

PLAY THERAPY: AN OVERVIEW AND MARKETING PLAN

by

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Abstract

Play is essential to child development because it contributes to the cognitive, physical, social, and emotional well-being of children and youth. The integration of play and play therapy techniques with child and family therapy offers a creative, age appropriate way to provide mental health treatment. This report offers an overview of play therapy, the therapeutic value of play, the historical background, theory, techniques, materials, and settings. Further, it provides the reader with many therapeutic modalities in which to implement play in family therapy. Because play therapy is a specialized field, this report also provides the reader with information on how to use this to create a marketing niche. This report was written with the Masters' or Doctoral student in mind, as well as practicing therapists; with hopes to provide them a creative avenue in which to enhance their current therapeutic modalities.

Table of Contents

Acknowledgements	v
Dedication	ix
CHAPTER 1 - Introduction	1
CHAPTER 2 - Overview of Play Therapy	3
What Is Play?	3
What Is Play Therapy?	5
The Therapeutic Factors of Play	7
History of Play Therapy & Theoretical Foundations	11
Efficacy & Research Outcomes	15
CHAPTER 3 - Major Approaches in Play Therapy	17
Directive and Nondirective Approaches	17
Filial Therapy	19
Child Goals:	20
Parent Goals	20
Family Goals	20
Sand Tray Therapy	21
Theraplay	25
Prescriptive Play Therapy	28
CHAPTER 4 - Education of the Play Therapist	30
Registered Play Therapist	30
Marriage and Family Therapy	31
Child Development	32
CHAPTER 5 - Settings and Materials for Play Therapy	37
The Play Therapy Room	37
Toy Selection	39
Categories of Toys	40
Portable Play Therapy Rooms	42
Play Therapy Settings	43

Schools:	44
Hospitals:	46
CHAPTER 6 - Marketing a Play Therapy Practice	49
Market Research	49
Target Populations	50
Purpose and Goals	52
Marketing Message.....	52
Marketing Strategies	54
Budget, Track & Modify Results.....	55
CHAPTER 7 - Conclusion.....	57
References.....	59

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Dedication

This paper is dedicated to my father, Leland McNeil, who passed away two weeks after I started graduate school. Dad, you were always my rock, and there was more than once during this process that I felt your hand on my shoulder giving me the strength to go on. You always told me that my education was the only thing that people couldn't take away from me, and I have taken that to heart. I only wish you were here to see me graduate and receive my master's degree. I miss you so much and long to hear you say, "I love and support you" just one more time. I can only hope that somehow, somewhere, you are looking down on me and that you are proud of me. I love you, Papa.

CHAPTER 1 - Introduction

Tyler walks into a playroom that is stocked with toys, puppets, art supplies, dolls and dollhouses and many other play materials. The kind lady tells him he can play with the toys in anyway he chooses. As he begins to play, the lady talks to him about his play and reflects his feelings.

Sarah and her mother walk into a room with no toys at all, where a woman sits on the floor with them and sings songs and plays games. They don't talk about problems, only about all the things that make Sarah special. They blow cotton balls back and forth, pop bubbles, and Sarah and her mother engage in a game of "Mother May I".

Jose walks into a room with lots of toys and puppets. A man directs Jose to choose any of the puppets and make up a story that has a beginning, middle, and end. The man then talks to Jose about the story and makes suggestions about how to solve the story's dilemma.

Maria walks into a room with a large tray filled with sand, and many shelves with miniature toys on them. There are toys that look like animals, people, superheroes, trees, bridges, and almost anything Maria could imagine. The lady asks Maria to choose any of the miniatures to make a picture in the sand. The lady then asks Maria to tell a story about her picture and asks her questions about the picture.

All of the above examples are different implementations of play in a therapeutic modality called "play therapy". Play therapy is a structured, theoretically based approach to therapy that builds on the normal communicative and learning processes of children (Carmichael, 2006; Landreth, 1991; O'Connor & Schaefer, 1983). As seen in the above examples, the curative powers of play are utilized in many ways. Play therapists strategically utilize play therapy techniques to help children express their troubles when they do not developmentally possess the verbal skills to express their thoughts and feelings (Gil, 1991).

The following pages of this report will introduce the reader to a modality of therapy aimed at treating specific issues in children. This report was written with the Master's or Doctorate level student in mind, who is studying a mental health discipline;

as well as any licensed therapist who is interested in working with children. This report will especially speak to those who have a systems orientation and who wish to treat children within the context of their families.

This report will provide an overview of play therapy, including the theories that form the theoretical foundation of play therapy. This report will also include the rationale of using play as a therapeutic modality with children, as well as the efficacy of this modality. Major treatment methods of play therapy will be discussed as noted in the above case examples. Further, this report will provide the reader with information on how to use play therapy in various practice settings. Finally, this report will provide the reader with the information on how to market him or herself as a play therapist, including forming a business plan and creating a marketing niche.

The reader will be reminded throughout the report that play therapy is a specialized field, which requires extensive specialized training, coursework, and experience. This additional training is required beyond completing a Master's or Doctorate degree in a mental health discipline and passing the state licensing exam. This is proposed to the reader because it is unethical for a therapist to implement therapy outside their scope of practice and may be harmful to those we intend to help. Therefore, this report is designed to be an informative introduction to play therapy and not a substitute for the in-depth training which is required to practice play therapy.

CHAPTER 2 - Overview of Play Therapy

This chapter will provide the reader with an overview of play therapy. This overview will provide an explanation of play and play therapy. Further, it will discuss the importance of play in child development and the rationale for including play in child therapy. Next, the chapter will discuss the history and theoretical foundations of play therapy. Finally, this chapter will discuss the efficacy of play therapy, and future research directions.

What Is Play?

According to Smith (1982, as cited in Schaefer, 1993), child development researchers have produced evidence that play facilitates a child's gross and fine motor development, cognitive development, and social adjustment. What exactly is play? Unfortunately, play is difficult to define. Schaefer (1993) even goes so far as to state, "Play like love, happiness, and other psychological constructs, is easier to recognize than to define" (p.1). This quote poses a problem to aspiring play therapists because, in order to understand play therapy, one must first understand play. According to Schaefer (1983), no single comprehensive definition of the term "play" has been developed. The most quoted definition was developed by Erik Erickson (1950, as cited in Schaefer, 1983), "play is a function of the ego, an attempt to synchronize the bodily and social processes with the self" (p. 211). Although there are many different definitions of play, there is a consensus on the common characteristics of play (Schaefer, 1993). The following list adapted from Schaefer (1993) provides seven characteristics of play. The more of these characteristics present in a child's activities, the more likely the behavior is play:

- Play is characterized by internal versus external motivation. Pleasure is generated from the play itself, therefore, one does not have to pressure or motivate a child with external rewards. Play is a reward in itself because of the pleasure the child derives.

- The child is more concerned about the play itself than the outcome or successful completion of the activity. In other words, the play process is more important than the end result.
- Positive feelings accompany play which are derived from the play itself and are a result of the activity. This can be evidenced in children by witnessing their smiles, laughter, and joy during the play.
- The child is actively involved in play and often becomes so engrossed he or she loses awareness of time and surroundings.
- Play has an “as if” or non-literal quality. This means play is carried out as if it is fantasy, and not real life.
- Play gives the child freedom to impose novel meanings on objects and events. This is seen in the variations of the child’s play, which results in creativity and innovation.
- Play is different from exploratory behavior. Instead of a child’s looking at an object and saying, “What is this and what can it do?” Play tries to answer the question, “What creative things can I do with this object?”

One of the reasons play is difficult to define is because it changes as children develop. Four stages of cognitive development in play have been described by child development theorist Jean Piaget (1951, as cited in Schaefer, 1993). As a play therapist, it is important to become familiar with these stages, so one can plan age appropriate play interventions. Further, understanding normal play behavior will help the play therapist recognize abnormal play behavior and address it accordingly. The stages, adapted from Schaefer (1993), are listed below with a short explanation:

- ***Practice play:*** This stage of play occurs in infancy during the first year of life. This type of play involves nongoal-directed activity with objects under the child’s own control. An example of this type of play is an infant’s repetitively banging and dropping a rattle.
- ***Construction or combinatorial play:*** This type of play begins at 15 to 24 months and consists of purposeful construction or combining behaviors. For example, a toddler may stack blocks on top of one another or group objects by function or shape.

- ***Symbolic or pretend play:*** This stage of play is most common from 2 to 6 years, and is perhaps the most interesting and creative forms of play. The child uses fantasy to play “as if” they were another person, object, or situation other than themselves. An example would be pretending to be a “mommy” and feeding a doll. Piaget considered this type of play as “assimilative”, in that the child adapts reality to his or her own needs, i.e. using a block as a car or truck.
- ***Games with rules:*** This is a mature type of play and is common in children ages 5 and older. Checkers is an example of this type of play.

Although play is difficult to define, it has distinguishable characteristics. It is also important to note that the above examples resemble play in adjusted children.

Maladjusted children may display more aggressive behavior in their play, may play with only a limited number of toys, and may express more dysphoric feelings, conflictual themes, play disruptions, and negative self-disclosing statements than adjusted children (Landreth, 1991). These statements are made with caution, however, and it is important for the reader to understand that the manner in which a child plays is not an absolute indication of an emotional disturbance. Other factors including environmental, recent events, or strong feelings may also change the context and characteristics of a child’s play.

What Is Play Therapy?

The term “play therapy” often leads professionals who are unfamiliar with child therapy to misunderstand what play therapy is. Play is an important part of play therapy but the emphasis should remain on the term *therapy*. Play is an intervention, based on theoretical premises, and is accepted as a recognized mode of therapy (Carmichael, 2006). The process may appear simple on the surface but the depth of the therapy is challenging and requires a great deal of training to do it successfully (Carmichael, 2006).

Play therapy is defined as, “an interpersonal process wherein a trained therapist systematically applies the curative powers of play to help clients resolve their psychological difficulties” (Schaefer 1993, p. 3). Traditional therapies have required clients to be verbal participants in their therapy. However, children’s feelings are often

inaccessible at a verbal level (Landreth, 1991). Developmentally, children lack the cognitive and verbal ability to express their feelings and are emotionally unable to handle the intensity of these feelings or adequately express them in a verbal exchange (Landreth, 1991). Further, according to Piaget, children are not developmentally able to engage fully in abstract reasoning or thinking until approximately age eleven (Craig & Kermis, 1995). This puts the child at a disadvantage for the regular “talk therapy” because their thinking is so concrete. However, play allows the child to make the abstract concrete through the medium of tangible items (Carmichael, 2006).

Play, therefore, provides children with a solution to the aforementioned cognitive deficits, and builds upon the strengths of being a child. Play is a fun, enjoyable activity that can elevate a child’s spirit, and brighten his or her outlook on life. It expands self-expression, self-knowledge, self-actualization, and self-efficacy. Play promotes healthy development and relieves feelings of stress and boredom. Further, it stimulates creative thinking and exploration, regulates emotions, and boosts the ego (Landreth, 1991). Play connects children to others in a positive way, and can aid in the therapeutic process by facilitating a healthy relationship between the therapist and client. Because play is fun, it helps the child engage in the therapy session more quickly. Finally, children can communicate their difficulties more effectively through play than they can through language (APT, 2000).

Chethik (1989 as cited in Gil, 1994) makes an important point about the use of play as therapy. He states, “Play in itself will not ordinarily produce changes, therefore, the therapist’s interventions and utilizations of play are critical” (p.4). Gil (1994) further encourages the therapist to be an active observer-participant in the therapy process, rather than a playmate. Gil (1994) states, “Play in therapy must be facilitated by an involved clinician in a meaningful way. Some of the most frequent errors made in child therapy are allowing a child to play randomly over an extended period of time, ignoring the child’s play, or providing the kind of toys that distract children rather than promote self-expression” (p.4).

