PLAYTHERAPY™
VOLUME 14, ISSUE 3 • SEPTEMBER 2019

Back to Basics

Understanding and articulating the therapeutic powers of play, and overlaying clinical theories and practical approaches is foundational to solid play therapy practice. In this issue, we asked experienced play therapists to bring us back to the "basics" of seminal and historically significant play therapy theories and one historically significant approach.

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PLAYTHERAPY™
VOLUME 14, ISSUE 3 • SEPTEMBER 2019

FEATURES

PLAY THERAPY THEORIES

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SPECIAL SECTIONS

CLINICAL EDITOR

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From the Chair

Chair Tami Langen, LISW-S, RPT-S

As I reflect on the growth and change that APT experienced in 2019, three things strike me most: connections, credentials, and communication.

APT is a growing, vibrant professional community. We recently surpassed 7,100 members, yet we remain connected through committees, Leadership Academy, Facebook, Instagram and Twitter platforms, and our state branches. These *connections* will be kindled and renewed at the APT conference in Dallas next month!

Our Approved Provider and RPT/S Credentialing programs are undergoing changes to update and strengthen the training and credentialing processes. The Credentialing program was conceived in 1993, before the advent of online learning platforms. Many thanks to our Continuing Education & Registration Committee, Credentialing Task Force, and APT Founders for ensuring that our *credentials* represent the highest standards for members and for the field.

Amid changes and growth, APT "advance[s] play therapy and provide[s] a professional and diverse community to support those engaged in play therapy practice, instruction, and supervision" (Ends Policy 5.00) by prioritizing *communication* through the Play Today e-newsletter, the *IJPT, Play Therapy™* Magazine, social media platforms, and the a4pt website. One of our professional organization's strengths is having a national office staff that offers live, helpful answers to our membership questions.

It has been extremely meaningful for me to serve as your Board Chair. Through sustained connections, bolstered credentials, and quality communication, our APT community has remained strong and committed to providing the very best services to our most vulnerable population. Thank you for being an APT member!

ENDS POLICIES

The Association for Play Therapy, a national professional society, promises to 1) advance and promote play therapy as a credible mental health treatment and, in order to better serve the public, 2) assure affordable access to information, recommended best practices, Registered Play Therapist and Supervisor credentials, education and training, and peer connections necessary to enhance the play therapy expertise and success of its member mental health professionals.

BECAUSE APT EXISTS:

5.01	The public is aware of play therapy and its positive benefits.
5.02	Mental health professionals can increase their play therapy knowledgeand expertise.
5.03	Licensed mental health professionals can earn and display credentialsto publicly promote their play therapy expertise.
5.04	Reliable and credible research supporting the efficacy of and related to the field of play therapy will be shared and opportunities for further research will be promoted.
5.05	Mental health professionals can access the benefits of an engaged and vibrant play therapy community.

APT observes the Policy Governance© Model. The board scans the mental health environment and then determines which Ends (outcomes or impacts) will best advance play therapy and assist play therapists. It then holds its only direct report, the CEO, accountable for collaborating with members to produce the programs that accomplish those Ends.

GLOBAL ENDS POLICY 5.00

The Association for Play Therapy (APT) exists to advance play therapy and provide a professional and diverse community to support those engaged in play therapy practice, instruction, and supervision.

Kathryn Lebby, CAE, CMP

PLAYTHERAPY™

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The Meta Effect in Play Therapy Research

| DEE C. RAY, PHD, LPC-S, RPT-S & YUNG-WEI DENNIS LIN, PHD, LPC-C

We have exciting news on the play therapy research front this month! Dr. Yung-Wei Dennis Lin will be co-chairing the APT research committee along with Dr. Dee Ray. Dr. Lin is an Assistant Professor at New Jersey City University and pioneer in meta-analytic techniques applied to play therapy research. In this article, we would like to introduce play therapists to meta-analysis and what it means for the everyday practice of play therapy. Both of us have been involved in the interpretation of meta-analyses of play therapy for many years and seek to transform a complex statistical procedure to viable information for play therapists.

Over the course of 80 years, researchers have sought to prove that play therapy is beneficial for children. However, a major challenge in play therapy research is that most randomized controlled studies, the type of studies that determine effectiveness, involve a small number of participants. This challenge typically limits researchers' ability to generalize their research findings on play therapy effectiveness. Fortunately, statisticians have developed a promising solution: meta-analysis. By integrating statistical findings from individual studies, meta-analysis allows researchers to overcome the limitation of small sample size and generalize research findings on treatment effect to a client population.

In play therapy research history, there are four meta-analytic studies examining play therapy effectiveness (e.g., Bratton, Ray, Rhine, & Jones, 2005; LeBlanc & Ritchie, 2001; Lin & Bratton, 2015; Ray, Armstrong, Balkin, & Jayne, 2015). Bratton et al. (2005) and LeBlanc and Ritchie (2001) explored the effectiveness of multiple play therapy approaches while Lin and Bratton (2015) and Ray et al. (2015) explored research outcomes on the effectiveness of child-centered play therapy (CCPT). These meta-analyses reviewed over 130 individual play therapy studies ranging from 1947 to 2011 and included over 5,000 children.

What do these four meta-analytic studies tell us? First of all, play therapy, including CCPT and school-based play therapy, is unquestionably effective for children in general. Among all the child participants included in these four meta-analyses, those who received play therapy treatment demonstrated statistically significantly higher improvement (0.3-0.8 standard deviations more) than those who did not. If we use human IQ as an analogy, such improvement is similar to enhancing an IQ score by 5 to 12 points. More specifically, on presenting problems, these meta-analytic researchers illustrated that play therapy is highly effective on reducing children's overall behavioral problems, personality concerns, social adjustment concerns, anxiety/fear, developmental/adaptive concerns, and also enhancing children's self-efficacy, academic achievement, and parent-child relationship.

In addition to specific presenting problems, researchers of these meta-analytic studies also presented other substantial outcomes for clinicians to share. For example:

- Play therapy is effective in a variety of settings, including school settings, outpatient clinics, residential settings, and critical-incident settings. Clinicians who work with children in these settings may consider seeking play therapy instruction and practice in order to provide this evidence-based treatment.
- There is no gender difference in play therapy effect. Both male and female children can equally benefit from play therapy.
- Play therapy is equally effective in individual and group treatment formats.
- Play therapy has been shown to be effective for children ages three to twelve years old. Children younger than 8 years of age particularly respond to CCPT with even greater effect than their older counterparts. Again, this finding confirms the general belief in play therapy that young children do not have adequate language capacity and need their natural means of communication, play, in their treatment process.
- Play therapy, especially CCPT, appears to be a culturally responsive intervention based on findings that ethnically diverse children respond to play therapy with substantial positive effects. Researchers in play therapy have made a concentrated effort to study the effects of play therapy with diverse samples of participants.
- Positive effects of play therapy can be demonstrated after one session with optimal play therapy treatment effect falling within 30-40 sessions. Play therapists may need patience in their practices and should consider encouraging parents to have more patience for their children's progress, too.
- Parent involvement is extremely important in children's treatment progress and can greatly enhance play therapy treatment outcomes. Thus, clinicians should consider involving parents in children's play therapy treatment.

With such strong and generalizable meta-analytic findings, play therapy is undeniably an evidence-based treatment for children. We encourage play therapists to share these generalizable findings to their clients and their communities. And we encourage our play therapist researchers to "research on" in the journey to initiate and sustain effectiveness research on play therapy.

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CLINICAL EDITOR'S COMMENTS:

The authors emphasize considering therapeutic powers of play before overlaying clinical theory and play therapy approaches into treatment.

The Therapeutic Powers of Play:

The Heart and Soul of Play Therapy

| MARY ANNE PEABODY, EDD, LCSW, RPT-S & CHARLES E. SCHAEFER, PHD, RPT-S, APT CO-FOUNDER

Without a doubt, the field of play therapy constitutes an enormous, burgeoning field of practice and inquiry. There are now thousands of play therapy books and articles; hundreds of trainings; numerous theories, models, and techniques; as well as a growing number of Registered Play Therapists (RPT) and Supervisors (RPT-S). Eager practitioners currently have access to a range of educational content across various delivery formats. While this explosive growth is certainly cause for excitement and celebration, it is also cause for reflection and caution. We argue that without understanding specific foundational play therapy content prior to undertaking advanced training, play therapists could easily find themselves in the middle of an expansive buffet of "too many choices" and, perhaps more alarming, practicing in a haphazard fashion.

Given that play therapy is an interdisciplinary field, most Association for Play Therapy (APT) members are already fully licensed in their respective mental health disciplines (88%) and, therefore, seek play therapy training as a secondary field of study or specialization, with 52% of the total membership having obtained the RPT/S or School Based-Registered Play Therapist (SB-RPT) credentials (K. Lebby, personal communication, February 25, 2019). Interdisciplinarity adds thought diversity and professional advantages to the play therapy field; however, having so many professions involved in the initial foundational training may make defining terms and understanding key concepts particularly confusing (Ashby & Clark, 2014; Peabody & Schaefer, 2016). Therefore, we believe a solid understanding of play therapy begins with investigating definitions, supporting evidence, and highlighting foundational content.

One foundational educational content area that we feel is essential to all play therapists, even preceding theoretical content, is a deep understanding of the therapeutic powers of play. Briefly, the therapeutic powers of play are the mechanisms in play that actually produce the desired change in a client's dysfunctional thoughts, feelings, and/or behaviors (Schaefer & Peabody, 2016). Indeed, the prominence of these powers are evident in the definition of play therapy by the Association of Play Therapy (APT, n.d). Just as an in-depth understanding of child development is foundational to play therapy, we argue that training in the therapeutic powers of play creates an understanding of why and how play creates therapeutic change. We believe this foundational knowledge is a pre-condition to effective clinical decision making and treatment planning. Furthermore, we believe the therapeutic powers of play should be listed as one of the required core content areas of study in APT's credentialing application for becoming an RPT/S or an SB-RPT, so that play therapists demonstrate full understanding of how play is the active force producing change that leads to positive treatment outcomes, regardless of theoretical orientation or preferred play therapy approach (e.g., directive, nondirective, combination).

Historically, Schaefer (1993) identified 14 therapeutic powers of play based upon a review of the literature and play therapists' clinical experiences. Later the list was expanded and revised to include 20 core therapeutic powers of play (e.g., Schaefer & Drewes, 2014). Based on similarity of treatment goals, the 20 powers were classified into the following four categories: facilitates communication, fosters emotional wellness, enhances social relationships, and increases personal strengths (Schaefer & Drewes, 2014, see Figure 1). We encourage readers to explore each of these powers in depth and to receive ongoing training and supervision in how and when to apply therapeutic powers in their clinical decision making and practice. Although the play therapy field is dynamic and ever-evolving, we believe this list of 20 is not exhaustive, thereby necessitating continual refinement, expansion, and ongoing review (Drewes & Schaefer, 2016).

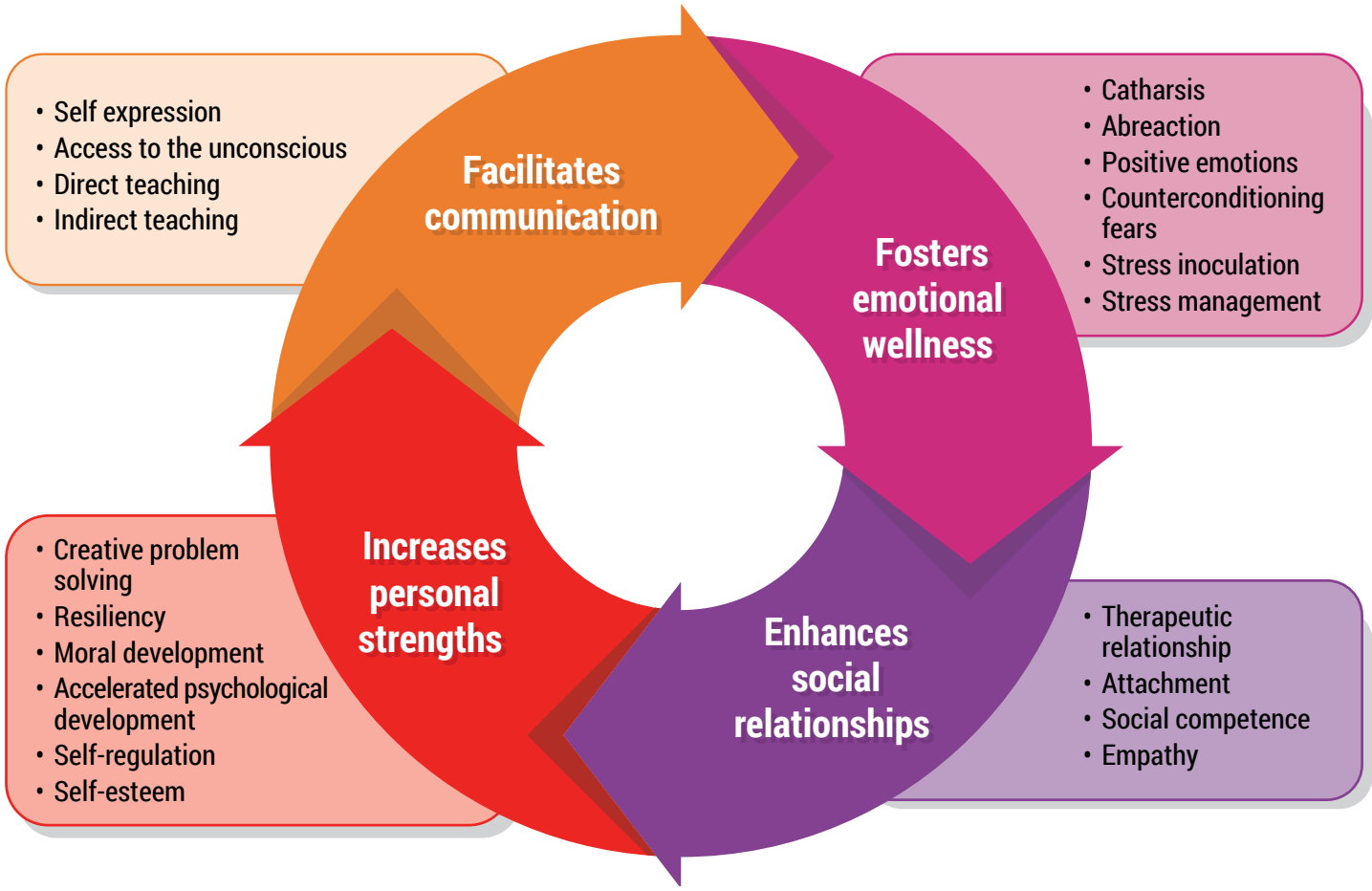

Figure 1. The 20 therapeutic powers of play. Graphic adapted and reprinted with permission from Dr. Judi Parson, Deakin University, Melbourne, Australia.

