". Often children do not know what is bothering them or how to verbalize it (Hall, Kaduson, & Schaefer, 2002). Play has been described as the natural language through which children communicate (Kottman, 2001). Play is a developmentally appropriate means of doing therapy with children, and is therapeutic in and of itself (Ablon, 1996). Play is a crucial tool in counseling and can reveal an immeasurable amount about the child and his or her world (Hall, Kaduson, & Schaefer, 2002). Play can be used as a means of establishing rapport, an assessment tool in therapy with children, and a vast number of interventions can be developed utilizing play techniques (Campbell, 1993). Professionals who might utilize play therapy techniques are not limited to registered play therapists; professionals using play therapy techniques may include mental health counselors, school counselors, social workers, psychiatrists, and physicians.

While most researchers agree that play is a valuable tool in therapy, there is some disagreement on the most effective way to implement play therapy. Some researchers believe play therapy is very productive with a certain type of client

while others disagree. Based on differing theoretical orientations, some believe the therapist should do a lot of interpretation about the child's play in therapy (Kottman, 2001); others believe the therapist should not interpret at all (Landreth, 2002). If a play therapist does decide to use interpretation, it can be difficult to determine whether the therapist's interpretation was effective or accurate (O'Connor, 2002).

There are a variety of therapy techniques, and many are more effective with certain types of clients than with others. Researchers have examined which type of approach is most effective in helping clients with certain issues and which type of approach may not work as well. Clients who are appropriate for play therapy are discussed later in this paper (Kottman, 2001; Landreth, 2002).

As there are many different play therapy tools, there are many theoretical approaches to play therapy. Many theorists have differing and even opposing views of the child, pathology, and the role of the helper (Kottman, 2001). Most theorists first applied their ideas to working with adult clients and later altered them to fit the unique needs of children. The approaches discussed in this paper include the following: Adlerian play therapy, Client-Centered play therapy, Cognitive-Behavioral play therapy, and Psychodynamic play therapy.

There are certain types of toys that researchers recommend should be available during play therapy (Kottman, 2001; Landreth, 2002). There are also recommendations about the setting in which play therapy should take place in order to optimize effectiveness (Kottman, 2001; Landreth, 2002).

The purpose of this paper is to determine with what clients play therapy is an effective mode of treatment, explore some of the theoretical approaches to play therapy, and determine what type of setting is appropriate for conducting play therapy.

Play Therapy Effectiveness with a Variety of Clients

Some play therapists work with adult clients, but the majority work only with children. Most play therapy clients are ages 3-11, but can be as old as 15. The age of the client depends largely on the client's rate of development. Play therapy has been shown to be effective with a wide variety of clients (Kottman, 2001).

According to Kottman (2001), play therapy has been shown to be an effective way to treat clients with behavioral problems at home or school, and clients with anxiety, phobias, low self-esteem, abuse issues, depression, grief, neglect, social problems, family problems, disabilities, illness, and environmental trauma. Play therapy is also recommended for adopted/foster children and clients with certain disorders, such as Posttraumatic Stress Disorder, Dissociative Disorder, and Adjustment Disorder (Kottman, 2001).

Carmichael (1994) posited that play therapy is an effective mode of working with children who have physical disabilities. Children with physical disabilities often suffer from low self-esteem, peer rejection, inexperience with decision making, and feelings of inadequacy. They might also experience frustration due to the fact that they have to be dependent on others at times.

Carmichael (1994) focused on Client-Centered play therapy and discovered that it helped these children to better understand what their abilities are, to gain confidence, and to better understand themselves.

Slagle and Martin (1991) established that play therapy is effective when working with children who have trichotillomania. This disorder is characterized by the pulling and removal of one's own hair. Children with this disorder pull hair from their heads, eye lashes/brows, pubic area, and underarms. Children with trichotillomania are believed to respond to play therapy because it allows them the opportunity to explore their feelings and to become aware of their thoughts about themselves (Slagle & Martin, 1991).