Play not only has the power to facilitate normal child development but it also has the power to alleviate abnormal behavior (Schaefer, 2003). While play is powerful, it is the therapist’s interventions that are essential to facilitating healing. The therapist must

be trained not only in his or her own discipline but also in child development and play therapy as a specialization. Chapter Four will discuss the basic knowledge a practitioner of play therapy must possess to ethically administer this specialized type of child therapy.

The Therapeutic Factors of Play

A therapeutic factor is an element in the therapy process that exerts a beneficial effect on clients (Schaefer, 1993). If a factor results in clinical improvement of some sort, it is therapeutic. This improvement can result in either a decrease in symptoms or an increase in desired behaviors (Schaefer, 1993). Regarding play therapy, therapeutic factors are the part of play that contributes to positive therapeutic outcomes. The following is a list of fourteen therapeutic factors of play and the benefits they produce for the child. This list is adapted from Schaefer (1993).

- **Overcoming resistance:** Children who attend therapy often feel as if they have done something “bad” and may expect criticism, rather than support from the therapist. Play is an excellent way to establish rapport and alliance with a child, since it is a behavior that is interesting, enjoyable, and natural to children. Once rapport is established, the child most likely will commit to therapy and work towards change.
- **Communication:** Play is to the child what verbalizations are to the adult—the most natural medium for self-expression. Children can communicate through play on both a conscious and unconscious level. On the conscious level, play allows children to enact thoughts and feelings of which they are aware but developmentally cannot express. On the unconscious level, children use play to express their unconscious wishes and conflicts. Through play, children often reveal thoughts, feelings, and conflicts of which they are totally unaware. This was first realized by Sigmund Freud, and will be discussed in the following section.

- ***Mastery:*** Play is an activity that satisfies a child's innate need to explore and master his or her environment. When children are engaged in an activity that is enjoyable, they tend to keep at it longer. This persistence is likely to produce success in mastering the task. These types of play experiences contribute to a sense of power, control, and mastery of the environment. Mastery is especially important for children who live chaotic, disrupted lives, or have experienced such a loss of control, as in a sexual abuse victim.
- ***Creative Thinking:*** Play encourages children to improve their problem-solving skills. Further, it promotes creativity and flexibility because it allows children to experiment with new options without fear of negative consequences. By "trying on" new ways to deal with a problem, children can find alternate and more effective solutions to real life social and emotional issues.
- ***Catharsis:*** Catharsis is the arousal and discharge of strong emotions, both positive and negative, for therapeutic relief. In play therapy, clients can release intense feelings of anger, grief, or anxiety that have previously been difficult or impossible to express. The safety of the playroom allows the opportunity for emotional release without the fear of retaliation or censure.
- ***Abreaction:*** Abreaction is the reliving of past stressful events and the emotions associated with them. It is a more heightened process than catharsis in that the discharge of affect is greater. In play, children can slowly mentally digest and assimilate traumatic experiences by relieving them with an appropriate release of affect. Children deal with stresses and traumas by playing out similar situations and gradually achieving mastery over them. In play, the child is in control of the events and there is less anxiety because it is just pretend.
- ***Role-play:*** Role play offers children the opportunity to try out alternative behaviors through acting. In therapy, children are encouraged to role-play new behaviors they may never have considered before. This allows them to experience what it feels like to behave in this new way and to consider the pros and cons of the behavior. Role playing can also help children develop

empathy by putting themselves in another's shoes to understand their thoughts, feelings, and actions.

- ***Fantasy:*** Children learn about themselves and enlarge their world by fantasizing. Pretending gives the child power over the world, even when he or she does not have much control in real-life. This power boosts the ego and increases an internal locus of control, which is the internal belief that one has the power to make positive changes in his or her life. In fantasy play, children can compensate for their real life weaknesses, hurts, and losses, as well as satisfy unmet needs, thus giving them mastery over their environment.
- ***Metaphoric Teaching:*** Myths can help shape belief systems and give meaning to life. Myths are processed in the right hemisphere of the brain (Watzlawick 1978, as cited in Schaefer, 1994). Thus, messages can be directly communicated to the child's unconscious through stories, fantasy play, and drawings. Through metaphors, the therapist can provide myths that address the source of conflict, fears, and hostilities in the child's life, and offer more adaptive solutions. By identifying with a story's character, a child's sense of isolation and hopelessness can be replaced by the sense that the problem is shared by others and is solvable.
- ***Attachment Formation:*** One way to establish feelings of secure attachment in children is to replicate the positive parent-infant relationship through sensorimotor play. Playful interactions involving touch and smiling are perhaps the most natural and enjoyable ways to form an attachment with the child in the playroom. Without basic attachment in infancy, children are prone to emotional problems later in life (Jernberg 1979, as cited in Schaefer, 1994). Two types of therapy, based on the basic premise of attachment, are Theraplay and Developmental Play Therapy. These two modalities will be discussed in detail in later chapters of this paper.
- ***Relationship Enhancement:*** Play facilitates positive relationships by promoting fun-filled interactions between child and therapist that focus on enjoyment rather than achievement. Further, play facilitates feelings of warmth and closeness between therapist and child, which contribute to the

child's sense of well being. When a child feels accepted, respected, and is held in high regard, they are more likely to form a solid sense of self. On the other hand, if a child feels rejected, he or she will respond to the lack of warm relationships by acting out with defiance, aggression, and withdrawal.

- **Enjoyment:** The most apparent and fundamental aspect of play is that children enjoy it. Children play because it is fun; they do not need incentives. The play provides pleasure in itself. These positive aspects of play provide two therapeutic advantages. First, play contributes to a sense of happiness and well-being. Second, enjoyment is a powerful antidote to the stresses of living. Having fun and enjoying playing can relieve the child from feelings of anxiety, hopelessness, and worry.
- **Mastering Developmental Fears:** Play can reduce anxiety by the process of systematic desensitization. This is the process of being exposed to fearful stimuli in a safe environment. For children in play therapy, the child may be exposed to a fearful situation while relaxed in play. The pleasure of play counteracts and neutralizes the fearfulness so the child can perform the desired behavior. Through repeated play experiences, the strange and scary become familiar and no longer frightening.
- **Game Play:** Games are a primary way for children to become socialized, because the players must agree upon a set of prearranged rules. Game play also contributes to a child's cognitive, social, and emotional development by playing fair, taking turns, and learning to win and lose graciously. They can help distractible children focus and sustain their attention. Also, games allow children to see the immediate consequences of their actions, which aids in developing a sense of internal locus of control. Finally, the challenge of games helps children overcome feelings of boredom and develop a sense of mastery.

The above therapeutic factors do not necessarily constitute change during the therapy process. Rather, the above are factors that aid in change. It is important to remember that the therapists' interventions and relationship with the child also facilitate change and can augment the therapeutic factors. Further, knowledge of these therapeutic

factors of play can aid the play therapist in understanding the power of play and aid in implementing appropriate therapeutic interventions.

History of Play Therapy & Theoretical Foundations

Sigmund Freud is the first person in professional literature who described using play as a psychological intervention (Landreth, 1991). In 1909, Freud worked with a young boy, “Little Hans” who suffered from phobias. Freud did not work with the child directly, rather he had the boy’s father record the child’s play patterns and report them back to Freud. Based on these observations, Freud provided Hans’ father with interpretations of the underlying conflicts and made suggestions for interventions (Kottman, 2001). Freud believed children played out their unconscious concerns and conflicts. Further, he suggested play had a role in the process of mastery and abreaction (Kottman, 2001).

Hermine Hug-Hellmuth was the first psychoanalytic therapist to directly use play with children in therapy. Starting in 1921, Hug-Hellmuth began providing children in therapy with play materials to express themselves and viewed play as an essential part of child analysis (Landreth, 1991). Further, Hug-Hellmuth recognized the difficulty in applying traditional adult psychotherapy to children, as children could not verbalize their anxieties and showed no interest in free association (Landreth, 1991).

Two other psychoanalysts Anna Freud (daughter of Sigmund) and Melanie Klein, used play to work with children; albeit in two very different ways. Freud advocated using play mainly in order to build a strong therapeutic alliance between child and therapist, whereas Klein proposed using play as a direct substitute for verbalizations (Schaefer & O’Connor, 1983). Both Freud and Klein proposed the ideas that play is the child’s way of free associating and uncovers their unconscious conflicts and desires (Gil, 1994).

Margaret Lowenfeld was a contemporary of Melanie Klein and Anna Freud, but developed a form of child psychotherapy that greatly differed from Klein and Freud’s work. Lowenfeld considered herself a psychoanalyst but believed play was a concrete example of how the child thinks (Carmichael, 2006). She focused more on the child’s ability to organize and make sense of the world and personal experiences, rather than the

child-therapist relationship (Carmichael, 2006). Lowenfeld's main contribution to play therapy was the development of the "world technique." This technique was developed, using a tray filled with sand, in which she would ask the child client to "build a world." The child would then build their "world" using miniature toys Lowenfeld provided. She collected miniatures for her clients to use that represented objects, people, places, animals, and things from daily life (Carmichael, 2006). The world technique was later expanded by Dora Kalff, a Jungian therapist, who developed sand play therapy. This technique is based on Jungian principles and views the sand tray as symbolic of the child's psyche (Carmichael, 2006). Further, Kalff believed that, during the sandplay process, the conscious mind relaxes its control. This allows access to the unconscious material lying beneath the surface (Kalff, 2003). This is done by the selection of figures and the process of the sandplay. The awakening of the unconscious and the silencing of the conscious mind promotes what Jung referred to as "transcendent function", which makes possible a completely new outlook on life (Kalff, 2003). Over the course of sandplay, inner order gradually grows out of chaotic experiences, as evidenced by the sandplay work. For example, sandplay pictures that first express emptiness and loneliness may begin to show new life and growth.

Another technique, using psychoanalytic theory as its basis, was structured play therapy. Structured play therapy was a goal oriented technique developed in the late 1930s. According to Schaefer & O'Connor (1983), all structured play therapies consisted of three commonalities: they were based on a psychoanalytic framework, they believed in the cathartic value of play, and the therapist played an active role in determining the course and focus of therapy. One well-known practitioner of structured play therapy is David Levy. In 1938 he developed Release Therapy to treat children under the age of 10 years who had experienced some specific trauma (Kottman, 2001). Levy provided children with certain toys aimed to recreate the traumatic event but did not direct them to play with the toys in a certain manner. Release Therapy was based on Sigmund Freud's concept of repetition compulsion theory. This is the idea that, given security, support, and the right materials, a child could replay a traumatic event over and over until he or she was able to assimilate its associated negative thoughts and feelings (Schaefer & O'Connor, 1983).

In 1936, Otto Rank shifted away from psychodynamic ideas about therapy with children. Rank deemphasized the importance of the child's past and the unconscious; instead focusing on the relationship between the child and the therapist in the here and now (Landreth, 1991). Jesse Taft, Fredrick Allen, and Clark Moustakas based their work on this concept, which was dubbed relationship play therapy. In relationship play therapy, the primary emphasis is placed on the curative power of the emotional relationship between the therapist and child (Landreth, 1991). There is no attempt to explain or interpret past experiences; instead the focus remains on present feelings and reactions. This approach reportedly led to a considerable reduction in the length of therapy (Landreth, 1991).