Despite the importance of understanding these change mechanisms, we also are acutely aware that knowledge of these concepts constitutes only a first step, the proverbial tip of the iceberg. Play and child therapy process research must traverse a longer journey to close the existing gap between them, and we encourage future researchers to examine and isolate these mechanisms (Kazdin, 2014; Schaefer & Drewes, 2014). Yet, gaps also can present remarkable opportunities for exploration and growth that continuously can expand our play therapy knowledge, which can result in strengthening our abilities to provide more targeted and efficient treatments.

These therapeutic powers of play have been referred to in the literature as the "heart and soul" of play therapy (Schaefer & Drewes, 2014, p. 4), exemplifying their essence in initial play therapy knowledge. With this foundational knowledge, therapists are better positioned during their comprehensive individualized assessment of each client to identify the core cognitive, affective, and interpersonal processes involved in the presenting clinical concern, and to apply specific powers of play designed to activate the desired change. Without this strong grounding, a clinician may operate with more of a "hope this works" mentality, rather than a purposeful understanding of how the therapist can initiate, facilitate, and strengthen play to impact change.

> ***"Starting with the therapeutic powers of play lays a solid foundation and provides a learning progression onto which therapists then may overlay seminal or historically significant theories or add techniques."***

Because play therapists are ethically responsible for delivering effective interventions (Bratton & Swan, 2017), we argue that effectiveness starts with understanding the therapeutic powers of play, and this foundational knowledge serves them well in the complex, advancing play therapy field. Developmentally, including the therapeutic powers of play early in their training trajectory will help students and therapists who may have somehow missed this critical content to augment their mental health practice with a play therapy approach. Starting with the therapeutic powers of play lays a solid foundation and provides a learning progression onto which therapists then may overlay seminal or historically significant theories or add techniques. This content should be covered well before engaging in advanced courses or trainings, but also should be emphasized in those, too.

Sometimes stepping back before stepping forward again can feel counterintuitive, yet centering play therapy training around the therapeutic powers of play acknowledges the deep responsibility we have in understanding how and why play fosters therapeutic change and our role in the change process. We urge play therapists to take the imperative to gain this knowledge seriously, as understanding the inner workings of the craft is a hallmark of a successful play therapist. We encourage readers to ensure that the heart and soul of play therapy continues to beat loudly, deeply, and strongly within the entire play therapy community and its practice.

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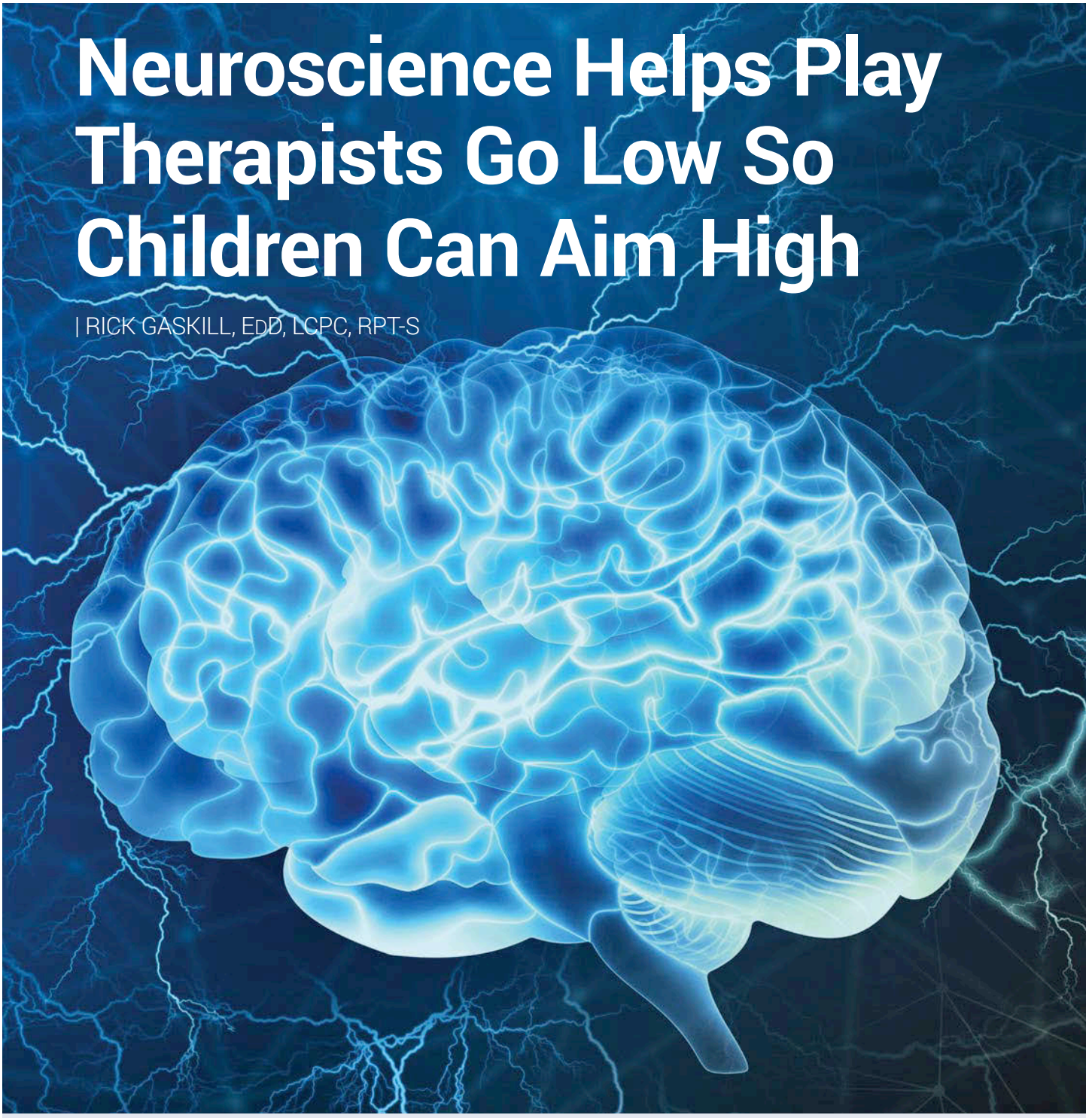
| RICK GASKILL, EdD, LCPC, RPT-S



"Traumatic experiences create alterations in key neural networks in the brain. These stress-related networks span multiple areas of the brain - from the brainstem to the neocortex, and, therefore, 'getting at' these systems in order to provide therapeutic 'activations' to create positive change is difficult using our conventional cognitive-heavy approaches. The beauty of play is that it engages these widespread networks in controllable, predictable, and moderate ways. Play engages sensory, motor, emotional, and cognitive systems. These play therapy 'experiences,' therefore, are a recipe for effective therapeutics and resilience building."

Bruce Perry, MD, PhD

CLINICAL EDITOR'S COMMENTS:

The author explains how play therapy facilitates positive neurodevelopment experiences.

This issue of *Play Therapy™* Magazine provides an extraordinary review of historically significant play therapy theories, techniques, and approaches. Incredibly, we began just 100 years ago, when Sigmund Freud conducted the first psychotherapy session with "Little Hans." After many adaptions, we have developed a wide assortment of models, theories, techniques, and associated expressive approaches. Today, play therapy is an evidence-based treatment modality. It has been a long journey, but it is not over.

The next century promises continued evolution of play therapy due in part to neuroscience. In the 1990s, known as the "Decade of the Brain" (Goldstein, 1994), neuroscience began exploring the development of the human brain through advanced imaging techniques. Through this research, science began creating structural and functional maps of neural connections in the human brain by age and diagnostic categories. Neuroscientific findings provide empirical support for and validation of many of play therapy's philosophical underpinnings and treatment models. Perry (2008) listed six core elements of positive neurodevelopmental experience, clearly illustrating support for play therapy: relevant, repetitive, relational, rhythm, rewarding, and respectful.

Relevant

To be relevant, the neural network one intends to change must be the target of activation (Perry, 2008). Systems that fail to be activated fail to change. Low-brain areas regulate homeostatic life support functions and are frequently disorganized by trauma, producing somatic symptomatology. Until these regions achieve stasis, higher-brain areas (cortex) cannot function well. This foreshadows academic failure with traumatized children. Consequently, treatment of regulatory functions must precede cognitive functions. The low brain lacks rational, logical thought and does not understand language; therefore, somatosensory activities and movement activities are generally recommended.

Play therapists are very sensitive and supportive of a child's need to play in the sand, pour water, to rock, swing, or simply to spin on a chair as regulatory processes. To adapt to older children, play therapists have developed an extensive array of expressive play activities, such as art, dance, yoga, and dramatic play. Children often choose these low-brain activities in the playroom or in their home as a way to regulate themselves. These activities supply repetitive somatic experiences, known as bottom-up therapy, and are neurologically critical to the treatment process. Neuroscience supports the notion that trauma heals from the bottom up. These activities often are more impactful if they are repeated at heart rate (60 to 80 bpm) and in a sensory modality the child finds pleasurable.

Repetitive

Long-term memories and learning are formed by repetitive experiences over time, consciously or unconsciously (LeDoux, 2015). Trauma is often associated with the lack of predictability, increased chaos, or the loss of control; the absence of positive, consistent, or repetitive experiences can trigger powerful reactions (Blaustein & Kinniburgh, 2010). Routines and predictability are critical to security, promoting a sense of safety, and learning. The low brain requires many repetitions to develop regulatory capacity.

Play therapists from all theoretical orientations promote structure and predictability for children. Keeping the play therapy room organized the same way, following the same routine in the therapy session, or honoring the child's playful rituals are methods supporting routine, repetition, and a sense of safety in the relationship and the environment. Repetition of rituals communicates unity in relationships, and that connectedness has not changed (Gaskill & Perry, 2017). Neuroscience clearly affirms repetition and routines increase learning and are calming to the brain (unconscious arousal regions). Rituals are the glue that holds relationships together. Further, neuroscience supports play therapists' use of limit setting, boundaries, positive relational experiences, and esteem building (Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005).

Relational

Neurologically, we are born to love (Szalavitz & Perry, 2010). Our health and ultimate survival depend on close relational ties with others. Neuroscience declares that human beings are interdependent creatures. Researchers suggest warm positive emotions contribute to ideal neural functioning and child development, while frowning and negative emotions suppress neurogenesis (Gaskill & Perry, 2017). Positive relational interactions regulate the brain's stress response systems and help create positive and healing neurophysiological states, promoting health and healing (Ludy-Dobson & Perry, 2010). Early experiences with caregivers become the organizing network through which children will view the world, make decisions, and relate to their community (Perry, 2001).

Play therapists have voiced the importance of attachment and relationships. Additionally, play therapists are well aware that the child-therapist relationship is pivotal to play therapy process outcomes (Landreth, 2012), as we communicate "I am here, I hear you, I understand, and I care" (Landreth & Bratton, 2006).

Rhythm

The ability to enter into an attuned state with the child is the quintessential driver/change agent of healthy development and the foundational aspect for all other core elements in play therapy (Gaskill & Perry, 2017). This attuned relationship is central to teaching children to self-regulate; thus, it is a key issue in treating poorly regulated children. Children lacking this experience have difficulty forming healthy attachments later in life.

Neuroscience posits that self-regulation is the culmination of a remarkable process of organizing and integrating profoundly complex neural networks. The attunement process creates a synchronous relationship between child and play therapist largely accomplished through face-to-face gaze, eye-to-eye contact, and suspension of one's own thoughts and feelings so as to "enter the world of the child" through his/her eyes, feelings, and thoughts (Landreth, 2012). All play therapy theories and modalities emphasize the importance of this relationship between the child and the therapist (O'Connor, 2000). Teaching these skills is a fundamental part of play therapist training (Landreth, 2012).

Rewarding

All children and all people need to experience reward. Dopamine, a neural chemical, is responsible for the pleasant feeling we experience in relationships with primary caregivers and the desire to repeat the experience with others. If we do not have sufficient injections of dopamine in our system, we become depressed and seek dopamine producing events in our lives. Human beings seek dopamine release in healthy ways (e.g., warm human relationships, spirituality, moral behavior, music, rhythm, dance, etc.) or in other ways (e.g., through drugs, alcohol, destructive sexual behavior, salt, sugar, fat, cutting, burning, etc.). Neuroscience informs us that as arousal goes up there is less activation of the reward network. Seriously traumatized children may perceive even subtle power differentials (threat), can experience greater autonomic arousal and a diminished sense of reward; they can feel paralyzed or defensive and explore the world less and withdraw (Gaskill & Perry, 2017). Play therapists have always understood that children come to the playroom and interact with us because it is fun, pleasurable, and safe (Landreth, 2012).