Levy-Warren (1994) stated that play therapy can be successful with children living in poverty, but it tends to look different than play therapy with other populations. These children have a tendency to play in ways that seem unimaginative and repetitive to the therapist. This can be frustrating to the therapist and parents because it seems as though therapy is not progressing at a reasonable rate. Levy-Warren (1994) cautioned that the therapist must be aware of the purpose of the child's play behavior. He or she might be attempting to create an experience that is predictable and in which he or she is in control; quite contrary from the chaos of his or her daily life. It is important to examine the possibility of counselor biases in play expectations when working with impoverished children (Levy-Warren, 1994).

Children with some types of issues seem to respond to play therapy best when it is combined with other types of treatment. These issues include enuresis/encopresis, mental retardation, learning difficulties, Attention Deficit Hyperactivity Disorder (ADHD), Major Depressive Disorder, and Separation Anxiety Disorder (Kottman, 2001).

While play therapy has been shown to be effective with a variety of clients, it is not recommended as the treatment of choice for some. Children who have intense conduct disorder, signs of psychosis, or extreme Attachment Disorder are not recommended for play therapy. These children tend to respond better to alternative, often more intensive methods of treatment (Kottman, 2001).

Theoretical Approaches to Play Therapy

There are several different approaches to play therapy. For purposes of this paper, Adlerian play therapy, Client-Centered play therapy, Cognitive-Behavioral play therapy, and Psychodynamic play therapy will be discussed. These differing schools of thought have somewhat conflicting ideas about the child, pathology, and the role of the helper in the play therapy process.

Adlerian Play Therapy

Adlerian play therapy is a fairly directive approach where the therapist is actively involved in the therapeutic process with the child (Kottman, 2001). The therapist is not to be viewed as an expert, but rather as an equal to the child (Kottman, 2001). In order to implement Adlerian Play Therapy, one must be familiar with Adler's Individual Psychology Theory (Kottman, 2003). Adler

hypothesized that human beings have an inherent social interest if they are psychologically healthy. He also believed that individuals are better viewed as whole, not the sum of their parts. Another component of Individual Psychology is that human beings are constantly moving towards goals they have set for themselves (Kottman, 2003). These goals serve to meet their needs in positive or negative ways. Individuals view their experiences based on their own set of beliefs about themselves, others, and their environment. These beliefs are commonly called private logic. This private logic is often not congruent with fact (Kottman, 2003). Adlerians believe that all people are unique and special, and focus on the strengths of the individual (Kottman, 2003; Kottman & Johnson, 2003). A major focus of Adlerian theory is that all behavior has a purpose (Kottman & Johnson, 2003). Adlerians also take into account that the child perceives the world in his or her own way (O'Connor, 2000).

According to Kottman (2003), there are four basic stages of Adlerian Play Therapy. The Adlerian Play Therapist completes these steps with the child through play with art materials, puppets, animal figures, dolls, role playing, and several other play methods. The therapist also completes these stages with the child's parents while consulting with them. The four stages include building a relationship, exploring the client's lifestyle, helping the child gain insight into his or her lifestyle, and reorienting and reeducating the client, parents, and possibly the child's teacher (Kottman, 2003).

During the relationship building stage, the counselor works to establish a relationship with the child and his or her parents. This is done by reflecting the client's feelings, asking questions, interacting, setting limits, and establishing an egalitarian relationship. The counselor uses many of these same methods in working with the child's parent(s) (Kottman, 2003).

In learning about the child's lifestyle, the therapist watches the child play, observes interactions, asks questions, and encourages the child to use art techniques as a form of expression. The therapist also obtains information from parent(s) and possibly teacher(s) (Kottman, 2003). Kottman (2003) stated that the therapist is looking for information pertaining to the goals of the child's behavior (attention, power, revenge or proving inadequacy), the Crucial C's (connection to others, capabilities, counting/being valued by others, and courage/lack of courage), personality priorities (control, pleasing, superiority, or comfort), ordinal position, family environment, and strengths of the child (Kottman, 2003). Adlerians believe that all behavior is purposeful and the therapist must examine what the child is trying to accomplish with his or her behavior (Kottman, 1997).