In 1951, Carl Rogers developed the client-centered approach to therapy with adults. Virginia Axline adapted this approach into a nondirective, client-centered play therapy technique (Schaefer & O'Connor, 1983). Axline believed children naturally move toward positive growth if they are provided with a relationship in which they experience unconditional acceptance and safety (Kottman, 2001). Further, she believed change occurred within the child as a result of the relationship with the therapist, rather than the application of specific techniques. In contrast to earlier psychodynamic theories, Axline did not believe the play therapist should interpret the child's play or praise their behavior (Kottman, 2001). Garry Landreth expanded on Axline's work, combining many of her ideas with concepts described by Ginott and Moustakas (Kottman, 2001). He developed his own approach to play therapy called "client centered play therapy", and is considered one of the leaders of the field today. Bernard and Louise Guerney also adapted many of the ideas inherent in nondirective, client-centered play therapy to teaching parents to work directly with their children using "filial therapy" (Kottman, 2001). The Guerneys developed strategies for training parents in nondirective play therapy techniques designed to build the parent-child relationship and enhance the child's self-esteem. A more detailed explanation of filial therapy will be discussed in Chapter Three.

In the 1960's the behavior therapies were developed, based on the principles of learning theory (Gil, 1994). Until recently, there were few examples of behavioral theory directly applied to the practice of play therapy (O'Connor, 2000). However, in 1993,

Susan Knell incorporated cognitive and behavioral interventions within a play therapy context (Kottman, 2001). Cognitive-behavioral play therapy is structured, directive, and goal oriented. It uses behavioral techniques and cognitive strategies within a play framework to teach children new ways to think about themselves, their relationships, and problem situations (Kottman, 2001).

In the 1970's there was much interest working with children who were struggling with attachment disruptions and the pathology that developed from these disruptions (Kottman, 2001). Attachment theory is the theoretical framework for child developmental play theories that resulted from the attachment concerns of the 70's. Two of the most prevalent child developmental theories include Developmental Play Therapy and Theraplay. Developmental Play Therapy was a therapeutic technique developed by Viola Brody in 1978. This technique evaluated the developmental stages of clients and then tailored the therapeutic approach to provide the elements of nurturing missed by children in their early attachment to their parents (Kottman, 2001). In developmental play therapy, the therapist is a very integral part of the process and engages the child in many forms of nurturing touch, such as holding and rocking (Kottman, 2001). It is the belief of developmental play therapy that, by providing remedial nurturing to the child, he or she will be able to move forward in the developmental process (Kottman, 2001), thus alleviating symptomatic behaviors. Based on the works of Brody and Des Lauriers, Ann Jernberg developed a technique that was coined Theraplay (O'Connor, 2000). This technique is based on typical parent-child interactions and includes four dimensions that model those healthy interactions. The dimensions include structuring, challenging, engaging, and nurturing activities. The sessions are therapist-directed and aim to improve impaired parent-child relationships through duplicating positive parent-child interactions (Kottman, 2001). A detailed description of Theraplay will also be presented in Chapter Three.

Another important part of the history of play therapy was the formation of the Association of Play Therapy (APT). APT was the brainchild of Kevin O'Connor and Charles Schaefer. In 1982 APT, the first worldwide organization dedicated to the advancement of play therapy, was formed (Carmichael, 2006). In 1990, APT developed

national certification and training criteria in hopes for recognition of play therapy as a specialty in the field of psychotherapy (Carmichael, 2006).

Efficacy & Research Outcomes

The most recent emphasis within the field of play therapy has been to indicate the efficacy of play therapy as a therapeutic intervention in mental health treatment for children (Carmichael, 2006). Unfortunately, play therapy has long been criticized for a lack of adequate research base to prove its efficacy (Ray, Bratton, Rhine, & Jones, 2001). Most of the research on play therapy has been qualitative and anecdotal, reported by practitioners of play therapy (Carmichael, 2006). These types of studies do not follow the more rigorous quantitative methods and are often laden with researcher bias (Carmichael, 2006).

To address these criticisms, several meta-analysis' have been completed to test the efficacy of play therapy. A meta-analysis is a method of study designed to test the effectiveness of a modality (Ray, et al, 2001). It combines many smaller studies to determine an overall effect. Bratton and Ray (2000) analyzed the results of more than 100 case studies, documenting the effectiveness of play therapy as an intervention. The authors found that these studies provided support for the efficacy of play therapy as a treatment modality for children with the following issues: social maladjustment, anxiety/fear, negative self-concept, "mental challenges", or physical or learning disabilities. Further, they found that the participants of these studies demonstrated elevated levels of positive behavior and decreased levels of symptomatic behavior after play therapy interventions.

Unfortunately, this initial meta-analysis was criticized because many of the studies lacked the ability to be generalized to a broader population because of the small number of participants (Carmichael, 2006). Further, many of the studies compared play therapy to no treatment at all, which does not allow play therapy to be compared to other interventions. A further meta-analysis was then conducted by Ray, Bratton, Rhine, and Jones (2001), using 94 play therapy studies taken from 1947 to 2001.

In this expanded study of the effects of play therapy, Ray et al (2001) found a substantial positive effect in treatment outcomes across modality, gender, clinical versus

non-clinical populations, settings, and diverse play therapy theories. Two main factors appeared to increase the effectiveness of therapy: parent involvement and duration of sessions. Parental involvement significantly increased the effectiveness of play therapy in promoting positive outcomes for children. Increasing the number of sessions allowed the therapist and child to explore more issues in greater depth. The authors found that the effectiveness of play therapy continued to increase in relation to the number of sessions up to 35-45 sessions. At 45 sessions, effectiveness leveled off and then declined.

LeBlanc and Ritchie (2001) also conducted a meta-analysis of 42 studies conducted both in the U.S and abroad. They found that the two types of play therapy that proved most effective were filial therapy and parent-child interaction therapy. Filial therapy is a non-directive form of play therapy and parent-child interaction therapy is considered a directive, behavioral approach (Carmichael, 2006). Both of these types of therapy had parental involvement as a major component of therapy. LeBlanc and Ritchie's (2001) study supports the Ray et al (2001) study in that inclusion of parents and duration of sessions contributed extensively to the success of play therapy as an intervention. However, LeBlanc and Ritchie (2001), found the benefits of play therapy declined after 35 sessions, rather than the 45 sessions found in Ray et al (2001). Regarding parental involvement, LeBlanc and Ritchie (2001) hypothesized that the inclusion of parents may be a greater contribution to the success of play therapy, rather than the exact modality. This conclusion was drawn because two of the most effective modalities, filial therapy and parent-child interaction therapy, have two distinctly different theoretical foundations (Carmichael, 2006), as mentioned above.

Overall, play therapy has been demonstrated to improve a child's self-concept, decrease anxious behaviors, lessen externalizing and internalizing problem behaviors, and increase social adjustment (Ray, 2006). As noted in the above studies, more research is needed to compare the effectiveness of play therapy with other child-focused psychotherapy techniques. Further, play therapy research needs to demonstrate generalizability of results, which can happen by increasing sample size. Although play therapy has been used as an intervention with many types of childhood problems, little research has looked at what specific theories or techniques are best suited with certain populations (Carmichael, 2006). Finally, the multicultural aspects of play therapy have

not been examined. This section only provides a glimpse of the possible research areas of play therapy, and it is exciting to think about the possibilities.

CHAPTER 3 - Major Approaches in Play Therapy

This chapter is designed to inform the reader about the major approaches in play therapy. This is by no means an extensive list, but aims to provide the reader with an overview of the most widely used approaches, and ones that are best incorporated with family therapy. For the purpose of this paper, directive and non directive (client-centered) approaches, filial therapy, sandtray therapy, Theraplay, and prescriptive play therapy will be covered.

Many of the approaches used today in play therapy originated from adult orientated individual therapy. These include psychoanalytic theory (1909), the humanistic theory of Rogers (1959), and behavioral as well as cognitive behavioral approaches (Ellis, 1971, Beck, 1976, Bandura, 1977). Others arose from child-centered therapies and their recognition of children's special needs in therapy. Those that reflect this belief include developmental and relationship approaches as well as release play therapy (Landreth, 2002). The filial and ecosystemic models of play therapy developed from broadening the individual view to include the child's system (O'Connor, 2000).

Directive and Nondirective Approaches

All play therapy is conducted in either a directive, nondirective, or combination approach. Virginia Axline is the creator of the nondirective or client centered approach. She discerns the difference between the directive and nondirective approaches as, "Play therapy may be directive in form-that is, the therapist may assume responsibility for guidance and interpretation, or it may be nondirective; the therapist may leave

responsibility and direction to the child”(Axline, 1947, as cited in Schaefer and O’Connor, 1983, p.21).

Axline studied under Carl Rogers and subscribed to his theoretical foundations (Carmichael, 2006). The Rogerian principles are based on the assumption that the client has within them the ability to solve their own problems and strive for growth. (Schaefer & O’Connor, 1983). During the nondirective or client-centered approach, the child client leads the play and the therapist facilitates growth. This is done by accepting the child as they are. The therapist is warm, empathic, and understanding. The child is allowed to lead the play with the understanding that he or she has the ability within him or her to resolve his or her own issues and problems. Of course, this is also fueled by the supportive, non-judgmental, therapeutic environment. The relationship between the child and the therapist is also a key factor in facilitating growth and healing in the child. The non-directive therapist gives the child undivided attention and refrains from making interpretations or giving directives (Gil, 1994). This shows the child they are accepted exactly as they are. Through the acceptance and sensitivity of the therapist, the child learns to trust and develop a sense of security (Carmichael, 2006). This trust allows the child to go deeper into the self and find the courage to discover his or her own solutions.

Regardless of the approach, it is important to understand that nondirective play therapy is always helpful during the diagnostic and assessment phase (Gil, 1994). By accepting the child as they are and not interpreting their play, the child is free to show the therapist their inner struggles. Non-directive play is also especially useful to establish trust with the client as well as build rapport. By providing the client with unconditional positive regard, the therapist is setting the stage to perceive the child in a most likely different way that they have previously experienced. Through the process of accepting the child’s attitudes, feelings, and thoughts, the therapist enters the child’s world. Once contact has been made with the child in this way, a trusting relationship can begin to form (Landreth, 1991).

The directive approach is therapist directed. This type of play therapy is based on the early structured therapy, and stems from the belief in the cathartic value of play (Kottman, 2001). One of the historical figures in structured play therapy was Levy (1938). He developed release therapy to help children deal with traumatic experiences.

He would pick certain toys that he felt would recreate the traumatic event for the child. He would not direct the child to play with them in a certain way; rather he believed the child would resolve the issue through catharsis (Kottman, 2001). Catharsis is the release of pent up emotions which produces therapeutic relief. Therefore, the recreation of the traumatic event allowed the child to release the pain and anxiety it caused.

In all structured or directive play therapy, the therapist takes the lead in determining the goals and course of therapy. The active role of the therapist is the distinguishing factor between the directive and nondirective approaches. According to Gil (1991), "Directive therapists structure and create the play situation, attempting to elicit, stimulate, and intrude upon the child's unconscious, hidden processes or overt behavior by challenging the child's defensive mechanisms and encouraging or leading the child in directions that are seen as beneficial (p.36)." For example, a directive therapist may ask the child to draw a picture of their family doing something or use the doll house to describe his or her "typical day".

Generally, directive approaches are shorter term and symptom orientated. The therapeutic environment remains safe and nurturing; the therapist just guides the topics that will be addressed through the child's play. Directive play therapy can be especially useful in the managed care settings, when the numbers of sessions are usually limited. Further, directive play is useful in family therapy because it affords adult members the understanding that they are working toward specific goals.

Filial Therapy

Filial therapy is a unique therapeutic intervention in which the parents are taught to become therapeutic agents for change in the lives of their children. Filial therapy is a type of parent training that incorporates "training in play therapy skills, parent-child play sessions, and supervision experience" (Rennie & Landreth, 2000, p.19). The primary techniques taught in filial therapy are tracking, restating content, reflecting feelings, and setting limits.