Respectful

Finally, a major component of creating a sense of safety, warm relationships, and a sense of relational pleasure is respect for the child's racial, cultural, ethnic, religious, spiritual, and socioeconomic background (e.g., Gil & Drewes, 2005; Gil & Pfeifer, 2016). This has always been of utmost importance to play therapists and fundamental to their training.

Conclusion

Undoubtedly, play therapy theory and practice will be required to evolve and adapt to new scientific information about the human brain. Future research and practice likely will enhance understanding of cognitive versus somatic treatment modalities, the number of positive repetitions required, and the adequate adult-to-child social ratios necessary to promote neurogenesis. Still, it is clear that play therapy approaches from all theoretical perspectives are compatible with much of the current neurological research.

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CLINICAL EDITOR'S COMMENTS:
Valente Orozco shares how he discovered Gestalt play therapy and his reasons for becoming an RPT-S.

Being Fully Present and Alive Supports Children in Experiencing All of Themselves

| VALENTE OROZCO, MSW, LCSW, RPT-S

My journey into play therapy begins with my own experience as a child. Growing up in a family where education and social justice were placed in high regard, and being the son of a college professor, I was routinely surrounded by intellectuals and messages on the importance of championing the rights of the less fortunate and underrepresented. At the same time, I was a creative and artistic young man. While the adults discussed matters of society, politics, and social issues, I felt more fully alive in my room listening to the Beatles and trying to figure out just how Jimi Hendrix played guitar like that. These early experiences initially led me towards music and education as potential fields of study.

With these experiences as my background, I entered college and became increasingly aware of the social issues of the world, in particular, the lack of voice and advocacy for children in society. The standards and expectations of our "adult" world seemed to support less and less of what I was learning about child development, my experience with my own daughter, and that with other children in my life. Passionate about advocating for children, I decided that a social work degree was the right professional choice to pursue.

After completing my formal education, I began my path to licensure. I was fortunate to have internship and work experiences with children all along the way. I joined APT and began attending various trainings in all different types of play therapy. Nearly ready for licensure, a supervisor of mine gave me *Windows to Our Children* by Violet Oaklander, PhD. It changed my life. I decided to train at the West Coast Institute for Gestalt Therapy with Children and Adolescents, the Pacific Gestalt Institute, and to undertake my RPT-S.

Completing my RPT and RPT-S were incredibly important in my work with children. Before I began my RPT training, I had worked with children for many years, and had never encountered another RPT! I began to spread the word about APT, the importance of demonstrating competence, and supporting the integrity of the play therapy profession the RPT/S credential affords for those of us who work with children. Earning the RPT and RPT-S exemplifies demonstrating a commitment to and the achievement of a high standard of practice for working with children. For trained and licensed professionals, obtaining the credentials represents a dedication to maintaining the necessary skills for responding to the needs of children and to supporting children therapeutically.

Practicing Gestalt play therapy has afforded me some of the most rewarding experiences of my professional life. Developing awareness, finding effective ways to meet needs, promoting self-expression, and genuinely BEING with one another are the processes through which I help children and their families engage. Using play to develop dialogue with a child, finding just the right crayon or musical instrument to express oneself, can be just as meaningful – if not more – than using words alone.

There are moments with a child in therapy when I recognize my own playfulness and creativity from childhood come alive in the room. In Gestalt play therapy, the more we as therapists are fully alive in the work we do with our clients, the more support there is in the relationship for children to experience all of themselves.

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ADLERIAN Play Therapy

| TERRY KOTTMAN, PHD, LPC-S, RPT-S & JEFF ASHBY, PHD, ABPP, RPT-S

Developed by Terry Kottman in the early 1990s, Adlerian play therapy (AdPT) allows children to engage in a therapeutic process that values them as creative, resourceful, and whole. AdPT combines the underlying concepts of Alfred Adler's theory of individual psychology (Adler, 1931/1958; Carlson & Englar-Carlson, 2017) with the principles and practices of play therapy and allows play therapists to develop their own style in the playroom. In AdPT, the therapist conceptualizes clients from an Adlerian perspective while strategically and systematically drawing from a plethora of directive and nondirective skills and techniques to facilitate and encourage clients to change their cognitive, affective, behavioral, and relationship patterns (Kottman & Meany-Walen, 2016, 2018). This panoply of techniquess allows therapists to develop their own unique style in a theoretically consistent way to meet the needs of a diverse range of clients.

Basic Tenets

Fundamental assumptions underlying AdPT include: (a) people are socially embedded and have a need to belong; (b) children develop feelings of inferiority and strive to overcome these inferiority feelings their whole lives; (c) people are creative and self-determining; (d) all behavior has a purpose; and (e) reality is perceived subjectively (Kottman & Ashby, 2015). Adlerians believe that people are best understood in their social context. So, in AdPT, the therapist considers the ways clients find to belong and gain significance in all of their ecosystems. In AdPT, the therapist assesses clients' social interest and devises ways to support the development of community feeling and social skills in play therapy sessions and through consultation with parents and teachers.

According to Adler, one of the basic motivations for behavior is overcoming feelings of inferiority (Adler, 1958). Young children perceive they are "less than" others because they are not as competent as older, more well-developed people in their world. Adlerian play therapists work with clients to help them develop positive ways to strive toward being and feeling adequate.

Adlerians believe that people are self-determining and creative and have the freedom to make choices about their feelings, behavior, aspects of their personality, and attitudes (Carlson & Englar-Carlson, 2017). Therefore, one therapeutic goal is helping clients recognize that they have choices in how they perceive and react to situations and relationships. According to Adlerian therapy, all behavior is purposive. Due to Adlerian theory's phenomenological perspective, in which people filter their experiences through their subjective interpretation of events, Adlerian play therapists strive to understand clients' "take" on what has happened in their lives.

Psychopathology and Client Dysfunction

Although Adlerians believe that the etiology of some psychopathology is biological in nature, Adlerians tend to view client maladjustment as discouragement (Corey, 2017). Discouraged clients are "acting as if" their self-defeating mistaken beliefs about themselves, others, and the world are true. Clients are stuck in their feelings of inferiority, either giving up and wallowing in discouragement or overcompensating by displaying a "lesser degree of social feeling and ability to cooperate" (Adler, 1958, p. 23).

Treatment Description

When play therapists ask us, "What do I do when…?", the answer is almost always, "It depends," because there is not a universal answer. Progress unfolds through the four phases of Adlerian therapy, and Adlerian play therapists combine non-directive skills with directive strategies according to the phase of counseling and clients' specific needs (Kottman & Meany-Walen, 2016). In the first phase of play therapy, building the therapeutic relationship, Adlerians are mostly non-directive, though they may sometimes use directive techniques to deepen the connection with clients.

In the second phase, exploring the clients' lifestyles, Adlerians observe clients' behavior and discover clients' intrapersonal and interpersonal dynamics using questioning strategies and strategically planned activities. In thinking about clients' lifestyles, Adlerians consider: clients' strengths; functioning at life tasks (e.g., work, love/family, friendship); family constellation (i.e., psychological birth order); goals of misbehavior

(e.g., attention, power, revenge, inadequacy); the Crucial Cs (i.e., courage, capable, connect, and count); and personality priorities (i.e., pleasing, comfort, superiority, and control; Kottman & Meany-Walen, 2016, 2018). Based on lifestyle information gathered during the first and second phases of therapy, the Adlerian play therapist develops a conceptualization and treatment plan that guides the rest of the process.

The third phase is designed to help clients gain insight into their patterns of thinking, feeling, and behaving. In this phase, the counselor uses mostly directive techniques with a special emphasis on custom-designed stories and metacommunication to enhance clients' understanding of themselves and others.

The fourth phase, reorientation and reeducation, consists of a combination of therapist-directed activities intended to teach a variety of skills including problem solving, communication, anger and anxiety management, and metacommunication designed to teach and reinforce the client's constructive patterns of thinking, feeling, and behaving. Consulting with parents (and teachers) is an essential element of AdPT that supports any changes children might make in the process, and it unfolds in parallel to the individual work with children.

Therapy Goals and Progress Measurement

In general, the goals of Adlerian play therapy are for clients to (a) feel more connected to others and be able to interact with others in prosocial ways; (b) develop and practice more positive ways for belonging and gaining significance; (c) learn to cope with feelings of discouragement and inferiority in healthier ways; (d) recognize patterns of self-defeating beliefs, attitudes, and behaviors and shift them to more constructive patterns; and (e) notice when they are stuck in feeling inferior and develop coping strategies to address this (Kottman & Meany-Walen, 2016, 2018). Because Adlerian play therapists custom-design their treatment plans and interventions for specific clients, individual therapy goals are based on the presenting problem, the underlying dynamics of clients' interpersonal and intrapersonal struggles, and they focus on the client's strengths. Depending on the client's lifestyle assessment, therapists may choose interventions to help clients become aware of the choices they have in behavior (addressing goals of misbehavior), shift feelings of inferiority (e.g., by fostering the crucial Cs), or become aware of relational styles that undermine their social connectedness and practice new styles.

Therapeutic Powers of Play

Depending on the client, the Adlerian play therapist may use any number of Schaefer and Drewes's (2014) therapeutic powers of play. Throughout the phases of therapy and through the intentional application of directive and non-directive techniques, the Adlerian play therapist may apply any and all of these powers. In AdPT, there is a special emphasis on: facilitating clients' *self-expression* by exploring the child's lifestyle; *accessing the unconscious* by helping children gain insight into their lifestyle; *creatively problem solving* through interventions designed to reorient and reeducate the child; and building *resilience*, *self-regulation*, and *self-esteem* through interventions that foster the Crucial Cs. By using *direct and indirect interventions* with clients, the Adlerian play therapist activates many of the therapeutic powers of play.

Summary

AdPT is the application of Adlerian principles through directive and non-directive play interventions that facilitate positive change in clients in fun ways for play therapists and for clients. Because they get to be themselves in the playroom and have a theoretically consistent way of guiding the process, Adlerian play therapists have access to their own set of super powers: "Go confront the problem! Fight! Win! And call me when you get back, darling. I enjoy our visits" (Disney, n.d., "Edna Mode," *The Incredibles*).

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ATTACHMENT THEORY and Theraplay®

| PHYLLIS BOOTH, LMFT, LCPC, RPT-S & SANDRA LINDAMAN, MA, MSW, LCSW, LISW

Theraplay® is an evidence-based, relationship-focused play therapy that integrates current theories of attachment, physiological state, affect regulation, and interpersonal neurobiology. It offers an understanding of the power of face-to-face synchronized, reciprocal play.

Basic Tenets

Theraplay is modeled on the responsive, attuned, co-regulating, and playful patterns of interaction between caregivers and their babies that lead to secure attachment and life-long social-emotional health. We incorporate Bowlby's (1988) suggestion: "The pattern of interaction adopted by the mother of a secure infant provides an excellent model for the pattern of therapeutic interaction" (p. 126). Theraplay assessment and treatment looks at strengths and challenges in four dimensions of caregiver-child interaction: structure, engagement, nurture, and challenge (Booth & Jernberg, 2010). The focus of treatment is the relationship itself; caregivers are an essential part of the process so that they can carry on the newly developed patterns of interaction at home. In sessions, the therapist initially guides the interaction. Progressively, caregivers take the leadership role. Regularly scheduled caregiver-only sessions allow for additional reflection and problem solving. Theraplay may be combined or sequenced with other modalities for complex problems.

Theraplay stimulates the healthy development of the emotional brain from the bottom up, working within subcortical systems of safety and defense (Porges, 2011), affect regulation (Schore & Schore, 2008), and play, care, and joy (Panksepp & Biven, 2012). Three key elements are social engagement offered by the therapist; face to face, synchronous, rhythmic, and reciprocal play; and the provision of direct nurturing via positively attending to the body, soothing, and feeding (Lindaman & Mäkelä, 2018). Theraplay sessions are designed to contain alternating sequences of up-regulating play and down-regulating care within the child's window of tolerance and optimal arousal (Siegel, 1999). These processes also apply to group Theraplay, where the focus is on leader-child and child-child relationships (Siu, 2009, 2014; Tucker et. al., 2017).

Psychopathology and Client Dysfunction

Theraplay is helpful for children, from infancy (Salo, Lampi, & Lindaman, 2010) through adolescence (Robison, Lindaman, Clemmons, Doyle-Buckwalter, & Ryan, 2009), who have difficulty with social interactions with caregivers, other children, and other adults. Their caregivers often express dissatisfaction with the caregiver-child relationship. This relationship dysfunction arises out of inadequate or negative experiences that disrupt/interfere with the sense of safety and connection that is essential for healthy family development. The source of the disruption may stem from the child, the caregivers, or from stressors in the family environment. For example:

- A child may be born with difficulties in responsiveness, regulation, and/or sensory sensitivities that make it difficult for the caregiver to attune to the child (Hiles Howard, Lindaman, Copeland, & Cross, 2018).
- Children placed in foster or adoptive families have sustained loss and very probably neglect and abuse that interfere with trusting new caregivers and forming new attachments (Weir et. al., 2013).
- Caregivers may have their own childhood trauma and attachment insecurity, mental health issues, substance abuse, and/or marital problems that make it difficult to be emotionally available, responsive, and sensitive to the child (Norris & Rodwell, 2017).
- Life stressors ranging from typical family issues of divorce, sibling birth(s), and moving homes to overwhelming experiences of medical trauma, domestic or community violence, displacement from one's country of origin, and natural catastrophes disrupt family life and the security that caregivers desire for their families (Bennett, Shiner, & Ryan, 2006; Cort & Rowley, 2015).

Treatment Description

The Theraplay treatment process begins with an assessment, including a detailed intake interview with caregivers, observation of caregiver-child interactions via the Marschak Interaction Method (MIM), and a collaborative discussion of the MIM experience with caregivers (Booth, Christensen, & Lindaman, 2011). Next, the therapist plans treatment, employing the dimensions, and has a reflective and practice session with the caregiver.