After establishing an overview of the client's lifestyle, the counselor uses several methods to help the child become more self aware and decide what he or she would like to change. The counselor also uses these methods to make parent(s) (and possibly the teacher) aware of ways they can help the child by changing the methods of interaction (Kottman, 2003).

The last stage involves helping the child and parents implement and evaluate these changes. The counselor acts as a resource for the child and parents, and as an encourager. Toward the end of the last stage, the counselor, client, and parents discuss and prepare for termination of the counseling relationship (Kottman, 2003).

Client-Centered Play Therapy

Client-Centered play therapy, or Child-Centered play therapy as it is often referred to, is based on Roger's Person-Centered theory (Landreth, 2002). This theory is based on the ideas that the client is fully capable of knowing what is best for him or her, is motivated toward growth and self-actualization, and has the answers to help him or herself within. The therapist always has positive regard for the client, regardless of his or her choices. The goal of the therapist is to empower the child and to trust him or her throughout the therapeutic process. Child-centered therapists believe that the child's perception of him or herself greatly influences behavior (Landreth, 2002). The therapist does not direct the child's play during therapy, but is paying close attention and is involved (Kottman, 2001). The main element of Child-Centered play therapy is the relationship between the therapist and child (Sweeney & Landreth, 2003).

Because the therapist views the child as a whole, the focus of therapy is the child instead of the issue the child is being seen for. Consistent with this, the therapist does not set goals for the child, but trusts that the child will strive to

work out the issue(s) on his or her own during the therapeutic process (Sweeney & Landreth, 2003).

Child-centered therapists view personality as being based on "the person, the phenomenal field, and the self" (Landreth, 2002, p. 61). The child reacts to the environment as a whole; therefore an experience that affects one of these parts will have influence in the other areas as well. The 'person' consists of the child's emotions, cognitions, behaviors, and physical aspects. The 'person' is constantly changing based on the child's experiences (Landreth, 2002).

The phenomenal field consists of the child's experiences, including the unconscious. This phenomenal field is what the therapist seeks to understand, as it is the reality the child lives in. The purpose of the child's behavior is to meet his or her needs as perceived, based on his or her reality. This is why the therapist refrains from making judgments about the child or his or her behavior. Because these experiences cause constant change in the child's world, the child directs the play. He or she should not be encouraged to relive the past because his or her reality has changed since then. The child knows what he or she needs to work out in the playroom (Landreth, 2002).

The last tenet of personality is the self. Landreth (2002, p. 63) defined the self as "the totality of those perceptions of the child". The self is developed through experiences with other people. Like the other two principles, the self is always changing. The self is what drives children to seek to be viewed in positive ways by others (Landreth, 2002).

There are five stages of Child-Centered play therapy. In the first stage, the

child reveals negative emotions during his or her play. In the second stage, the

child demonstrates hesitant feelings, such as anxiety. During the third stage, the

child demonstrates negative emotions again, but personalizes them by directing

them towards people the child knows. The child might also exhibit behaviors

characteristic of younger children. During the fourth stage, the child again

demonstrates ambivalent feelings but they are positive as well as negative. These

emotions are also directed toward people the child knows. In the fifth stage, the

child generally demonstrates positive emotions (Kottman, 2001).

Cognitive-Behavioral Play Therapy

Cognitive-Behavioral play therapy is based on Beck's Cognitive therapy.

The basis of this theory is that an individual's thoughts greatly influence his or her

feelings and state of being (Knell, 2003). The way individuals react to their

environment is based on their beliefs about prior experiences. The way an

individual feels and acts is representative of how he or she perceives the world

(Knell, 1997). Clients are encouraged to examine their assumptions in therapy

and decide whether they are rational and productive. Changing one's irrational

thoughts to more positive and productive ones is expected to change (improve)

the way one feels (Knell, 1997).