Filial therapy was designed and implemented by Bernard and Louise Guerney in the 1960s. The Guerneys were frustrated by a lack of mental health services for children and families, so they developed a method of training parents in child-centered play

therapy skills (Rennie & Landreth, 2000). This method was adapted from many of the ideas inherent in non-directive, client centered play therapy, and consisted of a 6 to 12 month parental training period. Noting the needs of parents with time and financial constraints, Garry Landreth developed a 10-week model in the early 1990s (Bratton, Jones & Rhine, 2002).

Van Fleet (1991, cited in Ryan, Smith, & Van Fleet 2005, p. 243) outlined goals for the child, parents and family during the filial therapy process.

Child Goals:

- understand, express, and regulate their emotions
- develop problem-solving skills
- reduce maladaptive behaviors
- feel more trust and security with their parents
- gain mastery while being responsible for their own actions
- develop interpersonal skills

Parent Goals

- increase their understanding of child development and set more realistic expectations for their children
- increase their understanding, warmth, trust, and acceptance of their children
- learn the importance and interplay of their children's play, emotions, and behaviors
- communicate more effectively with their children
- develop greater confidence as parents
- reduce the frustrations experienced with their children and enjoy them more

Family Goals

- reduce or eliminate presenting problems and conflicts
- strengthen family relationships and bonds
- develop greater mutual trust and higher cohesion
- improve communication and coping skills

- have more enjoyable interactions with each other

Filial therapy is a method that is usually taught in a group format, consisting of six to eight parents. During these sessions, parents learn basic child-centered play therapy techniques to use with their children in weekly play times (Rennie & Landreth, 2000). Filial therapy training should only be implemented by a trained professional who is competent in the areas of child-centered play therapy and filial therapy (Ryan, et. al 2005).

As aforementioned, Landreth developed a model of filial therapy that provides a shorter, more succinct approach. Sweeney and Skurja (2001) provided an overview of Landreth's 10-week model. The following is a summary of that overview. During the filial therapy training process, parents learn how to recognize their child's feelings and are taught reflective listening and limit-setting skills. Parents implement play sessions at home for 30 minutes in a structured setting. These sessions are videotaped and reviewed in group. The therapist and other parents comment on the sessions and offer feedback. This training takes place in a supportive and empowering therapeutic environment in which the parents' relationship with their child is the focus. The results from this relationship, as well as the parents' acting as the therapeutic agent for change, produce longer lasting and fulfilling outcomes. These outcomes include reducing problem behaviors in children, helping parents learn skills they can apply in daily interactions with their children, and improving parent-child relationships (L.Guerney, 1997 as cited in Kottman, 2001).

Sand Tray Therapy

Sand tray therapy is an expressive and projective form of psychotherapy that uses sand as a therapeutic medium. This type of therapy can be used with children, adolescents, and adults; as well as with individuals, couples, and families. Sand tray therapy was originally developed by Margret Lowenfeld in 1939. She had become interested in and adapted the technique after reading H.G. Wells's book *Floor Games* (Homeyer and Sweeney, 1998). In this book, Wells used miniatures to play on the floor with his sons. Lowenfeld took this concept and began to use sand and water trays and asked her child clients to build "worlds" in the trays using miniatures. She developed this

system to understand the symbolism of each object placed in the sand by the children, thus giving her clues to the child's internal "world" (Kottman, 2006). This soon became known as the "Lowenfeld World Technique" (Homeyer & Sweeney, 1998).

Sand tray therapy must be differentiated from sandplay therapy. Sandplay therapy was developed by Dora Kalff, who had heard of Lowenfeld's work and adapted the approach, calling it sandplay (Homeyer & Sweeney, 1998). Kalff's technique is theoretically based on Jungian psychology and Eastern religious and spiritual beliefs (Beggs, 2004). Kalff believed the sand represented the child's psyche and the miniatures placed in the sand were representative of the child's innermost thoughts (Carmichael, 2006). She would then ask the child to produce a narrative that described the scenes the child created in the sand, further giving her insight into the child's psyche (Kottman, 2006).

While some therapists use the terms interchangeably, it is more appropriate to refer to the Jungian form as *sandplay* and the more eclectic and flexible approach as *sand tray therapy*. For the purposes of this paper, the author chose to focus on sand tray therapy because it is more of an integrative therapy, and thus more appropriate for the use in family and systemic therapy (Homeyer & Sweeney, 1998).

There are many benefits to incorporating or exclusively using sand tray work in therapy. Homeyer and Sweeney (1998) provide a summary of the rationale for using this experiential mode of therapy:

- Clients are able to use the sand tray to express emotional issues in a non-verbal, safe forum. Because children are not developmentally able to verbalize strong inner emotions, the sand tray allows them the space for emotional expression. The miniatures become their words and allow the client to consider new solutions to their problems, some which are not possible through verbal expression.
- Sand tray therapy has a unique kinesthetic quality, and gives the client the much needed sensory experience. People of any age do not merely experience trauma at a cognitive level but also a sensory level. Because children are pre-operational, they are developmentally unable to express their experiences. The sand and miniatures provide a safe sensory experience and a place to provide expression of emotions.

- Sand tray therapy gives the client necessary therapeutic distance by providing a projective medium. The client or family in emotional crisis is often unable to express their pain in words but may find expression through the sand and miniatures, which are projective mediums. It is simply easier for the traumatized client to “speak” through the miniatures, than to verbalize their pain.
- The therapeutic distance that sand tray therapy provides also gives the client a safe place to abreact. Children and families who have been traumatized need a safe place in which repressed issues can emerge and be relived (abreaction), as well as to experience the negative emotions which are frequently attached. The sand tray and miniatures provide such a place.
- Sand tray therapy provides safe and inclusive experience for families; allowing each member the freedom to express him or her self. The sand tray provides a level “playing field” in which all members can express themselves. Children do not have to compete verbally with other members of the family during sand tray therapy.
- Sand tray therapy provides appropriate limits and natural boundaries, which in turn promotes safety for the client. The careful structure of the sand tray therapy process and the carefully selected tools of the sand tray therapist provide the client with the boundaries that create the sense of safety needed for growth.
- Sand tray therapy provides a unique setting for the emergence of therapeutic metaphors. Further, the sand and the miniatures afford the client the opportunity to create their own therapeutic metaphors. Metaphors combine the concrete and abstract in a useful way and the most powerful metaphors are the ones the client generates. The sand and miniatures are ideal for clients to express their own therapeutic metaphors.
- Sand tray therapy is effective in overcoming client’s resistance, due to its non-threatening and engaging qualities. These qualities can captivate the involuntary client and unwilling family members.
- Sand tray therapy provides a needed and effective communication medium for clients with poor verbal skills. The sand tray therapy process creates a place where expression of needs and wants is not dependent upon words.

- Sand tray therapy also disarms verbalizations that are used as defense mechanisms. This refers to children who are “pseudo-mature” and present themselves as verbally astute or a sophisticated adult, who uses intellectualization and rationalization as a defense. The sand tray therapy cuts through these defenses and provides a nonverbal way to address them.
- Sand tray therapy creates a place for the child client or family to experience control. One of the primary results of crisis and trauma is a loss of control on the part of the victim. The self-directed process of sand tray therapy creates a place for control to be returned to the client. Conversely, for the client who is avoidant, the sand tray therapy process places the responsibility for and control of the process on the client. In these two ways, sand tray therapy helps the client achieve a greater internal locus of control, thus giving the client power to change.
- The challenge of transference may be effectively addressed through the presence of an expressive medium. Transference occurs when a client projects his or her own thoughts, feelings, and emotions about people in his or her family of origin onto the therapist (O'Connor, 2000). For example, in talk therapy the therapist may say something that the client perceives as sounding just like his or her father, which can lead to a slowing of progress. However, in sand tray therapy, the tray and the miniatures may become the objects onto which the client projects his or her emotions. Lowenfeld (1979, as cited in Homeyer & Sweeney, 1998), proposed that, in the creation of worlds in the sand, transference occurred between the client and the tray, rather than the client and therapist. The tray and miniatures may become objects of transference or the means by which transference issues are safely addressed.
- The qualities of sand tray therapy listed above create an atmosphere where deep and complex intra-psychic issues can be safely approached. Sand tray therapy serves to decrease ego controls and other defenses and foster greater levels of disclosure. It removes verbal defenses and creates an increased capacity to consider alternatives to his or her problems.

Sand tray therapy is a powerful therapeutic modality. However, it must not be implemented in a haphazard manner. The clinician must have proper training and the

treatment must be designed with purpose and intent. Any clinician who is interested in this type of therapy should seek further training and supervision.

Theraplay

Theraplay is an engaging type of therapy that is based on attachment and developmental theories. It aims to replicate healthy parent-child attachment relationships and uses four dimensions to do so. Each session includes structure, engagement, nurture, and challenge activities. The therapy is intense and designed for short term implementation. It actively involves parents, first as observers then as co-therapists.

Theraplay was developed by Dr. Ann Jernberg in 1979. It was first designed and used with children enrolled in Head Start programs in inner city Chicago. Jernberg derived the method from Viola Brody's Developmental Play Therapy. Developmental Play Therapy is a technique that emphasizes the use of physical contact and structured sessions (O'Connor, 2000).

When Theraplay was first developed, it was quite different from the traditional types of child therapy of the times. In the early days, most child therapy was based on adult psychotherapy or Rogerian, client centered therapy. Theraplay differed vastly in that the therapist took the lead and the focus was on the here and now, not on what happened in the past or any interpretation of symbolic play. Jernberg and Booth (2001) believed that, if they were going to change the child's view of him or herself, as well as the parents' way of relating, they needed to initiate a type of play that was based on natural parent-child relationships, rather than discuss the child's inner experiences. Therefore, they created a type of play therapy in which the essential force for change lies in the creation of a more positive relationship between a child and his or her parents (Jernberg & Booth, 2001).

Theraplay involved nurturing touch and lots of therapist direction, thus was considered "intrusive" by proponents of other child therapies. Again, this idea was based on the healthy nurturing touch and the parental structure that occurs between child and caregiver. The Theraplay therapist models these interactions by planning structured sessions which are emotionally attuned, interactive, and physical. As a result, the child

improves his or her attachment relationships and increases his or her level of trust, self esteem, and joyful engagement (Jernberg & Booth, 2001).

Another way Theraplay differed from traditional child therapies was that parents were actively involved in the therapy sessions. The therapist and parents worked together in session to engage the child in a healthier relationship. Further, parents were asked to extend the therapy by completing the activities at home with their child. This gave the parents opportunities to interact with their child in a safe, nurturing, and engaging manner. It also put the parents in charge in a fun way. These playful, attuned responses aid in the development of a secure attachment which leads to the capacity for emotional self-regulation, the capacity to understand and empathize with others, and increased feelings of self worth (Jernberg & Booth, 2001).

Jernberg and Booth (2001) were aware that their hands on, intrusive type of therapy was shockingly different. They acknowledge this by stating, “We believe that, if we are to change the child’s view of himself and the parents’ way of relating, we need to initiate the more active play that is very natural in the parent-child relationship but very different from the play of most other kinds of child therapy” (p. 36).

Jernberg and Booth (2001) proposed that the goals for the child in Theraplay are three-fold. First, Theraplay helps the child to replace inappropriate coping behaviors with healthy, creative, age appropriate solutions by offering activities which aid in self-control and self-regulation. Second, Theraplay aims to increase the child’s self esteem by emphasizing the child’s strengths and positive attributes. Third, Theraplay increases the positive interactions between the child and caregiver through emotionally attuned, interactive, physical play; thus enhancing the relationship.