Treatment includes caregiver-child-therapist weekly sessions and regular caregiver-therapist reflective and practice sessions. Theraplay therapists plan each session to provide a sequence of positive and co-regulated experiences. Weekly sessions are 40-50 minutes long. A typical session sequence follows:

- The therapist, caregiver, and child enter the treatment space in a pleasant, connected way (e.g., holding hands and taking big steps to pillows on the floor).
- The therapist sits across from child and caregiver, notices their special personal features, and, with the caregiver's help, attends to any "hurts" the child may have.
- Up regulating activity (e.g., popping bubbles with fingers, knees, elbows)
- Down regulating, caring activity (e.g., making powder handprints)
- Upregulating activity (e.g., jumping off a stack of pillows into caregiver's arms)
- Additional sequences of up- and down-regulating activities based on the child's window of affect tolerance
- Down-regulating soothing activity (e.g., sharing a food treat, drink, song)
- Exit with caregiver and child connected (e.g., piggy-back ride to the door)

This sequence creates opportunities for many joyful and quiet moments of physical and affective synchrony, as well as interactive repair if the therapist or caregiver mis-attunes to the child. Over time, the therapist creates experiences at the edges of the child's window of tolerance to expand emotional regulation and resilience.

Therapy Goals and Progress Assessment

The goals of Theraplay treatment are to create a responsive, attuned, regulated, and supportive relationship between the child and caregivers that provides the sense of safety, connection, and empathic understanding essential to healthy development and to reduce difficult behaviors associated with presenting problems.

Progress is measured by observing the following changes in interactions during sessions: The child is better regulated with fewer instances of defensive arousal or withdrawal, seeks playful interaction with and comfort from the caregiver, and is able to explore and reach out to the world. Caregivers recognize signs of child distress and respond in calming/regulating ways and are able to reflect on their experience. The interaction between child and caregivers is characterized by attunement, synchrony, moments of meeting, relational repair, and shared joy. Formal assessment is made via pre- and post-MIMs and using standardized checklists of child behavior and caregiver stress.

Therapeutic Powers of Play

Theraplay's accepting, responsive, co-regulating *therapeutic relationship* with both caregiver and child provides a reparative experience leading to a more positive view of self, others, and the world that addresses many of Schaefer and Drewes's (2014) therapeutic powers of play. We create a safe and supportive relationship between child and caregivers, which leads to secure *attachment* and puts *psychological development* back on track. Our empathic interactive repair of mis-attunements and reflection on the meaning of the child's behaviors, supports the development of the child's *empathy.* Our focus on co-regulation and on strengthening social engagement helps the child to become more *self-regulated* and *resilient.* Our provision of soothing care and shared joyful play leads to shared *positive emotions* and builds the child's sense of worthiness, *social competence*, and *self-esteem.* We create *stress inoculation* by helping children and their caregivers to enter and stay within a window of safety, social engagement, and optimal arousal. Caregivers learn how to provide *stress management* for themselves and their child. Additionally, Theraplay facilitates *self-expression* by responding to non-verbal and verbal emotional signals that are the foundation for more complex forms of communication.

Summary

Theraplay provides the face-to-face, reciprocal, joyful, and caring co-regulating interactions characteristic of secure attachment. The focus on the caregiver-child relationship gives the caregiver new tools and a deeper understanding of the child, creating a new meaning of togetherness and supporting the child's healthy development.

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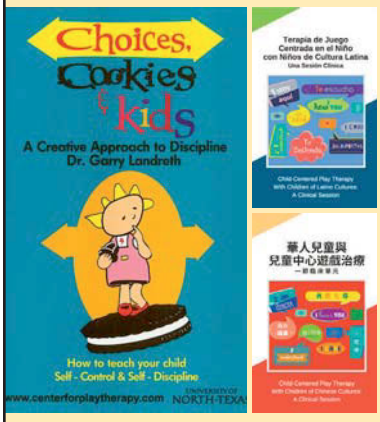

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CHILD-CENTERED Play Therapy

| DEE C. RAY, PHD, LPC-S, RPT-S & GARRY L. LANDRETH, EDD, LPC, RPT-S

Child-centered play therapy (CCPT) is a theoretically-grounded and evidence-based intervention that recognizes the relationship between therapist and child as the primary healing factor for children who are experiencing emotional and behavioral challenges. Axline (1947) developed CCPT by applying Rogers's (1951) person-centered counseling approach to children. Initially referred to as nondirective play therapy, Landreth (2012), Guerney (2001), Ray (2011), and others further defined and developed CCPT. CCPT is supported by almost 80 years of research on its effectiveness and is recognized by formal agencies as a promising evidence-based treatment (e.g., California Evidence-Based Clearinghouse for Child Welfare; APA Division 53 Society of Clinical Child and Adolescent Psychology). In separate meta-analyses, Lin and Bratton (2015) and Ray, Armstrong, Balkin, and Jayne (2015) reported that CCPT participation across varied settings and across cultures resulted in statistically significant improvements in emotional and behavioral problems and parent-child relationships.

Basic Tenets

According to person-centered theory, a child's construct of self develops through reciprocity between the child's innate self-actualizing tendency and personal perceptions of experiences and interactions with others (Ray, 2011). A child comes to evaluate self-worth based on perceived expectations and acceptance from others. Behaviors, emotions, and thoughts emerge holistically as a result of a child's view of self and ongoing experiences. Children who perceive incongruence between the way in which they see themselves and messages they receive from others are likely to develop rigid and fragile ways of being and manifest problematic behaviors, emotions, and thought patterns. "A powerful force exists within every child that strives continuously for self-actualization. This inherent striving is toward independence, maturity, and self-direction" (Landreth, 2012, p. 62).

CCPT focuses on facilitating an environment of safety, acceptance, and empathic understanding in order to unleash the child's natural tendency toward self- and other-enhancing growth. In CCPT, the therapist trusts the child's inner direction to move toward positive growth within facilitative relationships. The therapist recognizes that the best way to understand a child's behaviors and emotions is to empathically discover the way in which a child sees his or her world. CCPT is most effective when a therapist can provide, and a child can perceive, an environment and relationship accepting of the child's internal world, a relationship that leads toward personal integration and functionality (Ray & Landreth, 2015).

Perspective on Child Clients

In CCPT, the person of the child is the primary focus. Children may be referred for challenging behaviors and/or concerning diagnoses, yet the CCPT therapist seeks to build a relationship with the child, not the problem (Landreth, 2012). Maladjustment results from incongruence a child experiences between concept of self and encounters with others or the environment (Landreth, 2012). Problematic behaviors develop from an inability to reconcile self-perceptions in relationships or environmental demands. When children exhibit concerning behaviors, those behaviors are manifestations of the child's view of self and world. Hence, CCPT therapists do not view problem behaviors as representative of a deficit in the child, but as a child's attempt to be seen, heard, and accepted. Although CCPT therapists are trained in diagnosis, conceptualizing children through a medicalized, deficit-based perspective negates the very foundation of CCPT tenets and contradicts the goals of CCPT.

Treatment Description

CCPT occurs in a playroom supplied with carefully selected toys and materials that encourage the expression of a wide range of feelings, facilitate therapeutic use, and promote relationship building (Ray & Landreth, 2015). The setting often determines playroom size. Playroom materials, placed throughout the room within categories (i.e., real-life, acting-out/aggressive-release, creative/expressive), allow for visibility of each material.

CCPT practice is particularly concerned with providing an environment of safety in order to facilitate the child's exploration of self and letting go of rigid behaviors resultant from a threatened self-concept. Consequently, the child-directed nature of sessions is one unique and essential feature. The child decides session content by taking the lead in play and interaction. The therapist facilitates the child's exploration and attempts to empathically respond to the child's worldview by not guiding goals or therapeutic content (Ray & Landreth, 2015). Axline

(1947) outlined the principles of CCPT through emphasizing the primacy of relationship, acceptance, permissiveness, safety, attunement to feelings, belief in the child's ability to solve problems, allowance of child-directed play, patience with process, and limit-setting.

Specific types of responses consistent with CCPT guidelines include reflecting feelings ("You feel angry"), reflecting content ("You got in trouble at school"), tracking behavior ("You're picking that up"), facilitating decision making ("You can decide"), facilitating creativity ("That can be whatever you want"), encouraging ("You figured it out"), facilitating relationship ("You want me to know that you like me"), and limit setting. These responses are considered basic skills in CCPT and are used to demonstrate the therapist's belief in, acceptance, and understanding of the child. The CCPT manual (Ray, 2011) specifies the protocol for implementation of effective practice.

Goals of CCPT

Traditional reference to a treatment goal or objective is inconsistent with child-centered play therapy philosophy. Goals are evaluative and imply tracking specific, externally established achievements required of the client. Children should be related to as persons to be understood as opposed to goals to be checked off or persons to be fixed. Because a central hypothesis of CCPT philosophy is that the therapist has an unwavering belief in the child's capacity for growth and self-direction, establishment of treatment goals is somewhat contradictory.

However, CCPT therapists seek to facilitate an environment in which the child can experience growth, leading toward healthier functioning. The child leads the relationship where the child needs to be. When the therapist reaches the goal of providing a psychologically safe and accepting environment, the child is likely to engage in the innate process of moving toward greater independence and positive ways of being (Ray & Landreth, 2015). Although the CCPT relationship does not set specific behavioral goals, sufficient research evidence supports behavioral change as an outcome of CCPT. CCPT participation demonstrates positive and substantial change, as measured by instruments assessing externalizing and internalizing behaviors, parent and teacher relationships, self-concept, and academic achievement.

Powers of Play

The primary power of play in CCPT is the use of play as the common language between therapist and child within relationship. Play is the means by which the child contributes to the play therapy relationship and works through problems. A child is free to choose to play or not to play. Play is not applied or required by the therapist but serves as an expressive tool for children to communicate their inner worlds. Within the play therapy relationship, the child engages in self-expression, building attachment and empathy with others, problem-solving, and regulating emotions and behaviors. The powers that evolve within the relationship cultivate positive self-concept and resiliency.

Summary

CCPT is grounded in the philosophy that when children experience a genuine, accepting, and warm relationship, they will unleash their potential to move toward healthy, holistic functioning. The relational focus in CCPT philosophy lends its tenets and skills to application by systemic partners, such as parents, teachers and caretakers, through filial, child-parent relationship therapy (CPRT), and child-teacher relationship therapy (CTRT; Landreth & Bratton, 2019). The CCPT focus on a way of being with children, rather than doing to or for children, is a revolutionary approach to walking with children in their journey toward maturity, integration, and development.

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SPECIAL SECTION

FILIAL Therapy

| ROBERT F. SCUKA, PHD, MSW, LCSW-C, AND LOUISE GUERNEY, PHD, RPT-S

In 1964, Bernard G. Guerney, Jr. authored the first publication describing filial therapy (FT) and its rationale. Rooted in and developed as an extension of child-centered play therapy (CCPT; Axline, 1947), FT essentially is a psychoeducational approach to therapy that teaches parents the principles and techniques of CCPT. Parents learn to conduct therapeutically oriented play sessions with their own children under the supervision of the filial therapist. At the same time, parents are learning skills that enable them to better understand children's feelings, motivations, thoughts, and needs and more effectively respond to them at home.

Basic Tenets

FT represented a radical departure in therapeutic practice because it proposed involving parents directly in the therapy process with their children, an idea that many professionals regarded with profound skepticism. A significant part of Guerney's rationale for FT was his conviction that the medical model's emphasis on psychopathology, and in particular parental pathology as the purported source of the child's problems, was seriously misguided. Instead, Guerney's conviction was that (a) many parents simply lacked adequate parenting skills and (b) parents could be empowered to help their own children by teaching them CCPT skills, most importantly, the skills of following the child's lead, showing understanding through empathy, and limit setting. By teaching parents these skills in FT, parents would become the primary agents to achieve therapeutic goals by helping their children work through emotional challenges and/or behavioral issues. In this way, Guerney reasoned, FT would simultaneously leverage the natural parent-child bond to further therapeutic goals while strengthening the attachment between parent and child.

Suitable Populations for Filial Therapy

The most important factors regarding parent suitability for FT are the (1) level of motivation to participate in FT and strengthen the parent-child bond, (2) ability to regularly attend FT sessions and (3) willingness to carry out home sessions. Contraindications for parent inclusion in FT include: severe mental health and/or alcohol or drug dependency issues, significant cognitive limitations, extreme aggressive and/or unsociable behaviors, child endangerment issues, parental dissention around participation in FT (Guerney & Ryan, 2013).

The types of families and children that can benefit from FT include: families with difficult parent-child dynamics; children with depression or anxiety; children on the mild end of the autism spectrum disorders; children with mild cognitive deficits; children who have been adopted or fostered; children of divorce or remarriage; children with chronic or terminal illnesses; children who have experienced abuse or trauma, but currently are not in danger (Guerney & Ryan, 2013).

Contraindications for child inclusion in FT include: severe levels of unaddressed mental health issues, severe learning difficulties, psychoses, profound autism, high levels of aggression, or very serious attachment disorders (Guerney & Ryan, 2013).

Treatment Description

In its classic form, Guerney developed FT as a group therapy model in conjunction with his wife, Louise Guerney (Guerney & Ryan, 2013). Groups meet for 20 sessions for two hours, with a maximum of 10 parents and 10 children. (Adaptations of 10 to 12 sessions also exist.) Parents are brought together for the skills teaching component of the FT process. Then, each week, one or more parent-child dyads engage in a FT session while the therapist and other parents observe through a one-way mirror. Under the therapist's guidance, the group processes that parent's experience in the FT session and provides supportive feedback. All parents learn from observing each other's individual FT sessions. Parents then are prepared to conduct play sessions at home. A video is available that illustrates the group FT model (L. Guerney, 1980).