Although this type of therapy has typically been done with older children

due to the need for the client to see that his or her reasoning is illogical, altered

methods of Cognitive-Behavioral play therapy have been shown to be effective

with younger children. The therapist and the child work together to set goals and

work toward them throughout the therapeutic process. The therapist uses play

mediums to model appropriate behaviors for the child (Knell, 2003).

The Cognitive-Behavioral play therapist is very directive throughout the

therapy process. He or she models behaviors for the child, utilizes role playing,

and provides the child with desired tokens for learning new skills (Kottman,

2001).

The first stage in Cognitive-Behavioral play therapy is assessment.

During this stage, the therapist gathers information about the child by talking with

his or her parent(s), utilizing assessment instruments, observing the child, and

getting a feel for where the child is developmentally. The therapist is also trying

to find out more information about the presenting issue and how the child views it

(Kottman, 2001).

The second stage is introduction/orientation. In this stage, the parents and

therapist describe their views of the presenting problem to the child in a neutral

manner. The therapist also provides the child with information about play therapy

and how the process works. Together, the therapist and parents create a treatment

plan based on the presenting issue (Kottman, 2001).

During the middle stages of play therapy, the therapist utilizes particular

interventions to teach the child new coping skills. The therapist attempts to help

the child see how these strategies would also be helpful in his or her life outside

the playroom (Kottman, 2001).

During the last stage, the therapist explains termination to the child and makes it a gradual process. The therapist challenges the child to discuss how he or she will handle problems after therapy is over. The therapist helps the child to see how he or she has changed throughout the therapy process (Kottman, 2001).

Psychodynamic/Psychoanalytic Play Therapy

This type of play therapy is based on Freud's Psychodynamic theory. The basis for this theory is that children pass through defined stages and trauma during any one stage will cause the individual to regress to it later in life. The client unconsciously represses these traumas or forbidden wishes due to their sexual or aggressive content (Lee, 1997). The trauma must be worked out in therapy for the individual to proceed developmentally. This also applies to children. The focus of this type of therapy is not to resolve the presenting issue, but to go deeper and promote healthy development by clearing up what is obstructing it (Bromfield, 2003).

As in Client-Centered play therapy, the therapist aims to build a positive relationship with the child. The therapist maintains a positive view of the child throughout the process and expresses this to the child. The therapist is consistently respectful of the child and what he or she is expressing. It is best to be honest and direct when communicating with the child (Bromfield, 2003).

The therapist must work out his or her own feelings that are invoked by the client or the client's issues. These feelings are called counter-transference and pertain to the therapist's own unresolved conflicts, not those of the client. The

therapist often does not express these feelings to the client, but at times will, if the therapist believes it might help the therapeutic process (Bromfield, 2003).

There are four stages in Psychodynamic play therapy. The first is introduction/orientation. In this phase, the therapist meets with the child and his or her parents to set up a schedule, explain attendance policies, and reiterate the need for consistent attendance. The therapist explains to the child why he or she is in play therapy and helps the child learn the proper terminology for expressing his or her feelings. The therapist also works to build the relationship with the client during this stage (Lee, 1997).

The second stage is called negative reactions. In this stage, the child is likely to resist the therapeutic process and might express negative feelings toward the therapist. This might cause the child to refute the potential value of play therapy, at least for a time (Kottman, 2001). This might be caused by the client transferring negative feelings he or she has about others (most likely caregivers) onto the therapist. The therapist must examine his or her own feelings about the child's behavior and rejection. This stage can disrupt the treatment process if not evaluated carefully (Lee, 1997).

The third stage is called working through. In this stage, the therapist makes interpretations to the child about what is causing him or her problems. The child must work to internalize the interpretation of the therapist and make changes based on it in order to proceed developmentally. The interpretation might need to be repeated several times until the child accepts it. The problem may continue to

manifest itself in different ways and the therapist must continue to interpret to the client (Lee, 1997).