Parent-child interactions are stressed in Theraplay, and the sessions include four dimensions that parallel healthy parent-infant attachment relationships. The four dimensions, structure, engagement, nurture, and challenge, are outlined below (Jernberg & Booth, 2001):

- **Structure:** This models the appropriate parental hierarchy, in which the adult is in charge. This relieves the child of the burden of being in charge. Further, if the child lives in a chaotic environment, the structure of the sessions is reassuring. In these ways, structure of the sessions provides internal and

external order for the child. This dimension is especially useful for the controlling, overactive, chaotic, and over-stimulated child.

- **Engagement:** This dimension replicates the give and take, attuned relationship between a parent and child. The goal is for the child to be seen and felt. These activities are full of excitement and surprises and offer pleasant stimulation and variety. These activities are especially appropriate for the withdrawn, avoidant, and rigid child. Such children need to be enticed out of their withdrawal or avoidance by an empathic intrusion aimed at engaging them in a pleasurable relationship. As a result the child learns how to communicate, share intimacy, and enjoy personal contact.
- **Nurture:** Nurturing activities provide comfort and stability to the child, which in turns helps the child feel the world is safe, predictable, warm, and secure. Again this fits the appropriate parental hierarchy by the parent's providing care, security, and nurturance. These activities help build the child's self esteem by giving the message the child is lovable, valued, and cared for. Nurturing activities are especially helpful for children who are overactive, aggressive, or pseudomature.
- **Challenge:** This dimension replicates appropriate child development and encourages children to move ahead and become more independent. These activities are done as a partnership between the therapist and child or caregiver and child, never alone. They promote feelings of competence and confidence by helping the child take age appropriate risks. The therapist ensures the child is always successful and adjusts the activity accordingly. Challenging activities are especially useful for children who are withdrawn, timid, or rigid.

It should be noted that Theraplay is not recommended for all child clients. The Theraplay Institute offers several contraindications. Theraplay is contraindicated for children who are dangerous and acting out and hospitalization is needed. Psychotic children also may need intensive in-patient psychiatric treatment. Children who have been sexually abused or traumatized within the last six months first need focused trauma work. Further, foster and adopted children, with a history of significant loss and trauma, may need other attachment based trauma treatment. The Theraplay Institute recommends

such treatments by Hughes (1997, 1998), Gray (2002), Levy and Orlans (1998), and Keck and Kupecky (1995, 2001). Finally, Theraplay is not recommended for children whose parents are seriously mentally ill or who may harm them in any way.

It is also important for the clinician to understand that Theraplay is service marked which is equivalent to a trademark. This means that clinicians must receive training and certification in Theraplay in order to use the method. The certification process involves intensive training and supervision in the Theraplay method.

Prescriptive Play Therapy

As explained in the above sections, most play therapists fall into the directive, nondirective, or combination of both approaches when treating children. Strictly child-centered therapists believe that all answers to the child's struggles lie within them. Since nondirective play therapy has roots based on psychoanalytic theory, this can mean a long and sometimes frustrating experience for the child. Directive play therapists believe in streamlining the therapy process by introducing interventions that are aimed at helping the child move through their issues.

Some therapists may always begin the therapeutic relationship by establishing a safe, trusting environment through the use of nondirective play. Once they have gotten to know the child and developed a sense of what the child needs, they may move to a more directive format. Normally, the clinician chooses their direction, based on their theoretical foundations. Some clinicians have realized that a "one size fits all" approach doesn't work with diverse populations of clients. These clinicians implement what Schaefer (2001) has called a "prescriptive play therapy approach".

This approach borrows from different theories and techniques in order to fit their interventions to the needs of a particular client. It needs to be pointed out that a prescriptive approach differs from what Norcross (1987, as cited in Schaefer 2001) called a "kitchen sink eclecticism" (p. 59). This latter type of approach is atheoretical and borrows from various schools of thought. It is haphazard and ineffective and may even be dangerous to some clients, according to Norcross.

Prescriptive play therapists do, however, use theory and empirically supported interventions to guide their treatment. They use scientific evidence to match an intervention to a disorder and tailor it to meet the individual needs of the child. In order to do this in a theoretically sound manner, the clinician must have extensive knowledge of each guiding theory in play therapy. They must also have extensive experience in working with children and their parents so they can implement their interventions in a skillful manner. For example, a prescriptive therapist may use cognitive behavioral interventions such as relaxation techniques and guided imagery to address anxiety. Further, the same therapist may also use sand tray therapy (which is rooted in psychoanalytic theory) to discover the underlying issues behind the child's anxiety that he or she is unable to verbalize.

This type of play therapy is also best suited to the therapist who is flexible and skillful in adapting treatment protocols to their own personal style. For example, the therapist will be directive and structured when implementing a behavioral approach, but quite nondirective when following a child-centered orientation. In sum, according to Schaefer (2001), "The cardinal premise of the prescriptive approach is that the more tools clinicians have in their therapeutic tool box, the more effectively they can treat a wide range of disorders" (p. 65).

CHAPTER 4 - Education of the Play Therapist

This chapter will provide the reader with information in becoming a Registered Play Therapist. In addition, it will include supplemental information on child development that will help the play therapist in their work with children and families.

Registered Play Therapist

To become a registered play therapist, one must take additional coursework and have specialized supervision. There are many therapists working in the field who claim to use “play therapy” or state they are a “play therapist” without the proper credentials. This is unethical and provides a disservice to the children with whom these therapists are working.

According to Landreth (1991), “Play therapy is much more than gathering a few toys together and sitting in a room or office watching a child play. Special skills are needed and a way of communicating and interacting that is not common with adult clients” (p. 104). Because of this, the Association of Play Therapy (APT) was formed as a national professional organization in 1982. They began offering registration to qualified mental health professionals who have completed specific coursework and supervision. APT has provided criterion with which registration is possible. This criterion is listed in the following section. RPT refers to Registered Play Therapist, and RPTS refers to Registered Play Therapist Supervisor:

- ***License:*** RPT/S applicants must hold current or active mental health licenses (or, if unavailable or not applicable, certifications) for clinical practice.
- ***Education:*** RPT/S applicants must have 1) earned a Master's or higher mental health degree from an institution of higher education and 2) completed an APT-designated core graduate coursework, i.e. ethics, child development, theories of personality, principles of psychotherapy, and child/adolescent psychopathology.
- ***General Clinical Experience:*** RPT/S applicants must have completed at least two (2) years and 2,000 hours of supervised clinical experience, not more than 1,000 hours of which may be pre-Master's degree. RPT-S applicants must have completed an additional three (3) years and 3,000 hours of clinical experience which need not be supervised and must be at least five (5) years of experience beyond a Master's mental health degree.
- ***Play Therapy Training:*** RPT/S applicants must have completed at least 150 hours of play therapy specific instruction from an institution of higher education or APT-approved providers of continuing education.
- ***Supervised Play Therapy Experience:*** RPT/S applicants must have completed at least 500 hours of supervised play therapy experience that included at least 50 hours of play therapy supervision. RPT-S applicants must have completed an additional 500 hours of play therapy experience which need not be supervised.
- ***Supervisor Training:*** Not applicable for RPT applicants. RPT-S applicants, however, must have completed at least four (4) hours of supervisor training that is not included in the 150 hours of play therapy training.

Marriage and Family Therapy

Understanding the entire family system is a benefit to any clinician. Marriage and Family Therapists (MFT) are well versed in systems theory and how all members of the system interact. It is the opinion of this author that play therapy and family therapy go hand in hand, and understanding and utilizing both can be a tremendous advantage to helping clients. Children do not grow up in isolation. Therefore, it only makes sense to include their other family members, especially parents, in the therapy process.

Understanding systems theory, as MFTs do, allows the clinician to help the family also understand relationships and how they affect each person in the system.

The Behavioral Science Regulatory Board (BSRB) is the governing board through which Marriage and Family Therapists become licensed in Kansas. According to the BSRB, in order to become a licensed Marriage and Family Therapist in Kansas you must:

- Be over 21 years of age
- Have obtained a Masters or Doctorate degree in Marriage and Family Therapy OR a related field which contained coursework considered to be equivalent to the Marriage and Family Therapy Program
- Merit public trust as demonstrated by professional references and attestations
- Passed a nationally standardized exam at the basic level

Although the academic path is the easiest way to obtain training in Marriage and Family Therapy, there are other ways. The American Association for Marriage and Family Therapy (AAMFT) holds a national conference every October that offers presentations on various topics in family therapy. In addition, AAMFT offers other, smaller, conferences throughout the year. There are also many training institutions located throughout the U.S. that provide training in various aspects of family therapy. For example, The Minuchin Center for the Family is located in New York. It was founded by Salvador Minuchin and focuses on Structural Family Therapy but also has influences in feminism and multiculturalism (Nichols & Swartz, 2004). More information about Marriage and Family Therapy can be obtained by visiting <http://www.aamft.org>.

Child Development

Play aids and encourages normal child development. According to Smith (1982), as cited in Schaefer (1993), “Child development researchers over the past twenty years have produced evidence that play facilitates a child’s gross and fine motor development, cognitive and language development, and social adjustment” (p.3). It is important for a play therapist to also understand child development so they will be aware when something goes awry. They also need to tailor their interventions to match their client’s developmental levels. Further, play therapists need to be cognizant that issues, such as

trauma and grief, may cause a child to regress or act below their developmental level (Filley, 2006).

Many child development theorists inform the world of play therapy. It is advisable for play therapists to become familiar with them and use their understanding in treating child clients. Listed below is an overview of the major child developmental theorists, and how they impact play therapy.

- **Sigmund Freud:** described child development as a series of ‘psychosexual stages’. He was interested in childhood events and how they shaped the child’s life. However, he focused mainly on pathology and related it back to a disturbed psychosexual stage. Freud is the father of psychoanalytic theory, which informed the early play therapies, and still has influence in many contemporary play therapies, such as Release Therapy (Kottman, 2001).
- **Erik Erikson:** proposed development throughout the lifespan. He differed from Freud in that his stages were psychosocial rather than psychosexual. His psychosocial stages focused on overcoming internal conflicts. Trauma or crisis in one stage can produce difficulty in moving to the next stage (Craig & Kermis, 1995). Children may become “stuck” in one of the psychosocial stages, and have difficulty managing the internal conflict of that stage. For example, if an infant experiences a world which is inconsistent, painful, stressful and threatening, they learn to expect more of the same and believe life is unpredictable and dangerous (Craig & Kermis, 1995). As play therapists, it is essential to understand these stages, recognize where the child is stuck, and help them overcome the conflict. If the child in the above example comes into play therapy, the play therapist would want to focus on building trust, and offer kindness and consistency to help the child become “unstuck”.
- **Jean Piaget and Lev Vygotsky:** both cognitive theorists, although they held very different beliefs regarding how children develop. Piaget developed a stage theory based on the child’s cognitive development. He believed children progress through stages of development based on age, regardless of culture or social context (Bloch, 1978; Walden, 1998; West, 1988; as cited in Beggs, 2004). Instead, Piaget prescribed to a more biological view of child development. Piaget

was a big proponent of play and how children communicate through this medium. He focused on the symbolic function of play and believed play bridges the gap between concrete experience and abstract thought (Landreth, 1991). For example, in play the child deals with concrete objects which are symbols for something else the child has experienced directly or indirectly. Play represents the attempt of children to organize these experiences, and may be one of the few times in the child's life they feel in control and thus more secure (Landreth, 1991). Piaget also categorized children's cognitive development through play. These categories, again defined by age, were discussed in detail in Chapter Two. The author will provide a brief overview here. Piaget's categories include practice play (sensorimotor play in infants), construction play (beginning at 15-24 months), symbolic or pretend play (most common from 2-6 years), and games with rules (ages 5 and up) (Schaefer, 1993). Vygotsky, on the other hand, believed that a child's cognitive development was influenced by social and cultural influences. Vygotsky believed children learn about the world and make sense of it by learning the shared meanings of others (Craig & Kermis, 1995). As play therapists, it is important to note this and consider the context of the child's play. Further, taking the child's social environment and its influence on the child's cognitive development is an important consideration when assessing children.