Given the challenges of assembling groups of parents on a common schedule, FT has been adapted for implementation with individual families (e.g., VanFleet, 2013). Ortwein (1997) developed a manual that filial therapists can use to train families in FT skills.

Therapy Goals and Progress Measurement

The outcome goals of FT are to:

- Provide parents with an understanding of their children's feelings, motivations, needs, and behavior and how to respond appropriately with empathy and limit setting
- Improve the parent-child relationship
- Reduce problem behaviors in children through improved self-regulation
- Increase children's self-acceptance, positive emotions, self-esteem, and self confidence
- Enhance parenting skills involving empathy, attentiveness, encouragement, and effective implementation of parental authority via the recommended approach to limit setting

Because FT was such a departure from practices of the day, B. Guerney and colleagues conducted extensive research at Rutgers University under the auspices of a 5-year NIMH grant (1967-1971) on the efficacy of mothers conducting therapeutic play sessions with their children. In a preliminary study, Stover and B. Guerney (1967) demonstrated that parents could be trained to conduct CCPT to the requisite standards of effectiveness. Further extensive measurement of mother and child responses in FT sessions over that five-year period made clear that both mothers and children met therapeutic goals (Guerney & Stover, 1971). Children demonstrated a significant reduction in previously identified problems and an increase in self-regulation, while parents experienced a significant increase in their ability to relate to their children through empathy and to manage their children's behavior more effectively. The results of this comprehensive five-year study laid the foundation for the expanded use of FT, leading it to become widely used in the US and abroad with a wide variety of populations and therapeutic issues and in a variety of cultures internationally.

CLINICAL EDITOR'S COMMENTS:

Filial therapy is an historically significant approach to play therapy. Derived from child-centered play therapy, it was intentionally placed after CCPT in this issue.

The Filial Problem Checklist (Stover, Guerney, & O'Connell, 1971) was the principle measurement instrument used for measuring pre-/post-changes in the NIMH study and in subsequent research on FT in clinical practice. It has uniformly demonstrated that parents perceive their children's behavior much more positively from pre-treatment to post-treatment and at three month intervals during treatment (e.g., Sywulak, 1979), and at three-year follow-up (e.g., Sensue, 1981). The Filial Problem Checklist remains a useful measurement instrument.

Powers of Play

FT makes systematic use of family members as primary change agents. The vehicle of change is the therapeutically oriented process of play, which creates positive bonding experiences that strengthen attachment between parent and child.

In addition, the summary NIMH report by B. Guerney and Stover (1971) showed that the process or mechanism of change was the parents' increased ability to employ acceptance and empathy, as well as allowing children to be self-directive during play sessions and employing effective limit setting to establish safety, emotional security, and respectful authority with and for their children.

> ***FT makes systematic use of family members as primary change agents. The vehicle of change is the therapeutically oriented process of play, which creates positive bonding experiences that strengthen attachment between parent and child.***

The impact of these changes in parent behavior included "significant statistical changes in children over the weeks of therapy in ratings of affection, aggression, dependence, leadership, contact with their mothers, and role-playing" (Guerney & Ryan, 2013, p. 28). Moreover, Sywulak (1979) demonstrated that the positive changes in parent variables preceded and fostered positive changes in children's outcomes.

Conclusion

A meta-analysis of all play therapy modalities for which research existed at the time (e.g., Bratton, Ray, Rhine, & Jones, 2005) demonstrated that filial therapy was the single most effective form of play therapy, proving that B. Guerney was prescient that filial therapy would have a lasting and salutary effect on the practice of both family therapy and play therapy.

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COGNITIVE BEHAVIORAL Play Therapy

| ATHENA DREWES, PsyD, RPT-S
& ANGELA CAVETT, PhD, RPT-S

Cognitive behavioral therapy (CBT) is the most researched, evidence-based, empirically-validated treatment approach that incorporates cognitive and behavioral interventions in a systematic and goal-oriented manner. When paired with play and play-based activities, cognitive behavioral play therapy (CBPT) provides a therapeutic model for how to view children's problems and provide a structure for sessions that has been shown to be effective in treating many different disorders. Children under eight do not have abstract thinking or language abilities necessary for CBT. Consequently, CBPT was developed to be developmentally appropriate by integrating play (Knell, 2011). However, CBPT has not been extensively researched, although it has been extensively utilized and written about.

Basic Tenets

CBT theory underlies CBPT practice (Knell, 2011). Based on behavioral concepts of classical and operant conditioning and social learning, the goal is to help change negative behavior. CBPT is predominantly a structured, directive and goal-oriented treatment modality that systematically incorporates empirically demonstrated techniques. It includes cognitive and behavioral interventions within a play paradigm allowing the child mastery and control over his/her environment while being an active participant in change (Knell, 2011).

CBPT focuses on the child's thoughts, perceptions, feelings, and environment, while providing a strategy for the development of more adaptive thoughts and behaviors. Traditional play therapy materials are used, especially puppets for role playing and gradual exposure, and books using a bibliotherapy approach. Play is used to teach skills, alter cognitions, create alternative behaviors, generalize positive functioning across various environments, and reduce symptoms.

Operant conditioning (Skinner, 1938) is most commonly employed through positive reinforcement of behaviors. Systematic desensitization (Wolpe, 1982), based on classical conditioning, is utilized for exposure. CBPT typically provides positive reinforcement in the form of praise or tangible rewards; psychoeducation, affect education and regulation; cognitive coping and problem-solving skills; calming skills, including relaxation and mindfulness; narratives; and exposure therapy interventions (Cavett, 2015). Caregivers are involved in treatment and taught CBPT concepts, positive reinforcement and time out, for increasing their child's expected behaviors.

Psychopathology and Client Dysfunction

In CBPT, "there is no personality theory, per se, that underlies this theory" (Knell, 2009, p. 203), rather, psychopathology is caused by unhelpful thoughts. Beck (1976) posited that irrational thoughts are the underlying reason for psychopathology, and subsequently impact feelings and behaviors (cognitive triangle). Irrational thoughts resulting from trauma, abuse, negative life events, etc., lead to negative affect (e.g., depression, anxiety) or behavior (e.g., defiance, aggression, avoidance). If thoughts are changed, then both feelings and behaviors can change.

> ***"Once the child has acquired adequate coping strategies, problem-solving skills and trauma narratives are explored through play, art, or drawing..."***

Treatment Description

Psychoeducation is integrated throughout all phases of treatment. A three-headed dragon puppet (Drewes & Cavett, 2012) helps children learn the cognitive triangle, with each head separately representing thoughts, feelings, and behaviors. Children learn how to identify and quantify intensity of feelings and understand associated physiological sensations through directive play therapy interventions (i.e., gingerbread person feelings map; Drewes, 2001) or bibliotherapy.

Once the child has acquired adequate coping strategies, problem-solving skills and trauma narratives are explored through play, art, or drawing (Cavett, 2018). Coping skills, such as relaxation, mindfulness meditations, guided imagery, and sensory experiences are taught to reduce physiological arousal and affect dysregulation. CBPT utilizes exposure therapy through

systematic desensitization for excessive fear combined with coping skills to decrease anxiety. Homework is given at each stage of therapy, so the child will practice skills in multiple settings, aiming for generalization of behaviors.

Classes of problems typically treated include internalizing behaviors (e.g., anxiety, depression, shyness) and externalizing behaviors (e.g., impulsiveness, aggressiveness, opposition).

> ***The child is praised for successful skill acquisition and positive behavioral changes are reinforced. As skills develop, negative affect or problem behaviors decrease and goals are met, child, caregiver, and play therapist work towards termination, which is framed as a graduation.***

Therapy Goals and Progress Measurement

The goal of treatment is to change behavior by changing underlying thinking and perceptions and altering reinforcers that maintain problematic behaviors. Goal setting is a critical first step, using measurable objectives for mastery. It addresses what factors are maintaining negative behavior, strengths and weaknesses in coping, and other factors influencing the problem (e.g., peers, caregivers, school). Treatment progress and effectiveness are regularly assessed, and goals revised with the caregiver, child, and teacher.

CBPT takes into account development, in particular cognitive-developmental factors, in assessment and treatment planning. Play-based activities, such as the "caterpillar to butterfly treatment plan" (Drewes & Cavett, 2012), allow the child to collaborate and participate actively in goal setting, thereby fostering cooperation and involvement in treatment.

Treatment follows a component approach, which has no fixed length of implementation. All sessions start with an agenda and homework review, threading multiple components together. CBPT incorporates the following CBT components: psychoeducation, somatic management, cognitive restructuring, time out procedures, contingency contracts, homework, problem solving, didactic instruction, behavioral shaping, modeling and guided participation, role plays, skill training, and rehearsal. In addition, child, therapist, and caregiver may co-create a specific behavioral contract, a written agreement for preventing behavioral problems. It clearly delineates expectations and rewards to avoid confusion. The child is praised for successful skill acquisition and positive behavioral changes

are reinforced. As skills develop, negative affect or problem behaviors decrease and goals are met, child, caregiver, and play therapist work towards termination, which is framed as a graduation.

Therapeutic Powers of Play

CBPT employs the majority of therapeutic powers of play (Schaefer & Drewes, 2014), allowing children to express themselves, modify cognitions, and achieve mastery. It facilitates communication using directive components to facilitate *self-expression*, and actively utilizes *direct* and *indirect teaching*. It fosters emotional wellness by promoting *catharsis* and *abreaction*. *Positive emotions* are released through non-directive play and directive play-based techniques. *Counterconditioning fears, stress inoculation*, and *stress management* are addressed through play-based directive work and therapist modeling. CBPT enhances social relationships by creating a positive *therapeutic relationship* prior to start of treatment, with goals of *social competence* and *empathy* addressed through modeling and directive techniques.

> ***CBPT employs the majority of therapeutic powers of play, allowing children to express themselves, modify cognitions, and achieve mastery.***

It increases personal strengths through use of play-based techniques and play materials that target *creative problem-solving*, behavioral rehearsal, *resiliency, accelerated psychological development, self-regulation,* and *self-esteem.*

Case Example

Jasmine (pseudonym), age 5, witnessed domestic violence and developed symptoms of defiance, mild aggression, anxiety, and depression. During the initial stage, affective psychoeducation, using dolls with feeling faces and a three-headed dragon in role play, along with a doll house, allowed Jasmine to play out scenarios from her family life while identifying and expressing feelings through her doll characters. Jasmine's mother assisted in identifying thoughts and feelings that preceded her negative behaviors, and helped her use relaxation techniques (i.e., otter breathing: breathing in and out with the waves as the "baby" otter puppet rode the waves on its mother's tummy). As treatment evolved, Jasmine used play therapy materials to reenact scenarios and verbalize witnessing domestic violence. She explored affect and beliefs that she will become like her parents, either the "hurter" or "hurted" in relationships. During the working phase of therapy, play-based techniques helped Jasmine learn non-hurtful ways to express her affect, along with systematic desensitization and exposure techniques to address separation difficulties.

Summary

CBPT is rooted in the evidence-based theory of cognitive behavioral therapy. It utilizes play and play-based interventions to help children change their thoughts, feelings, and behaviors by restructuring each in a developmentally appropriate manner. Cognitive restructuring is accomplished when there is evidence that behavioral patterns have changed, thereby offering evidence of treatment success and goal mastery.

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POINT

Speaking the Supervisee's Theoretical Language is Important

HOLLY WILLARD, MSW, LCSW, RPT-S

It is best practice for play supervisors and supervisees to have the same theoretical orientation. We cannot be "jack-of-all-trades" play therapists or supervisors. Although it is critical to have a broad foundation in a variety of treatment and theoretical models, it is just as important to find a personal theoretical orientation in which to develop expertise. In order to efficiently and ethically provide clinical supervision, we need to have extensive training and commitment to specific theoretical models. If a supervisee is rooted in a theoretical model that is outside the supervisor's competency, it is a disservice to the supervisee – and could be unethical – to provide supervision.

Play therapists must adhere to ethical codes as delineated by their licensing bodies (Donald, Culbreth, & Carter, 2015). For example, the American Counseling Association (2014) Code of Ethics recommends supervisors possess theoretical foundations for their supervision and promote interventions grounded in theory or empirical/scientific foundation (Sect. C.7, Sect. F).

According to APT's (2016, 2019b) best practices and RPT/S criteria, play therapist supervisors need to have a well-rounded education in play therapy and respect theoretical approaches to play therapy that diverge from their own. Best practices also state that supervisors should have expertise in what they are supervising and follow their licensure recommendations (APT, 2016, Sect. H).

Play therapy models range from strictly non-directive to highly directive, therefore it is important for the supervisor to have a clearly defined theoretical approach and articulate it to the supervisee (Thomas, 2015). Many supervisors use their therapeutic orientation to structure their approach in supervision, believing that modeling the theoretical approaches will help the supervisees develop the skills and experience the model (Tracey, 2006).

Case Examples

During a play therapy supervision session, my supervisee expressed feeling overwhelmed by the varying theories and interventions in play therapy. After exploring contributing factors, we recognized ultimately that she was having a hard time translating her highly directive theoretical model into a mostly non-directive model. Although there was mutual respect and understanding of each other's theoretical model, each determined that she would have a more valuable clinical supervision with a supervisor who had expertise in her specific therapeutic model.

In a consultation with a group of predominately child-centered play therapists, a supervisor expressed concerns about a supervisee's behavior. There were audible gasps from the group as she described the direct questions the supervisee used in sessions her play therapy clients. However, in a different theoretical model, the supervisee's behavior would have been appropriate and even praised. It's concerning that supervisees could experience shame unintentionally based on a difference of theoretical orientation.

Conclusion

It is the supervisor's responsibility to identify the supervisee's needs and goals for play therapy supervision (Bernard & Goodyear, 2018). Supervisees experiencing a strong supervisory alliance have a more positive view of their own abilities (Watkins, 2014) and report higher levels of satisfaction in the supervision (Thanasiu, Rust, & Walter, 2018). In play therapy supervision, we should look for the best fit of therapeutic orientation and supervision goals. Aligning supervisors and supervisees based on theoretical model encourages common therapeutic language, values, and skills to optimize learning and to promote a positive supervision experience.