The final stage is termination. This process is expected to be difficult and painful for the child client because it is likely to be viewed as another loss of someone important in the child's life. The counselor works to help the child express and resolve his or her feelings about the loss of the therapist prior to the last session (Kottman, 2001).

Appropriate Settings for Play Therapy

Because the way the playroom looks is one of the first things that helps the child form an opinion about play therapy, the tone of the room is profoundly important. The room should have a warm feel to it. Toys and a room that look used are inviting to children (Landreth, 2002). The following are recommendations for an optimal play therapy setting, not necessarily requirements. An important concern to the therapist is ensuring confidentiality if play therapy work is done in alternate settings to the playroom (cafeteria, office, closet, library, classroom, etc.) (Landreth, 1987).

Kottman (2003) stated that there are several components necessary to ensure that play therapy is a successful experience for the child; these include the layout of the playroom in the building, types of toys available, and the attitude of the therapist. The play room should be as private as possible, ensuring that the noise from the play area will not disturb others and that others' noise will not disturb the play area (Kottman, 2003). The therapist might consider acoustic tiles

to reduce the noise from the playroom (Landreth, 2002). It is also helpful to have

a restroom located in or very near the play room (Kottman, 2003).

The playroom should be private so that the child does not feel that he or

she is being watched through windows or the door (Landreth, 2002). Windows

facing outside the building are okay, though. The floor should be sturdy and easy

to clean because the play room will often get messy. Carpet should be avoided

(Landreth, 2002. The walls should be washable. There should be a sink in the

room with cold water only. It might be helpful to adjust the sink so the water

pressure is weakened. This will cut down on messes (Landreth, 2002).

There are several types of toys that should be in the playroom. Toys

included in the playroom should include family/nurturing toys (dollhouse, animal

families, people puppets, baby clothes, etc.); scary toys (dinosaurs, plastic snakes

or rats, insects, sharks, etc.); aggressive toys (punching bag, handcuffs, dart guns,

foam rubber bats, etc.); expressive toys (watercolor paints, crayons, markers,

finger paints, etc.); and pretend/fantasy toys (masks, animal puppets, magic

wands, telephones, etc.). It is not necessary to have every toy listed for each

category, but a wide variety should be available in the play room (Kottman,

2003). Toys should be kept in an area easily accessible to children. Children

should be able to see and reach all available toys if at all possible (Kottman,

2003). Hand-made or commercially purchased puppets are a valuable asset.

Puppets allow the child to express problems from a distance and without

personalizing them (Currant, 1985). A variety of art materials such as crayons,

paper, markers, an easel, and a chalkboard are also recommended (Landreth, 2002).

The play room should be organized in a manner that the therapist is comfortable with. This will help the child feel safe and comfortable in the space as well. The play room should be reflective of the therapist or counselor's personality (Kottman, 2003).

Conclusion

Regardless of the specific approach, play therapy has been shown to be an effective method when working with several different types of clients. Due to its adaptive nature, knowledge of play therapy is an asset for anyone working with children. A professional working with children need not be a certified play therapist to implement play therapy techniques. If the counselor is educated about the principles of play therapy and has a good understanding of children, he or she will likely be able to implement at least some of the techniques effectively.

While there are many different theoretical perspectives, each has value. Many have differing views of pathology, but the common goal is to help the child function better in his or her environment. An important aspect in all of the above mentioned theories is the therapist's relationship with the child client. If the therapist is able to build a strong foundation, his or her interventions of choice will likely be more successful. If the therapist has a positive view of the child and is genuinely interested in helping him or her, the child will likely see this and respond to it.

The play area described above is optimal, but play therapy can be conducted in a variety of settings. Some counselors do play therapy at a table with only a few toys. School counselors do play therapy in their offices. With careful planning, play therapy assessment techniques and interventions can be carried out almost anywhere.

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