- ***Ivan Pavlov, John Watson, B.F. Skinner, and Albert Bandura:*** early psychologists who focused their research on overt, measurable, and observable behavior (Craig & Kermis, 1995). They found that children learn both functional and dysfunctional behaviors through classical conditioning, operant conditioning, and social learning. Classical conditioning is a type of learning in which a neutral stimulus elicits a response by repeated pairings with an unconditional stimulus (Craig & Kermis, 1995). The classic example of this is Pavlov's dog experiment in which he took the neutral stimulus, a bell, and paired it with the unconditional stimulus, food, to make the dog respond by salivating. Soon, he found the dog would salivate by merely ringing the bell. Operant conditioning is a type of conditioning that occurs when an organism is reinforced for voluntarily emitting a response (Craig & Kermis, 1995). What is reinforced is then learned. The

difference between operant and classical conditioning is that in operant conditioning, behavior cannot be elicited automatically (Craig & Kermis, 1995). The behavior must occur before it can be strengthened by conditioning or before it can be associated with a reward. Social learning is a theory in which people adjust their behavior based on noting the consequences or rewards of their own behavior (Craig & Kermis, 1995). For example, people notice which actions succeed, fail, or produce no result, and then adjust their behavior accordingly. Mainstream behaviorism has merged with cognitive theory to form cognitive-behavioral therapy. This integration has recognized the importance of thoughts on behavior (O'Connor, 2000). This has led to the recognition of more complex and individual behavior patterns. The cognitive-behavioral model looks at the interaction of an individual's cognition, emotion, behavior, physiology, and environment (Beck, 1967, 1972, 1976; Beck & Emery, 1985). These two theories have gone on to influence the development of Cognitive Behavioral Play Therapy (CBPT), as discussed in Chapter Two.

- **John Bowlby:** developed attachment theory. Bowlby believed attachment was based on ingrained behaviors in both the infant and the caretaker. He worked with Mary Ainsworth to develop his theory. Bowlby and Ainsworth believed that the child and caregiver's attachment relationship in the first 2 years of life forms the basis of all future relationships (Craig & Kermis, 1995). Because of this, it is the opinion of the author that understanding attachment theory is one of the most important fundamentals for a play therapist. Bowlby also found the quality of attachment relationships leads the child to form beliefs about him or herself. He coined this concept "internal working model". This internal working model is a set of beliefs about the availability of attachment figures and their likelihood of providing support in stressful times (Berk, 2003). The child's interactions with these attachment figures lead to core beliefs about him or herself and act as a guide for all future relationships (Berk, 2003). For example, a child who was responded to with care, sensitivity, and consistency, will develop the view that the world is a safe, secure, place. They then believe they are worthy of care and love,

hence their internal working model. These ideas build the basis for certain types of play therapy which focus on attachment, such as Theraplay.

- **Lawrence Kohlberg:** developed a theory that describes the development of moral reasoning. Piaget had previously described a two stage process of moral development. Kohlberg extended these ideas, and outlined six stages within three different levels (Craig & Kermis, 1995). Like Piaget, he believed children progress through these stages in a fixed order, that each stage builds on the preceding stage, and each stage is a whole, distinct moral concept (Berk, 2003). Kohlberg proposed that moral development is a continual process that occurs throughout the lifespan. The stages of moral development can inform a play therapist's view of their client's understanding of right and wrong. If a child client is in the preconventional level of Kohlberg's stages, morality is externally motivated (Berk, 2003). The child does what is right because that is what adult authority figures have told him or her to do and they do not want punished. This stage coincides with Piaget's preoperational to early concrete operational stage, which is from age two to six or seven (Berk, 2003). However, when the child enters the second stage of the preconventional level, the child becomes more egocentric and he or she follows rules when it is in his or her immediate interest. This type of moral reasoning occurs in Piaget's concrete operational stage, which includes children from ages six to seven years, to children aged 11 to 12 years (Berk, 2003). A child in this stage may follow the rules at school because they will get a reward, not necessarily because it is the moral thing to do. In the Conventional level, which coincides with Piaget's early formal operational stage and occurs between ages 11 to 12 years, the child desires to obey rules not because of self-interest, but rather because they want to ensure positive human relationships and societal order (Berk, 2003). In this stage a child will follow rules because they want to be viewed as a good person by their peers and family. Few children reach Kohlberg's last stage, the postconventional level. This level coincides with Piaget's formal operational stage and occurs around age 12 and older (Berk, 2003). In this stage, individuals move beyond unquestioning support for the rules and laws of their own society. Instead they view morality in

terms of abstract principles and values that apply to all situations and societies (Berk, 2003). In this stage a person is a free and willing participant in societal laws because the system brings about more good for people than if it did not exist. Further, an individual in this stage strives for equal consideration for all humans and respect for the worth and dignity of each person. For example, an individual in this stage would make decisions based on self-chosen ethics, conscience, and the good of all humanity, regardless of law or societal agreement. Understanding these stages can also help the play therapist explain the child's reasoning to his or her parents. By explaining how a child reasons morally, the play therapist may facilitate an understanding between parent and child, thus improving parent-child relationships.

CHAPTER 5 - Settings and Materials for Play Therapy

This chapter aims to provide the reader with information regarding the optimal setting for a play therapy room, as well as recommended toys and materials. Further, discussion will be provided regarding various settings for play therapy. While the most common setting for play therapy is the private practice setting or mental health center; the author will provide rationalization for including play therapy in two additional settings: schools and hospitals.

The Play Therapy Room

The playroom needs to convey a sense of warmth, security, and fun. This atmosphere is critical because it impacts the child and ultimately the therapy process. Playrooms may be a separate entity or they may just be a portion of an office. Regardless of the space, it needs to convey the message, "this is a welcome place for children".

The following list is adapted from Landreth's (1991) suggestions for the "ideal" playroom. This list includes recommendations for playroom size, location, and characteristics.

- The playroom should be about twelve feet by fifteen feet, or 150 to 200 square feet. This allows ample space for a group of two to three children, but it is not so big that the therapist will have to “chase” the child around the room in order to be close.
- The room should provide ample privacy, with no outside windows. In the case of windows, they should be covered with drapes or blinds. This privacy will give the children a sense of safety, security, and freedom to express themselves.
- The floor should have no or minimal carpeting. Vinyl floor tiles are recommended for durability, cost, and ease of replacement. If there are carpeted areas, they should be covered with sheet vinyl. These types of materials will give the child a chance to engage in “messy” play without worrying about damaging the floor.
- Wall coverings should be washable, so again, children can make messes without fear of repercussion. Washable enamel paint is preferred and the color should contribute to a bright, cheerful atmosphere.
- The playroom should be situated in an area where noise will not be a problem. It is also advisable that the playroom’s location is far enough from the waiting room as to respect the child’s privacy.
- The ceiling should be fitted with acoustical tile in order to decrease the noise level. This is especially important if the play room is adjacent to other therapy rooms.
- The playroom will need ample shelf space on at least two walls. It is important that the toys are displayed in an organized manner and easily visible to the child. It is recommended to fasten the shelves to the wall, and that they are made of a material that is sturdy enough to climb on. The top shelf should be no higher than thirty-eight inches tall.
- A small sink with cold running water is recommended. Hot water should not be available since it could possibly burn a child. A countertop with storage could accompany the sink area. This could provide an area for painting, clay, and other art work.

- A chalkboard or marker board attached to a wall or easel is useful for nonverbal expression.
- It is ideal to have small bathroom with entrance directly from the playroom. This will eliminate the need for the child to leave the playroom in order to use the restroom.
- Both child and adult size furniture is needed. Providing a child size table and three chairs along with adult chairs (for parents and therapist) is ideal. These should be made out of wood or molded plastic.
- If the budget allows, it is ideal to have a one-way mirror and sound equipment for videotaping and supervision.

The author provides these additional recommendations:

- Divide the room into sections. Have a nurturing area with pillows, blankets, stuffed animals and therapeutic books. Another area could include dress up clothes, hats, and unbreakable mirror.
- Include a sand tray area with miniatures displayed in an organized manner and grouped into categories.
- Have a puppet tree to display puppets located next to a puppet stage.

Toy Selection

Careful selection of toys and materials is essential in providing children with opportunities for self expression through their play. Toys need to have more than one use so as not to limit self expression. According to Schaefer (1993), “toys and play materials become an extension of the child’s self, just as words are an extension of the adult’s self” (p.55). Landreth (1991) echoes this when claiming that play is the child’s language and toys are their words. Based on these two statements, how the play therapist would gather that toy selection is very important. Landreth (1991) even goes so far as to advise play therapists, “Toys and materials should be selected, not collected” (p. 117).

When selecting toys, Landreth (1991) suggests the therapist ask the following questions:

- Do the toys encourage a wide range of creative expression?
- Do the toys allow for a full range of emotional expression?
- Are the toys interesting to the child?
- Do the toys contribute to expressive and exploratory play?
- Do the toys allow for nonverbal expression and exploration?
- Do the toys provide opportunities for mastery without guidance or structure?
- Do the toys allow the child to play in a noncommittal fashion?
- Are the toys sturdy for continuous and repetitive play?

It is also important to take into consideration the different ethnic and culture backgrounds of clients when selecting toys. This can be accomplished by providing dolls and doll families with various racial identities. Further, it is important to provide toys or miniatures that represent different religions or spiritual beliefs.

Kottman (2001) recommends the placement of toys remain predictable and consistent from session to session. This provides a sense of order and consistency for the child. Landreth (1991) emphasizes this by stating, “Since toys are the child’s words, the child should not have to go searching for the toys needed for expression” (p. 128).

Categories of Toys

The types of toys chosen for the playroom can determine the type or degree of expression by the child and, thus, careful selection is recommended. Toys can have a definitive purpose, such as a bop bag which invites the child to hit, punch, or kick. Other toys are nondescript, and encourage the child to use creative or symbolic expression. Blocks can become airplanes, trains, cars, fences, houses, and so forth (Schaefer, 1993). The following suggestions are provided by Landreth (1991) and Kottman (2001) and include a variety of structured and unstructured materials, designed to facilitate the child’s exploration and expression. Landreth (1991) groups them into three broad categories; Kottman (2001) describes five categories. The following list is adapted from both authors:

- ***Real-life Toys (Landreth, 1991), Family/Nurturing Toys (Kottman, 2001):*** These items are designed to represent things that may occur in the child's life or environment. Real-life toys include a doll family, doll house, puppets and nondescript figures such as a Gumby doll. These allow the child to directly express their hopes, fears, feelings, crisis situations, and family conflicts. These items also provide the child some distance from the actual events in their lives by attributing thoughts and feelings to the toys, rather than expressing them directly. Other toys in this category include cars, trucks, boats, planes, and a cash register. These toys provide the child a chance to engage in noncommittal play, without the expression of feelings. The cash register provides the child with control and a sense of order as the child sorts money and presses buttons. Kottman (2001) adds other nurturing toys to this category. She includes animal families, baby clothes, baby bottles, a cradle, a warm, soft blanket, stuffed animals/toys, sand in a sandbox, and a play kitchen with pots, pans, dishes, silverware, and empty food boxes. Kottman (2001) ascertains that these items promote the child-therapist relationship, and encourages the play therapist to choose doll families that include various ethnic groups.
- ***Acting Out/Aggressive-release Toys:*** These toys allow the child to symbolically express their anger and aggression, to protect themselves from their fears, and to explore their control issues (Kottman, 2001). Toys that can aide children in releasing their pent-up emotions include: bop bag, weapons (i.e. play guns, swords, and knives), toy soldiers and military vehicles, aggressive puppets, small pillows for pillow fights, a foam bat, plastic shields and handcuffs. By allowing aggressive play, children are able to express their intense feelings without judgment. The therapist then can reflect these feelings to the child with empathy and understanding. Later in the therapy process, the therapist can help the child to find ways to help the child cope with these intense feelings in a more appropriate, controlled manner.