THE **MIDDLE** GROUND

Theoretically Matched Play Therapy Supervision: Community Considerations

RACHEL MCROBERTS, MA, LPC-MHSP, NCC, RPT-S

A theoretically matched play therapy supervisory relationship may provide an initial alignment on common ground but is not always desired, practical, or possible due to the developmental level and professional needs of the supervisee, the widespread use of integrated approaches, and supervisor availability.

Although many play therapists may eventually choose an integrative or eclectic approach, a strong theoretical foundation is recommended for ethical and effective practice (Arthur, 2001; Bernard & Goodyear, 2018). Supervisees may have difficulty interweaving play therapy techniques into their existing theory of practice (Aguilera, 2010; Arthur, 2001; Demir & Gazioglu, 2012; Donald, Culbreth, & Carter 2015; Plchová, Hytych, Řiháček, Roubal, & Vybíral, 2016; Zhang & Sternberg, 2000).

Newer play therapy supervisees may initially question and explore their existing primary theoretical orientation, requiring supervisory assistance integrating play therapy into their working model (Association for Play Therapy, APT, 2019a). This would require a supervisor to be well versed in how to guide supervisees, regardless of the supervisor's primary theoretical orientation.

The supervisor's theoretical orientation has been shown to being highly influential on the supervisee (Fitzpatrick, Kovalak, & Weaver 2010; Murdock, Banta, Stromseth, Viene, & Brown, 1998), so goodness of fit is important. Although online supervision is becoming increasingly popular (Inman, Soheilian, & Luu, 2019), play therapists also have voiced their desire for an increased sense of community (Felton, 2016; Fountain, 2015).

There Are Other Important Aspects of Play Therapy Supervision

KAREN R. BURKE, LPC-S, RPT-S, CCST-T

Choosing the right play therapy supervisor is an important step in a supervisee's journey toward becoming a strong provider of play therapy. Many considerations should be taken into account to help build a relationship in which the supervisee can grow and flourish.

Theoretical orientation, although one facet to consider, should not overshadow other important aspects. In play therapy supervision, the importance of the supervisor and supervisee creating an environment of consistency, trust, and purposefully set goals, outranks the need for their theoretical orientation to be the same. Thomas (2015) explained that, "within play therapy, supervision approaches may vary by theoretical orientation, level of directedness, and supervision models, among other variables. The important aspect is to have a clearly defined approach that the supervisor can and does articulate to supervisees" (p. 2).

Experienced practitioners and educators use the supervision process to guide those with less professional experience and to support and challenge supervisees (VanderGast, Culbreth, & Flowers, 2010). When choosing a play therapy supervisor, it is important to choose someone who is skilled in the modality, themselves. Choose someone you can learn from and has insight to share from a path already traveled.

According to Ray (2011), play therapy supervisors should possess the knowledge, skill, and experiences of an advanced practitioner. They also should have congruence, unconditional positive regard, empathic understanding, and qualifications stemming from education on supervision, theory and practice, and tiered supervision, in addition to past and current play therapy experience (Ray, 2011). Choosing someone who has demonstrated supervision and play therapy skills, such as a Registered Play Therapist-Supervisor (RPT-S), is a step in the right direction and will be necessary for obtaining RPT/S credentials in the near future (e.g., Association for Play Therapy, APT, 2018a, p. 3; APT, 2018b, p. 23).

Another consideration that weighs in the decision to search for a theoretical match in play therapy may be the limited number of therapists qualified to provide that supervisions in a given area, if face-to-face supervision is desired. Accessibility may be especially difficult for those in rural or remote areas where play therapy supervision has not yet flourished. Saraceno et al. (2007) argued that a lack of available child mental health practitioners in rural areas leads these specialists to use their available time to provide direct services, instead of training or supervising other professionals. Although they reported on child mental health practices in low- to middle-income countries, their argument may stand for rural or remote areas in the US, as well. Therefore, trying to match theoretical orientations for face-to-face supervision could add an additional barrier to finding someone to guide supervisees as they grow into established, strong play therapists themselves.

Play therapy supervision may provide an excellent testing ground for learning and practicing different ways of helping clients through the use of play therapy techniques. Having a play therapist supervisor who has a different theoretical orientation and different approaches may offer a treasure trove of resources for the supervisee. Respect for differences in orientation or other practice variables lays the foundation for unleashing the full potential of the play therapy supervision experience. Under the umbrella of support that supervision can provide, the play therapy supervisee can take steps to enhance and strengthen skills with the important professional guidance of a play therapy supervisor.

At this time, though, APT members are not listed by theoretical orientation, which may limit informed selection of a supervisor.

A good supervisory relationship may include a theoretical match, but like all relationships, is much more complex. Supervisors must also model an aligned professional identity (Auxier, Hughes, & Kline, 2003; Bernard & Goodyear, 2018; Burkholder, 2012; Mullen, Luke, & Drewes, 2007; Phillips & Leahy, 2012; Smith-Adcock, Shin, & Pereira, 2015; VanderGast & Hinkle, 2015); and supervisor support contributes favorably to a supervisee's creativity and intrinsic motivation (Chong & Ma, 2010; Grant & Berry, 2011). Both are important for play therapists' professional development and may be obtained with a skilled supervisor of any theoretical orientation.

Play therapist supervisees are called to be self-reflective, identifying and communicating their professional development needs, such as theoretical alignment or skill integration, when seeking play therapy supervision (Bernard & Goodyear, 2018; Eryilmaz & Mutlu, 2017), especially now that new APT guidelines require supervision by a Registered Play Therapist-Supervisor (RPT-S) for credentialing (APT, 2019b). Play therapist supervisors must be aware of the complexities of factors that may influence supervisees' theoretical orientation and professional identity, including their background, values, and beliefs (Fitzpatrick et al., 2010; Vasco & Dryden, 1994); personality (Arthur, 2001; Bitar, Bean, & Bermúdez, 2007; Chwast, 1978; Scandell, Wlazelek, & Scandell, 1997); identity processing (Lile, 2017) and thinking style (Arthur, 2001; Demir & Gazioglu, 2012; Werries, 2015; Zhang & Sternberg, 2000); interactions with and emotional reactions to concepts and colleagues, and clinical experiences (Fitzpatrick et al., 2010). Listing theoretical orientation on APT member profiles could assist with choosing a supervisor when a theoretical match is desired and increasing the use of digital online classrooms for supervision (Inman et al., 2019) could encourage a stronger sense of play therapy community, and therefore professional identity, across theoretical orientations.

POINT, COUNTER POINT, THE **MIDDLE** GROUND

Must play therapy supervisors and supervises have the same theoretical orientation?

CLINICAL EDITOR'S COMMENTS:
This column features insights and differing perspectives on controversial play therapy issues. Contributors' views are their own.

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ECOSYSTEMIC Play Therapy

| KEVIN O'CONNOR, PHD, ABPP, RPT-S AND CLAUDIA VEGA, PHD

Ecosystemic play therapy (EPT) is a meta-theoretical, integrative approach developed in the late 1980s by Dr. Kevin O'Connor, co-founder of the Association for Play Therapy. EPT creatively addresses two important factors, which make psychotherapy with children different from psychotherapy with adults. Unlike adults, children undergo very rapid developmental changes. To be effective, therapists must both adapt to and promote these changes. Also, unlike adults, children are largely dependent on the systems in which they are embedded and, therefore, must rely on others to get their needs met. To address these differences, EPT draws on multiple theories, including psychoanalytic, object relations, attachment, cognitive, behavioral, family systems, and developmental, as well as multiple therapy models, including Theraplay® (Booth & Jernberg, 2010) and reality therapy (Glasser, 1975). EPT focuses "on conceptualizing children's difficulties in an environmental context and designing interventions to ensure that children's needs are consistently and appropriately met" (O'Connor & Braverman, 2009, p. xv). Although, commonly mislabeled a "directive" approach, EPT incorporates a wide variety of interventions ranging from minimally structured, child-led sessions to highly structured and targeted therapist-led interventions such as systematic desensitization or stress inoculation.

Basic Tenets

EPT therapists adhere to six basic tenets:

1. They maintain an ecosystemic perspective at all times, conducting a comprehensive, multi-systemic intake prior to initiating treatment (O'Connor & Ammen, 2013).
2. Early in the intake/treatment process, they assess the child's developmental functioning across dimensions.
3. They use the case-specific ecosystemic intake and developmental information to inform the case conceptualization and treatment plan (O'Connor, 2016).
4. Because children learn and develop best when optimally aroused, EPT therapists assume responsibility for managing the child's level of arousal during each session and throughout treatment. Further, because the amount of arousal each child finds optimal varies dramatically, as does each child's ability to self-regulate, the therapist intervenes and structures the session only when, and as much as necessary, to promote the child's ongoing growth and development.
5. They recognize that the therapist-child relationship is a necessary but not sufficient condition for treatment success. Therefore, they also develop a solid working alliance with the child by directly engaging him or her in setting the treatment goals. These goals are worded in terms of the needs the child would like to have met (e.g., spend less time being angry or spend more time having fun). Once developed, these goals are revisited at least once during every session to ensure the child knows the therapist is continuously focused on bettering the quality of his or her life.
6. They assume an advocacy role to ensure the various systems are meeting the child's needs as best they can. To whatever extent possible, the therapist works to activate systems as opposed to intervening directly. That is, the therapist works to support parents in requesting modifications to their child's educational plan as opposed to intervening directly with the child's school.

> ***"EPT promotes active, developmentally grounded interventions that engage children in problem solving"***

Psychopathology and Client Dysfunction

In EPT, psychopathology is defined as the inability to get one's needs met and/or the inability to get one's needs met in ways that do not substantially interfere with the ability of others to get their needs met (O'Connor, 1997), a definition similar to what Glasser (1975) called *responsible behavior.* Children's symptoms are understood to reflect their best effort to get their needs met in the absence of the ability

to engage in alternative problem solving or more functional behavior. Symptoms may develop due to individual, interactional, or systemic factors or, more likely, due to some combination of these.

Treatment Description

The primary focus of EPT is on the implementation of the various change processes and types of play described in the "Powers of Play" section of this article to resolve pathology and promote development. "EPT promotes active, developmentally grounded interventions that engage children in problem solving" (O'Connor & Braverman, 2009, p. xv) using a mix of experiential and cognitive/verbal interventions (O'Connor, 1994). With developmentally younger children, experiential interventions dominate and cognitive/verbal interventions serve a supporting function. As children develop, cognitive/verbal interventions take precedence so children can readily engage others outside the playroom to get their needs met. Additionally, as practitioners work "to promote growth and development on an individual level, (they) must also be committed to preserving and valuing diversity wherever and whenever possible" (O'Connor, 1997, pp. 239-240).

> ***In EPT, play is conceptualized as both therapeutic in and of itself and as the "spoonful of sugar that makes the medicine go down," that medicine being specific therapeutic change processes***

Therapy Goals and Progress Measurement

The overarching goal of all EPT is the optimization of children's functioning in the context of their ecosystem, or world (O'Connor, 1994). To achieve this, all EPT treatment plans have three common goals:

To maximize children's…

1. "… ability to get their needs met consistently and appropriately in the context of their developmental potential and their environment" (O'Connor & Ammen, 1997, p. 121).
2. Primary attachment and social relationships.
3. Developmental functioning.

In addition to these common goals, the EPT therapist may develop specific goals for the child, family, and the various systems impinging on the child's mental health and development (O'Connor & Ammen, 2013).

Treatment progress is measured in three ways. First and foremost, the therapist regularly asks both the child and the child's caregivers about their subjective experience of the progress being made toward the treatment goals. Second, EPT therapists regularly assess the child's developmental progress using measures such as the Developmental Teaching Objectives Rating Form (https://www.dtorf.com/). Finally, symptom specific measures, such as the Children's Depression Inventory 2 (CDI-2; Kovacs, 2010), are used as needed.

Powers of Play

The therapeutic powers of play "refer to the specific change agents in which play initiates, facilitates, or strengthens their therapeutic effect" (Drewes & Schaefer, 2014, p. 2). In EPT, play is conceptualized as both therapeutic in and of itself and as the "spoonful of sugar that makes the medicine go down," that medicine being specific therapeutic change processes. EPT recognizes six broad categories of play: physical (gross and fine motor), challenge/mastery, creative/constructive, language/communication, pretend/imaginative, and games with rules (Hughes, 2002; Parten, 1932; National Council for Curriculum and Assessment, 2009). These different types of play can facilitate the implementation of any of 23 change processes, organized in the following six categories (items from Drewes & Schaefer [2014] are *italicized*, items from Shirk & Russell [1996] are preceded by an asterisk [*]):

- Biological: physical-medical intervention, relaxation, stress release, and physical/ motor development
- Behavioral: *stress inoculation, desensitization,* and behavior modification
- Cognitive: *schema transformation, *symbolic exchange, interpretation, and *skill development
- Emotional: *catharsis*/*release, **abreaction*, *emotional experiencing, *affective education, and *regulation of emotions (i.e., *stress management*)
- Interpersonal: *validation and support; *supportive scaffolding, *corrective relationship, and collaboration
- Sociocultural: identity development, enculturation, and acculturation

The EPT therapist ensures the appropriate combination of play and change processes are used to resolve the child's difficulties and promote healthy development.

Summary

EPT is both a theory and a model of play therapy. As an integrative metatheory, it includes concepts from multiple theories and strategies from evidence-based play therapies (O'Connor, 2016). As a treatment model, EPT's systemic, developmental, and goal-oriented foci make it suitable for children of any age and with a variety of presenting problems (O'Connor, 2016).