- ***Scary Toys (Kottman, 2001):*** These types of toys provide the child with opportunities to deal with their fears. These toys can include snakes, rats, plastic monsters, dinosaurs, sharks, insects, dragons, alligators, and “fierce” animal puppets (i.e. a wolf, a bear, or an alligator). Kottman (2001) also suggests providing toys in the playroom that may represent a specific trauma (i.e. fire trucks and rescue vehicles for a victim of an apartment fire).
- ***Toys for Creative Expression and Emotional Release (Landreth, 1991), Expressive Toys (Kottman 2001):*** Expressive toys provide opportunities for children to express feelings, provide a sense of mastery, practice problem solving skills, and express creativity. Kottman (2001) recommends the following art mediums: easel and paints, watercolors, crayons, markers, glue, newsprint, Play Doh or clay, finger paints, scissors, tape, egg cartons, feathers, material for making masks, and pipe cleaners. Landreth (1991) encourages the play therapist to provide sand and water trays because they lack structure and can become whatever the child would like them to be. He also recommends blocks to encourage constructive and destructive play.
- ***Pretend/Fantasy Toys (Kottman, 2001):*** These toys include masks, costumes, magic wands, hats, jewelry, purses, a doctor kit, telephones, blocks and other building materials, people figures, zoo and farm animals, puppets and a puppet theatre, a sandbox, trucks and construction equipment, kitchen appliances, pots, pans, dishes, silverware, and empty food containers. These types of toys provide opportunities for children to express feelings, explore a variety of roles, experiment with different behaviors and attitudes, and act out situations and relationships that may occur in the child’s system. They also allow the child to act “as if” or describe the way they would like a certain situation to resolve.

Portable Play Therapy Rooms

Not all play therapists will have the space to create a separate play therapy room. Further, play therapists that provide play therapy in schools, hospitals, or in-home settings may need to transport supplies from one location or room to another. Landreth (1991) provides a list of toys and materials that meet the minimal requirements for conducting a play therapy session. These toys are recommended because they encourage a wide range of expression and can be transported with ease in a tote bag, suitcase, or laundry basket:

Crayons ▪ newsprint ▪ blunt scissors ▪ nursing bottle (plastic) ▪ rubber knife ▪ doll ▪ clay or Play-Doh ▪ dart gun ▪ handcuffs ▪ toy soldiers (20 count) ▪ play dishes and cups ▪ spoons ▪ small airplane ▪ small car ▪ Lone Ranger type mask ▪ Nerf ball ▪ bendable gumby or similar nondescript figure ▪ popsicle sticks ▪ pipe cleaners ▪ cotton rope ▪ telephone ▪ aggressive hand puppets (alligator, wolf or dragon) ▪ bendable doll family ▪ dollhouse furniture ▪ small cardboard box with rooms marked on the bottom (door cut in one side and windows in another or small dollhouse ▪ transparent tape ▪ costume jewelry ▪ small sand or rice tray ▪ inflatable punching bag

Play Therapy Settings

The above sections describe the ideal playroom and the ideal playroom location. This “ideal” playroom is most likely located in a private practice setting or community mental health center. The typical arrangement for these settings is to schedule a specific day and time for the client to visit the therapist in their location. However, the use of play therapy in settings other than the traditional office allows therapists to increase the availability of services for their clients. Further, when the therapist goes to the client rather than the reverse, it increases the consistency of contact with their clients.

This arrangement also makes sense from a systems perspective because it allows the therapist to have access to additional service providers. For example, if therapy occurs in a school setting, the therapist has access to the child’s teacher, classmates, and any school resources. The same applies to a child who is hospitalized. The therapist has access to the child’s medical team as well as other hospitalized children. Working within the system can provide cohesive treatment and expedite change. The following section

will provide an overview of two common settings for play therapy: schools and hospitals.

Schools:

Over the last few decades, school professionals have begun to recognize and accept play therapy as an effective therapeutic intervention with children in school settings. Play therapy can be implemented by school counselors, social workers, therapists, psychologists, or teachers. It can occur in a fully equipped play room, corner of a classroom, or in a counselor's office. Both individuals and groups can benefit from play therapy. It is important to remember that, in order to provide play therapy, the professional needs to have had adequate training and supervision. The following section will provide the rationale for implementing play therapy in school settings:

- Play therapy is developmentally appropriate. Elementary school children are developmentally in the preoperational stage (two to seven years) or the concrete operations stage (seven to twelve years). Children in these stages access information by doing (White & Flint, 1999). Since play is the child's natural medium of expression (Landreth, 1991), play therapy offers them an opportunity to express themselves and work through problem behaviors in a developmentally appropriate manner.
- Because play therapy occurs within the school setting, more children can be reached. This is true because of both location and accessibility. Play therapy can help children who may not otherwise qualify for mental health services. Although these children's behavioral and academic functioning is not severely affected, they may still experience stress that could potentially interfere with their school performance (Drewes, 2001). Stress-inducing problems include change in family status such as parental remarriage or birth of a sibling, death of a family member, parental alcoholism, relocation, hospitalization, or military deployment.
- More families can be reached. Many families of school aged children with emotional and behavioral difficulties do not have the financial resources or emotional insight to seek out mental health services for their children. They may not even be aware of the impact their chaotic or disorganized lives have on their children's

emotional or academic adjustment. Therefore, the school may be the only resource to offer preventative or interventive services to their child (Drewes, 2001).

- Schools provide the ideal environment for children's mental health services since they attend school everyday. Most children will attend the same school year after year, which affords the school clinician to have access to the child for nine months at a time. Children are readily available for appointments, and the play therapist does not have to count on overburdened parents to bring the child in for an appointment (Drewes, 2001). Further, providing play therapy in the schools eliminates the financial responsibility from parents, thus many low income families are able to receive mental health services.
- Children are familiar with the surroundings and the school staff. This allows the child to quickly build trust and form a therapeutic relationship. This can enhance the therapy process and allow the child to enter the "working phase" of therapy more quickly. The school clinician is able to provide a consistent, reliable, and stable environment for the child. Further, they offer consistent space, toys, and materials. This consistency is critical for children who come from chaotic and unpredictable environments (Drewes, 2001).
- Skills learned in play therapy can generalize to the classroom and other settings. For children with a variety of emotional disorders, anger management and appropriate expression of emotions can be taught using play therapy techniques. They are then able to try out newly learned behavioral management skills with peers. This is especially true in the group therapy format. Children are able to observe appropriate behaviors that others model, have a chance to try new behaviors in a social setting, and learn that inappropriate behaviors do not get desired results (White & Flint, 1999).
- Group play therapy allows the school professional to reach more students in a shorter period of time. According to White and Flint (1999), "the group approach is one of the most beneficial counseling tools available to the school counselor" (p.339). Group play therapy can be implemented for prevention, intervention, or crisis situations. For example, group play therapy can help students learn appropriate

- school behaviors (prevention), address problem behaviors (intervention) or help students deal with the death of a classmate (crisis).
- Play therapy in the schools affords the clinician the ability to consult with many people within the child's system. This interdisciplinary approach allows the play therapist to gather input from many other professionals that deal with the child in various capacities. Further, this provides an atmosphere in which the play therapist can offer suggestions to these various professionals to ensure the child's emotional and academic success.

Hospitals:

Hospitalization can cause angst and anxiety in anyone, and this is especially true for children. The child is placed in a strange environment with strange people who carry out all sorts of invasive procedures. For most children, this is likely an extremely traumatic, emotional, and stressful experience. Because of the stresses of hospitalization, health professionals have considered ways for children to positively cope with this experience. The application of play therapy principles can be found in hospitals internationally (Landreth, 1991). In the United States, Child Life Programs have been instrumental in incorporating playrooms and play therapy into the hospital environment (Landreth, 1991). Professionals who implement these programs in hospitals are called child life specialists and often have degrees in various fields of study, including child development, psychology, counseling, and education (Lingnell & Dunn, 1999).

The following section provides the rationale for implementing play therapy in hospitals:

- Directive play therapy can be used to acquaint children with hospital procedures. By using syringes, stethoscopes, masks, and other hospital equipment in combination with dolls or puppets, the play therapist can help the child understand medical procedures, thus greatly reducing a child's hospital-related anxiety (Landreth, 1991).
- Non-directive play allows the child to develop control over an otherwise powerless situation. By implementing non-directive play, the play therapist allows the child to choose and act out their experiences. This is a way in

which the child tries to make sense of what they have experienced and allows them control over the situation (Landreth, 1991). This type of play gives the child mastery over the situation and they can also fantasize about what they wish would happen. For example, the child may give a doll a “magic shot that doesn’t hurt a bit”.

- Group play therapy can provide relief from social isolation by providing opportunity for interaction with peers (Lingnell & Dunn, 1999). These interactions can enhance trust building as well as relationship building skills through interactions within the group. Further, the group setting provides a safe place for reciprocal relationships to form which can foster feelings of empathy, mastery, and self-esteem (Lingnell & Dunn, 1999).
- The playroom itself emphasizes health through activity, freedom of choice, mobility, and space. It allows the child to move from a passive sufferer to an active agent in their own medical care (Tisza et al (1970) as cited in Golden (1983)). The playroom also allows a natural setting in which to observe children. Physicians and hospital staff are able to observe children in this setting and more accurately judge the effects of the illness as well as the recovery process.
- Play therapy in hospitals affords the opportunities to work with the entire family system. Family play therapy increases the siblings understanding of and empathy for what their ill sibling is experiencing. Further, it allows them a chance to play an active role in their ill sibling’s hospitalization, while providing an opportunity to explore their own feelings about the situation (Lingnell & Dunn, 1999). Parents can also benefit from family play therapy by engaging in normal play with their child. This allows both parent and child to feel some normalcy in an otherwise chaotic and stressful situation. The play therapist can also teach the parents how to recognize and validate their ill child’s feelings, set appropriate limits, and help the child gain mastery over the situation. These skills can enhance the parent-child relationship, while giving the parents insight into their child’s feelings and behaviors (Lingnell & Dunn, 1999). Further, these play interactions can increase the parents feelings

of competence, when they may otherwise feel out of control and vulnerable in a crisis situation.

As emotional health improves, physical recovery becomes more rapid (Golden, 1983). Play therapy can lower the child's anxieties or at least keep them from worsening. This in turn aides in the medical care because the children become more cooperative, thus leading to quicker examinations and medical procedures that are carried out more smoothly (Golden, 1983).

CHAPTER 6 - Marketing a Play Therapy Practice

This chapter aims to provide the reader with an overview of marketing a play therapy program. This marketing overview is directed for private practice practitioners but can generalize to play therapy in other settings as well. This chapter will also afford the reader with information on how to promote the field of play therapy by following a business plan with goals and objectives.

Marketing a business is likely a foreign concept for most mental health professionals. However, play therapists in private practice are indeed business owners. The ultimate goal in marketing is for the target audience to remember the play therapist and the service they provide. Effective marketing will take time and money.

The successful play therapist will need to educate potential clients and professionals about play therapy and the benefits of this service. This education, as well as a marketing plan, will take time. Building a successful private practice does not happen overnight. The play therapist will need to remain consistent and relentless about getting their message out to the community. The following sections will provide key ideas to include when setting goals and marketing a play therapy practice.