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ADAPT: A Developmental, Attachment-based, Play Therapy

Authored by Jennifer Lefebre, PsyD, RPT-S
2018: CreateSpace Independent Publishing Platform
ISBN-13: 978-1478100942

The purpose of this book review is to share a content summary and to provide a brief evaluative discussion of *ADAPT: A Developmental, Attached-based, Play Therapy: A group treatment for children with complex trauma and attachment disorders* (Lefebre, 2018). The author presented the ADAPT model, designed as a 10-week play therapy group for children ages six to nine years old and their caregivers. The ADAPT model focuses on enhancing healthy attachments and alleviating trauma symptoms via play therapy activities that teach stress relief, emotional regulation, social, and mindfulness skills.

Lefebre (2018) provided a brief overview of attachment and trauma, shared the purpose of the ADAPT model, outlined the structure of each group session, and provided supplemental handouts and activity sheets. The ADAPT model is easy to understand, provides helpful mnemonics, and can easily be integrated into clinical treatment. Its advantages include scripted activities, pre-made handouts, and parental collaboration throughout the group process. Broadly, this book aids in encouraging additional play therapy group manual publication.

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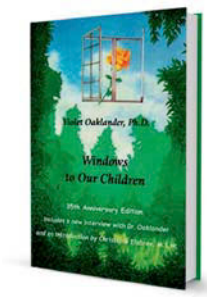
Windows to Our Children



Authored by Violet Oaklander, PhD, LMFT
2015: The Gestalt Journal Press
ISBN-13: 978-1938304026

Windows to Our Children is a cornerstone resource for all mental health practitioners around the world who work with children and adolescents. The book provides a keen perspective that allows the reader to witness the power behind various creative and expressive interventions utilizing the Gestalt therapeutic approach. Dr. Violet Oaklander conveyed the importance of children becoming aware of themselves and their overall existence in the world.

Dr. Oaklander explored the therapeutic use of fantasy, drawing, art construction and collage materials, storytelling, and various sensory experiences. She then elucidated the developmental purpose and curative qualities of the play therapy process. She also discussed some of the typical problem behaviors children present with when beginning therapy and identified approaches to assist children and adolescents in confronting and reducing these struggles. Of particular importance, she articulated how these behaviors serve as a protective mechanism and a means for mustering strength and surviving. She does not simply explain these interventions and play therapy processes; rather, she applies each activity to case material. The authentic application of each technique amplifies and solidifies its lessons and usability.

The 35th anniversary edition of *Windows to Our Children* also provides an intimate interview with Dr. Oaklander. It is enjoyable and personable to witness a behind-the-scenes look at one of the pioneers and major influencers on the field of play therapy. She provided insights about her process of writing this instrumental book and shared various experiences lived throughout her career. This book is a must-read for all child and adolescent clinicians!

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GESTALT Play Therapy

| FELICIA CARROLL, LMFT, RPT-S & VALENTE OROZCO, LCSW, PPS, RPT-S

In the 1970s, Violet Oaklander, PhD, was a classroom teacher of emotionally disturbed children while she trained to become a Gestalt therapist. She used creative modalities with her students, including clay, puppets, sand tray, drawing, to support greater awareness and integration. One of many originators of Gestalt Therapy, Frederick Perls, MD (1975), wrote, "The criterion of a successful treatment is the achievement of that amount of integration that leads to its own development" (pp. 52-53). In healthy growth and development, the child's behavior is purposeful, balanced, flowing from one experience to another. That is, it is integrated.

Oaklander, like many child therapists before her, applied theoretical and clinical concepts to the endeavor of therapy with children (Carroll, 2009a). In her book, *Windows to our Children: A Gestalt Therapy Approach to Children and Adolescents*, Oaklander (1978) presented the Gestalt approach to therapy with children and has inspired child therapists internationally.

> ***"From the Gestalt perspective, the symptoms that bring a child into therapy are indications of the child's unfulfilled attempts for self- regulation and in being supported in his worlds of family, school, and community."***

Basic Tenets

The principles of Gestalt play therapy are rooted in neuroscience, philosophy, organismic functioning, field theory, the arts, and knowledge of human development. Two major tenets that inform the therapy process are elaborated. Others are discussed throughout this article.

Organismic Regulation

Humans are organisms that strive for life and connection. The organism, using the functions of contact (e.g., senses, movement, emotion, and problem solving), directs its awareness towards identifying a need/want. With adequate self-support and environmental support, the need/want can be satisfied within given conditions. Yet, the child can interrupt this natural process to adapt to the demands of socialization, which can result in symptoms. The therapist attends to the child's adaptations of somatic states, emotional expression, and problem-solving skills. She provides support for him to re-experience his process of organismic regulation. As the therapy progresses, the child becomes more integrated with a greater sense of well-being and aliveness (Oaklander, 1978, 2006).

Dialogic Process

Gestalt play therapy is a mutually engaging relationship. The dialogic process (Carroll, 2009b; Oaklander, 1978, 2006) involves a relationship where child and therapist are impacted by each other. This relationship looks like an improvisational dance—spontaneous, interchanging roles, responsiveness. It requires the fully engaged presence of the therapist and the capacity to respond to her felt sense of the child's experience as expressed in language, creative modalities, and body tone. When the therapist and child confirm the meaning of these experiences together, the therapy process deepens.

Psychopathology and Client Dysfunction

The Gestalt play therapist observes and learns how the child attempts to get relational, emotional, physical, social, and intellectual needs/wants met. The child's developmental history is needed to understand the context and progression of the child's symptoms (Siegel, 1999, 2011). Current relational and self-supports are assessed. From the Gestalt perspective, the symptoms that bring a child into therapy are indications of the child's unfulfilled attempts for self-regulation and in being supported in his worlds of family, school, and community. The child's process towards growth and development

is interrupted and the child makes adaptations. The energy that the child would use for functional life activities is blocked, misdirected, or even denied expression. Behavioral, relational, emotional, and even physical symptoms can result. Some symptoms may be indications of neurodevelopmental or medical issues that must be carefully assessed for needed adjunctive specialized treatment (Grant, 2018).

Treatment Description

The Gestalt play therapist is responsive to the child's therapeutic core issues. Throughout the therapy process, the therapist focuses on the child's supports and how the child organizes his experiences and gives them meaning. There are certain elements that serve to guide the therapist through her reflections on the needs of the child and making decisions about effective interventions (Oaklander, 1978, 2006).

The most essential element is the necessity of sustaining the child and his parents' trust and promoting safety and security in the relationship. The child learns why he is brought to therapy so that he can participate in establishing consent, goals, expectations, and interventions.

Oaklander (1978, 2006) identified additional elements of the Gestalt therapy process. These are areas to explore, usually non-sequentially, to co-create experiences that support the child's ability to use his contact functions in order to strengthen his sense of self and support integration (see table, next column).

Elements of Therapy	Possible Modalities
Experiencing the contact functions and the child's process of making contact.	Sensory/body activities
Strengthening self-support and the child's sense of self.	Sand tray, drawings, games
Understanding emotions and emotional expression.	Books, music, role play, clay
Developing the capacity for an accepting, nurturing relationship with one's self.	Puppets, drawings
Experimenting with new ways to get needs/wants addressed.	Roleplay, homework
Building appropriate support with parents, teachers, etc.	Parent consultations
Closing the therapeutic experience.	Family involvement, acknowledgements

The therapist uses clinical judgment, therapeutic skills, and play therapy to provide enjoyment, interest, and depth to this process (Carroll, 2009b; Oaklander, 1978, 2006). Gestalt play therapy is grounded in an awareness of the culture of childhood and is informed by areas of diversity in planning clinical interventions.

Therapy Goals and Progress Measurement

The goal of Gestalt play therapy is integrated aliveness – the

networking of all organismic functions so that the child's basic physical, developmental, social, emotional, and intellectual needs/wants are understood and organized. Integration is an emergence that is not easily measured but is experienced.

The child who is integrated is very different from the symptomatic child whom the therapist meets initially. He is spontaneous and curious, playful and compassionate, energetic and responsive, active and quiet. He understands the meanings of emotions and how to regulate them. He allows himself to learn to the best of his abilities. He loves and allows himself to be loved. He is discriminate in relationships. He possesses a cohesive narrative of his lived experience that addresses the difficult and traumatic experiences of his life (Carroll, 2013). When the integrated aliveness of the child is present and daily life becomes easier, the readiness for therapeutic closure develops (Landreth, 2012).

> ***"The Gestalt approach provides a way for the therapist to understand the adaptive patterns and core issues that underlie a child's way of being in the world that cause him to need therapy."***

Powers of Play

From the Gestalt perspective, play is essential for integration. A playful attitude is necessary for curiosity and learning and is basic to social learning and problem solving (American Journal of Play, 2010; Panksepp, 1998; Schaefer & Drewes, 2014). The therapist heightens the child's awareness of the issues in his life through processing the creative modalities of play (Oaklander, 1978, 2006). In therapy, a child learns who he is and who he is not, what he wants and what he does not want. He develops mastery in many areas including emotional expression and social relationships. He learns to cope with frustration and learns from mistakes and losses. Play ties the experience of the child and therapist together and allows for the emergence of an awareness of possibilities that are novel and interesting.

Summary

The Gestalt play therapist is especially interested in how the child attempts to meet his needs/wants in conditions of non-support. The Gestalt approach provides a way for the therapist to understand the adaptive patterns and core issues that underlie a child's way of being in the world that cause him to need therapy. The process of Gestalt play therapy is a relational, creative, playful endeavor that results in the natural organismic integration of the child and a playful attitude in his life.

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JUNGIAN ANALYTICAL Play Therapy

| JOHN PAUL, "J.P." LILLY, MS, LCSW, RPT-S & ROSALIND HEIKO, PHD, RPT-S, ISST, NCSP

Jungian analytical play therapy (JAPT) believes that the therapeutic power of healing and transformation comes directly from within the child, and not from any outside technique/person. The source of that change lies within the unconscious; and healing is manifested symbolically through the process of play. Play is the method by which children are empowered to engage with difficult material. Through play, children make the ineffable distinguishable and audible, and are able to achieve healthy transformation.

Basic Tenets

Fundamental to understanding the basic tenets of JAPT is comprehension of the structure of the psyche in children, and the process of ego development (Edinger, 1992). Three distinct components of the psyche are: the conscious, the ego, and the unconscious. Consciousness is divided into two parts – personal and collective. As experienced by the individual, consciousness is connected to perception and reflection, learning and retention, differentiation and discrimination, as well as adaptation. Of course, chronological age, environmental influences, emotional experience, and expression and cognition greatly influence children's development (Ault, 1977).

The ego is that part of the psyche that mediates between consciousness and unconsciousness, concerning itself with cognition, maintenance of personality, personal identity, and learning. Fordham (1973) postulated that it gains its strength throughout life through a process of fragmentation (deintegration) when something new or stressful is encountered; and uniting and healing itself back together (reintegration) when skills are learned and used to resolve tensions following a new or stressful event.

The unconscious is also divided into two fundamental parts – the personal and the collective. The language of the unconscious is not expressed through words; but manifests through images, symbols, dreams, metaphors, and archetypal material. The personal unconscious holds the experiences of the person's life, while the collective unconscious holds the entire history of humankind. As the unconscious holds all of the necessary components for mastery, the JAPT practitioner promotes empirical manifestation of the healing language of the child through the symbolic language of play.

> ***"Client dysfunction in this model is found in all regions of the person's psyche, through the dysregulation of the ego in its relationship to the conscious and unconscious aspects of the psyche."***

Psychopathology and Client Dysfunction

Client dysfunction in this model is found in all regions of the person's psyche, through the dysregulation of the ego in its relationship to the conscious and unconscious aspects of the psyche. Psychic material can be repressed into the unconscious in the form of a protocomplex (Peery, 2003). Over time, this evolves into a full complex that Jung referred to as a "sub-personality," leading to demonstrating definable "symptoms," accompanied by powerfully charged emotions attached to an archetypal core. The child has no conscious awareness of the repressed material but is susceptible to being "triggered" by events on a conscious level. In this case, the unconscious becomes the receptacle for overpowering material, and is also the basis for transforming and resolving what initially overwhelmed the ego and began the process of dysfunction.

Treatment Description

Treatment begins with thoroughly examining the family system through three generations. Recent developments in epigenetics (Lucero, 2018) indicate that parents' unresolved issues can be passed down, picked up, and acted out by their children. So, we assess familial, developmental, medical, learning, social, and emotional history. JAPT, similar to neurological models, is a "bottom-up" approach (cf. Gaskill, 2019, this issue), focusing on developmental delays, trauma history, etc. Jungian therapists examine "symptoms" and behaviors to discover why and under what conditions they occur (Jung, 1960).

> ***JAPT assists the healthy attachment process and provides a container for the child to discover and integrate improved social competence and ego-adaptive functioning. The JAPT therapist models empathy for the child during play through attention given to behavior, thought, and especially emotions.***

The principle of temenos (the child's perception and experience of the play therapist, the play therapy room, and the therapeutic environment as safe and sheltered), is vital in the engagement with repressed or blocked material. The JAPT therapist vigilantly creates a safe and nurturing relationship with the child (Green, 2009), similar to a child-centered approach (Lilly, 2015). JAPT therapists use a myriad of techniques to create temenos, including directive and behavioral ones.

One of the defining features of JAPT is that the therapist is as much a part of the play therapy room as the play materials. The JAPT therapist must do her own therapy work in order to distinguish the boundaries and intersections of her issues and those of her clients through transference and countertransference. The roles of the JAPT therapist are Witness, Container, and Interpreter (Lilly, 2015). As Witness, we track behaviors/emotions when the child engages in therapeutic play. As Container, we hold shared client material in a self-aware/self-regulated state. As Interpreter, we facilitate the process of making unconscious material conscious, bridging client resolution of the "tension of opposites" through the transcendent function, where a new perspective is formed. Often children are unaware of this process, as therapists stay in the metaphor of symbolic play to maintain temenos while commenting on the engagement and resolution of the material.