Market Research

Before the play therapist can begin to market his or her practice, he or she will need some sort of analysis of the current market. This analysis allows the play therapist to identify a target audience, develop a successful marketing plan, and execute that plan. This initial research will also help the play therapist assess what services are actually needed in the community and how to implement those services. The following points will provide the reader with an overview of how a market analysis is accomplished.

- ***Research the competition.*** The play therapist will need to know who is providing the same or similar services in their area. This will allow him or her to recognize any gaps in services and make plans to fill those gaps. Further, the play therapist will need to know where their competition is located. This will afford the play therapist an opportunity to set up his or her office in an area that is in need of services, without saturating areas currently being served.

- ***Know the fair market value.*** What are other professionals charging for his or her services? One mistake therapists often make is charging below the market value just to secure clients. The message this sends is that their services are not worth as much as the competition. This is a disservice to the play therapist and his or her clients. The play therapist should charge fair market value for their services and decide whether they will provide sliding fee or pro bono services to a set amount of people (Austin, 2006). The play therapist will also need to weigh the pros and cons of providing discounted or pro bono services. Obviously, one of the cons would be not collecting a fee for his or her work or that the perceived value of the service is low. On the other hand, providing a sliding fee scale or pro bono services is one way the play therapist can give back to his or her community. Another benefit of providing reduced or free services is that the play therapist is able to reach out to families who may otherwise not receive therapy services.

Target Populations

The successful play therapist will need to focus on a specific target audience if they want to stand out from the crowd of other therapists in the area. A target population is a specific group of people who have similar needs. The logical target population for play therapists is children and families. While play therapy can benefit people of all ages, it is especially appropriate for children ages 3-12 (Carmichael, 2006; Gil, 1991; Landreth, 1991; Schaefer, 1993). Play therapy can also be implemented with couples and individual adults but this is not common. Targeting children and families does not mean the play therapist will never work with adults. It simply affords an audience to target your business.

By targeting a specific population, it allows the play therapist to be labeled an expert in their specific field. It is important to remember that the play therapist has the legal and ethical obligations to work only within his or her scope of practice. If a professional provides play therapy, he or she should obtain the education and supervision required to become a Registered Play Therapist (RPT). The following section provides a general list of logical target markets for play therapists.

- **Schools.** According to Turner-Clark (2005), schools with special needs programs have particular uses for play therapy interventions. By identifying the schools with these types of populations, the play therapist can target this market to gain referrals.
- **Pediatric offices.** Pediatricians frequently encounter concerned families who are dealing with the emotional and behavioral challenges of children. This is a logical target market for the play therapist and one that will likely lead to referrals.
- **Social service agencies.** Social service agencies are in the business of providing services to children and families. Further, they often provide many referrals for mental health services. By targeting these agencies, the play therapist can secure a portion of these referrals. This is especially true if he or she is the sole provider of play therapy services in the community.
- **Religious organizations.** Most clergy are not equipped to deal with the intense mental health needs that some families present. By informing the religious communities about play therapy services, the play therapist is likely to receive many referrals from this population.
- **Mom's groups.** Most communities have some type of socialization groups for mothers and their young children. MOPS (Mothers Of Preschoolers) is one example of this type of group. Targeting this population will provide a reference point for mothers concerning "normal" behavior. By sharing his or her knowledge and expertise with this population by means of speaking appearances, the play therapist will likely get referrals.
- **Child Care Providers.** Most child care providers are familiar with typical child development. However, they are usually not prepared to deal with extreme acting out, violent or regressive type behaviors. Offering child care providers education and information about typical vs. atypical child behavior, as well as how play therapy can help these behaviors, allows the play therapist to widen their referral source.
- **Other Community Agencies.** The play therapist will need to familiarize him or herself about resources offered in the community. Targeting agencies that

provide services to children and families would be an appropriate market. Each individual practitioner will need to decide which of these agencies in the community he or she will target.

- ***Other Mental Health Professionals.*** Many mental health professionals do not have the capacity or desire to work with small children. Developing a relationship with other mental health professionals can give a needed resource to those mental health professionals in their work and can afford the play therapist an opportunity to obtain many referrals.

Purpose and Goals

Before the play therapist can begin marketing their practice, he or she will need to set goals. These goals must be specific and quantify desired results. The following list provides suggestions for setting attainable goals:

- ***All goals should be concrete, realistic, and measurable (Austin, 2006).***
Completing goals in this manner allows the play therapist to track his or her progress and modify the plan as needed.
- ***Define target income.*** The play therapist will need to consider all overhead when determining his or her target income. Next, he or she should set a fee and determine the number of clients needed in order to meet the expected income. Further, the play therapist will need to set a target date. This target date provides a time line in which to attain the goals.
- ***Set short term goals (3-12 months) as well as long term goals (1-5 years).***
These are goals the play therapist will strive for in the near and distant future. The play therapist should keep in mind that, over the years, their practice may change, so their goals need to be fluid to reflect these potential changes.

Marketing Message

Once the play therapist has identified his or her target audience and set business goals, he or she will need to write a marketing message. This is a statement informing the audience about his or her services. This message should be articulated in a clear, easy to understand way. Clarity is the key to marketing (Austin, 2006). It is important for the

play therapist to articulate their services verbally and in writing in order to communicate effectively with potential clients. The play therapist should include the following proponents, adapted from Austin (2006), in his or her marketing message:

- ***Clientele.*** The play therapist needs to inform the audience about the clientele served. Most likely this will be children and families, unless a therapist specializes in play therapy with couples or adults.
- ***Information about Play Therapy.*** Because play therapy is a relatively new field, the play therapist will need to provide information about this type of therapy, including how it works, how it can help the client, what clients can benefit from it, and what the client can expect from the service. Further, it is important for the play therapist to translate psychological jargon and clinical issues into terms that clients will understand.
- ***Benefits of Services.*** The play therapist needs to clearly define the types of benefits the client will receive from therapy. This is an important aspect of marketing because consumers always want to know what's in it for them. Some of the benefits of play therapy include improving parent child relationships and decreasing acting out behaviors (Landreth, 1991).
- ***Specific types of problems.*** The play therapist will want to inform the client about any specializations of his or her service. This will be different for each individual practitioner. For example, one play therapist may specialize in attachment and trauma work, whereas another play therapist may specialize in developmental disorders.
- ***Testimonials.*** These are the stories from clients explaining how play therapy has helped his or her family. Testimonials are one way to get the message out about your work and how it can help others with their problems. The play therapist will need a release of information to publish the testimonial and should consider changing any identifying information in order to protect the client's confidentiality.
- ***Call to action.*** A call to action is an invitation for the client to contact the play therapist by telephone or email to make an appointment or inquire about

services. The only way a play therapist can help a client is if the client contacts them for services.

Marketing Strategies

The successful play therapist will need to determine what marketing methods he or she will use to attract clients. These methods may include brochures, newsletters, websites, public speaking, advertising, or direct mail.

- **Brochures.** These pamphlets are an effective tool because they provide the client with information they can read at their leisure. Brochures also afford the play therapist a means to provide the client with an extensive amount of information that can be referred to time and again. Brochures can be displayed in pediatricians' offices, school counselor offices, or any agency that serves children.
- **Newsletters and "Ezines".** Newsletters can be written by the play therapist to target current clients or potential referral sources. Publishing a quarterly newsletter is an excellent way to provide education about play therapy practice, as well as instructions to help professionals make appropriate referrals or gain an awareness of the therapeutic benefits of play for their clients. (Turner-Clark, 2005). An "Ezine" is a newsletter delivered by email (Austin, 2006). This type of marketing is free since it is generated through email. This is an excellent way for play therapists to advertise their specializations, educate clients and professionals about relevant issues, and provide online resources.
- **Websites.** In addition to having professional print materials, now more than ever it is essential to have an online presence (Austin, 2006). A website is a wide-focused marketing method that can reach an expansive audience (Turner-Clark, 2005). Websites are generally inexpensive to create and update, thus creating the opportunity to market to more people for fewer dollars.
- **Public Speaking.** This is another method of educating the public and professionals about play therapy. Beginning play therapists may want to

consider giving free talks to local organizations and clubs. Play therapists can also volunteer to speak at conferences or provide workshops on topics that are of interest to the target market.

- **Networking.** Networking provides a valuable opportunity for clinicians attempting to promote their private practice and play therapy (Turner-Clark, 2005). For the play therapist, joining advocacy groups that serve children is an excellent way to network. Attending local community events which are focused on children or families, such as a health fair, is another opportunity to network with other professionals and potential clients. Many communities have networking groups, such as the Chamber of Commerce. These types of groups provide an opportunity to meet and build relationships with other business people and professionals. Networking groups provide the play therapist exposure for his or her business.
- **Advertising.** Advertising provides the play therapist an opportunity to use the media to create awareness about play therapy. According to Austin (2006), advertising works best when the ads are targeting to a specific problem or population. For the play therapist the problem may be acting out behaviors and the population is children.

Budget, Track & Modify Results

All of the above marketing materials will cost money. Therefore, beginning play therapists want to examine their finances carefully and conduct research, regarding the cost of marketing materials. When determining his or her marketing budget, the play therapist must keep in mind the other costs he or she will incur while running the business.

The play therapist will want to track the results of his or her marketing efforts. One of the ways this can be accomplished is to include a place on the intake form for the client to describe their referral source. By tracking their marketing efforts, the play therapist will know the exact effectiveness of his or her marketing strategies. After obtaining this information, the play therapist can then modify the marketing strategies to fit the needs of the practice.

Marketing may be a “necessary evil” for play therapists but it is vital to the implementation and maintenance of a play therapy private practice. The play therapist will need to remember that he or she is only able to help people who are aware of his or her service and the way to make others aware of the service is to market it. Further, it is the opinion of the author that play therapy is a worthwhile service and the more one can inform the public, the better.

CHAPTER 7 - Conclusion

Let us review the case examples provided in the introduction:

After a few months of participating in Client Centered Play Therapy, Tyler begins to understand that he has the power within himself to solve his problems. He has discovered this through the therapeutic value of play and the unconditional positive regard offered by his therapist. Tyler began to exhibit less aggressive behaviors and his parents reported that he seemed to be a much happier child.

After a few short sessions of Theraplay, Sarah and her mother improved their relationship. Sarah's acting out behaviors lessened and she seems more confident. Sarah no longer feels the need to be in charge and her mother is more empathic towards her.

After a month of participating in directive play therapy, Jose finds that he is better able to control his anger and find alternative solutions to his problems. He has learned relaxation techniques and appropriate ways to express his feelings. His behavior and academic ability have even improved.

Maria has worked through her traumatic experiences using sand tray therapy. Maria was afraid to talk about what had happened to her but she was able to use metaphors within the sandtray experience to express her inner-most fears. Soon, she was able to come to a resolution and felt much more at peace.

These examples provide only a brief glimpse at the curative powers of play. Combined with the therapists' skilled use of specific therapeutic interventions, the results can be astonishing. The therapist can help child clients learn more adaptive behaviors when they are experiencing emotional or social turmoil. Further, through play therapy, children can learn to appropriately communicate and express their feelings, modify their behavior, and develop problem-solving skills.

This report was designed to give Masters and Doctorate level students, as well as practicing therapists, an overview of a specific mode of therapy to aid in their work with children and families. This was not intended to be an all-inclusive project, but rather an overview of play therapy. Hopefully, this report inspired the reader to learn more about

play therapy and how he or she can implement this specialized technique into his or her current theoretical understanding.

This report presented an overview of play therapy, the therapeutic value of play, and the historical beginnings of this modality. Further, because play therapy is a specialized field, the reader was encouraged to use this to create their own marketing niche. Play therapy is a fascinating modality and one that deserves a closer look by any clinician working with children and families. Play therapy holds the promise of helping the children of the future lead happier lives with fewer stumbling blocks along the way.

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