Therapy Goals and Progress Measurement

The goal of JAPT is to assist the child in engaging disturbing material safely so that she can use the symbolic materials (i.e., toys) to activate the archetypal "inner healer" to resolve complex dynamics and tensions responsible for symptomatic behavior.

JAPT therapists must create temenos in the playroom with the child, subsequently providing an environment within the play therapy room that allows the child to engage with difficult material that has caused deintegration, which disrupts the child's ego adaptive functioning (i.e., behavioral/emotional symptoms). JAPT practitioners work to understand symbolic play, which connects to the child's proto-, or fully developed, complex. Finally, JAPT therapists assist the child in recognizing some resolution of the tensions and complexes by making the unconscious conscious.

Therapeutic Powers of Play

JAPT is powerfully applicable to all the therapeutic powers of play (Schaefer & Drewes, 2014). JAPT facilitates communication by allowing for the child's full *self-expression, accessing unconscious material* through *direct and indirect teaching* to create and maintain temenos.

JAPT fosters emotional wellness by allowing for full engagement, leading to *cathartic* work. A full range of emotions are allowed: *abreaction, positive emotions,* and deeper complex work. *Counterconditioning fears* becomes a natural result of safe engagement. *Stress inoculation* and *stress management* empower the child through metaphors of change.

Establishing a trusting *relationship* is key. JAPT assists the healthy *attachment* process and provides a container for the child to discover and integrate improved *social competence* and ego-adaptive functioning. The JAPT therapist models *empathy* for the child during play through attention given to behavior, thought, and especially emotions.

Creative problem solving is enhanced when the child's healer archetype is activated. Repeated engagement opportunities increase ego *resiliency* and adaptive functioning. JAPT offers children opportunities to experience a calm environment in which to continue their development. This approach directly and indirectly fosters *self-regulation*, improving *self-esteem*. Learning to engage with and resolve complex material allows the child to discover new choices that are both socially and even *morally* acceptable.

Summary

Play therapists looking for a challenge in developing their expertise in analysis and interpretation in depth with child clients can find it in the theory and practice of JAPT. This requires engagement with clients in a safe space with dedicated attention to the therapeutic relationship, integrating Jungian concepts and interpersonal dynamics with expressive techniques, practicing exploration of the child's deeper meanings and spiritual connection towards healing and mastery.

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Staff Update

As APT membership continues to grow, so does the APT Staff! In order to meet the needs of our now more than 7,100 members, APT welcomes **Veronica Martinez** and **Yasmin Holt** as the newest members to join our team.


Veronica Martinez

Veronica graduated from California State University, Fresno (Fresno State) with a BA in Communicative Disorders (Speech Pathology Option), where she previously worked as a Student Office Assistant. Veronica now brings her strong clerical skills to APT as the newest Clerical Assistant, supporting membership, processing store orders, sending news releases, and fulfilling an array of other duties. Veronica received a very special Mother's Day gift earlier this year - a new baby girl! She is now a proud mother of two, with a four-year-old son and a baby girl who will be six months old this November.


Yasmin Holt

Yasmin also graduated from California State University, Fresno (Fresno State) with a BA in Psychology. During her time at Fresno State, Yasmin volunteered with the Peer Ambassadors of Wellness at the Student Health and Counseling Center, where she became an advocate for mental health and presented on a variety of topics, included anxiety, stress, and depression. She settled in Fresno after moving frequently in her youth due to her dad's military service. (Thank you for your continued service Senior Chief Petty Officer Holt!) She aspires to enter Fresno State's Social Work Master's program to reach her goal of working with children from military families. As the new Credentialing Program Assistant, Yasmin will be assisting the credentialing department with various upcoming projects!

Membership Campaign

APT congratulates the 2019 Membership Campaign winners, **Nicole Bartlett,** MA, LPC-S (LA), **Kathryn Clayton,** MA, LPC, RPT-S (MO), and **Kimberly Mossman,** MSW, EdS, LICSW, RPT-S (MA). These three lucky APT members referred one or more new members during the annual Membership Campaign (March 1 – June 30, 2019) and were entered into a random drawing to win one of following prizes:

- **Bose speaker ($100 value)**
- **Nespresso machine ($175 value)**
- **$250 Amazon gift card**

Thank you to all the APT members who did their part in growing the play therapy community by referring new members!

- CALENDAR -

SEPT. 5	APT Annual Conference Early Registration Deadline
OCT. 1-6	APT ANNUAL CONFERENCE
OCT. 25-29	APT to exhibit at AAP in New Orleans, LA
DEC. 13	Leadership Academy Enrollment Deadline for 2020 class
JAN. 24	2020 Annual Conference Proposal Deadline
MAR. 15	Awards of Excellence Nominations Due
MAR. 31	Board of Director Candidate Questionnaires Due

New Office Extensions

APT installed a new phone system in July, giving the APT staff a new set of extensions. As always, we welcome your call!

Veronica Martinez	559-298-3400 x 304
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Esther Gomez	559-298-3400 x 306
Megan Dawes	559-298-3400 x 308
Yasmin Holt	559-298-3400 x 309
Alex Jarrell	559-298-3400 x 310
Claudia Vega	559-298-3400 x 312
Diane Leon	559-298-3400 x 314
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Congratulations New RPT, RPT-S & SB-RPTs!

Congratulations Registrants! Join us in celebrating the following licensed professionals in their attainment of our Registered Play Therapist (RPT), Registered Play Therapist-Supervisor (RPT-S), and School Based-Registered Play Therapist (SB-RPT) credentials during the months of May through July!

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PSYCHOANALYTIC Play Therapy

| AUDREY PUNNETT, PHD, RPT-S, CST-T/ISST & ERIC J. GREEN, PHD, LPC-S, RPT-S, SP

Psychoanalytic play therapy is mindful of the symbols in the child's play, which is a manifestation of the unconscious mind. The key concept of this theory is the exploration of the unconscious. The psychoanalytic community tends to view the therapist's role more as a professional posture than the use of a specific technique. Attention is focused on a child's anxieties, defenses, and fantasies (as they appear in play and verbalizations).

Basic Tenets

Psychoanalytic play therapy finds its foundations in the works of Sigmund Freud, Hermine Hug-Hellmuth, Margaret Lowenfeld, Anna Freud, and Melanie Klein (Punnett, 2016). For the Freudian psychoanalyst, "the personality develops out of the need to fulfill the pleasure principle, all the while attempting to negotiate reality demands without incurring superego strictures" (Lee, 1997, p. 46).

Although Freud never worked with children, his followers extended the theories to include models suited for work with children and adolescents. Object relations theory, ego psychology, and self psychology expanded on Freud's concepts (Abraham, 1994; Blanck & Blanck, 1979, 1994; Kernberg, 1976, 1980; Klein, 1969, 1975; Kohut, 1971, 1977, 1978). These subsequent modifications are generally referred to as psychodynamic psychotherapies—a way of working with children that considers both the psychoanalytic and analytic traditions.

Psychoanalytic theory conceptualizes clients' difficulties according to Freud's developmental stages: oral, anal, and phallic stages. The hallmark is the resolution of the Oedipal conflict during this last phase, and the major components of the personality are developed by the end of the Oedipal period. During the latency period (6 years old to puberty), changes are consolidated. During the last phase, the genital stage, from adolescence onward, the primary task is to develop an intimate relationship.

Psychopathology and Client Dysfunction

Psychopathology occurs with the development of an overly strong preference for any one instinct (a *fixation*), which could lead to potential regression in times of stress. When the therapist encounters a child's regression, s/he looks for the underlying period of inadequate satisfaction in the child's life. Anna Freud observed blockages in a child's progression of development as the underlying cause of psychopathology; the goal of psychotherapy, then, is the removal of these blockages so a natural healthy development can proceed. According to psychoanalytic theory, removing blockages occurs by carefully interpreting the defenses, and later the drives, as repressed material becomes more conscious.

> ***"In psychoanalytic psychology, problems are viewed as disturbances when regulating impulses between the id, ego, superego. The ego fails at regulating the demands of the id, the superego, and the external reality."***

In psychoanalytic psychology, problems are viewed as disturbances when regulating impulses between the id, ego, superego. The ego fails at regulating the demands of the id, the superego, and the external reality. This leads to anxiety and maladaptive defenses/behaviors. There are periods of deintegration and integration, that is, anxiety followed by the reestablishment of a steady state, or *regulation*. As the child grows, this interactive field brings the child into the mother-child adaptive relationship with the environment. Thus, growth moves from instinct-centeredness to ego-centeredness with resultant failures evidenced in developmental disorders and illnesses. Psychological growth occurs when a child relies less on the id or pleasure principle and more on the ego or "I," as we know it, to make more logical decisions.

Applying the Theory

Muriel (pseudonym) was an upper-elementary school-aged African-American female residing in the southern US. She was referred for

treatment due to violent behaviors at home and school. Her maternal grandmother was given temporary custody four years prior, due to the mother's substance abuse disorder and the mother's use of parental alienation through a campaign of denigration against the child's father. Muriel engaged in contact refusal with her father and his family. At the onset of treatment, Muriel was playing out the unconscious and unresolved conflicts between her parents, especially during their contentious family dissolution. In Freudian terms, parents' projections of unsatisfied drives or desires become a burden to children.

Muriel was a lucid dreamer, and she enjoyed sandplay; she drew symbols from her dreams and painted them. Symbol work, exploring unconscious drives, is one of the hallmarks of psychoanalytic play therapy (Green, 2012; 2014). Through the engagement of the unconscious via sand, symbol, and dream, Muriel strengthened her ego by replacing maladaptive defenses, symptoms, thoughts, and behaviors with more functional ones. Reunification therapy was completed by the child and father as well, and parent-child contact resumed.

Therapy Goals and Progress Measurement

The goal of psychoanalytic play therapy is to help children develop their unique identities and experiences so they can adapt, despite their particular life circumstances, and can meet the goals (i.e., healthy expectations) of family, school, and society. The goal for psychoanalysis is to allow for and support the normal processes of childhood, to allow the ego to work unencumbered to remove unconscious conflicts, repression, and fixations. This goal is attained through free association; and in child therapy, this is the play experience itself.

Interpretation is used once the therapeutic alliance is solid. Interpretation is directed to integrate unconscious/repressed representations in order to make them more consciously tolerable and improve ego strength/coping. The therapist works to strengthen the ego, to help children accomplish developmental reorganization, to address conflicts and defenses, and to make way for the emergence of the Self (Kohut, 1971, 1977, 1978). Progress is measured by a decrease or resolution of presenting symptoms, increased ego strength, ability to make reasonable decisions, and often decreased interest in coming to play therapy.

Therapeutic Powers of Play

Essential to psychoanalytic play therapy is to provide a protected space in which the children or adolescents feel free to be themselves. Play comes natural to children, and thus, is the language in which the therapist and child communicate to resolve the issues. Specifically, psychoanalytic play therapy corresponds to Schaefer and Drewes's (2014) therapeutic powers of play in facilitating communication through *access to the unconscious* and ultimately through *self-expression*; fostering emotional wellness through *abreaction*, the expression and emotional discharge of repressed emotions and *catharsis*; enhancing social relationships through the *therapeutic relationship*, *attachment* through the transference, resulting in increased *social competence* and *empathy*; an in increasing personal strengths through better *self-regulation*, increased *self-esteem*, better *problem solving* and *resiliency*.

The ability to play includes the freedom to be spontaneous on both the child and therapist's part, where the therapist empathizes without overidentifying with or being repulsed by the child's behavior. Understanding the dynamics transpiring between the child and the therapist, transference and countertransference, can lend further insight into the child's issues by bridging the child's inner and outer worlds. The use of ego-strengthening activities related to the developmental age of the child is important (i.e., age appropriate games or play).

> ***Psychoanalytically oriented play therapy emphasizes symbolic meaning and is focused on anxieties, defenses and fantasies in order to understand the underlying dynamics of the presenting symptom(s).***

Therapeutic techniques include parallel play, conjoint play, and directed play in which the therapist models a strong dependable ego that can encourage and support development. The therapist uses his/her own ego to assess feeling states, emotions, and fantasies from within to analyze the child's play, and intervenes using these insights, always with the child's presenting symptom and history in mind.

Summary

Psychoanalytically oriented play therapy emphasizes symbolic meaning and is focused on anxieties, defenses and fantasies in order to understand the underlying dynamics of the presenting symptom(s). The symptoms are dynamic and diverse, influenced by internal and external experiences. The goal for development is to keep pace with chronological and mental abilities, to free the flow of energy so it is not inhibited by the use of defense mechanisms, and to help children develop their unique identities such that they can adapt to meet the demands of family, school, and society (Punnett, 2016).

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The Importance of Clinical Theory

"Play therapy theory. A set of interrelated ideas and principles that provide a broad theoretical framework for understanding how experiences affect children, how psychopathology develops, and how to remedy it through play interactions" (Schaefer & Peabody, 2016, *Play Therapy, 11* (2), 20-24).

"Theory gives structure to intuition, engaging the whole of the therapeutic mind."
Mandi Meléndez, LMFT, LPC, RPT, NCC

"A theory is a direction, not a destination."
Charles Schaefer, PhD, RPT-S

"Theories are the foundations on which we build our therapeutic houses."
Jason Zoellers, LPC, RPT-S

"Theory drives practice."
Claudia Vega, PhD

"Being grounded in clinical theory is as important to a play therapist as a map is to an explorer."
Sueann Kenney-Noziska, LISW, RPT-S

"Theory brings conviction to your noticing."
Marshall Lyles, LPC-S, LMFT-S, RPT-S

"Clinical theory provides the strong roots and essential foundation needed in the healing journey."
Claudia O'Campo, LPC, NCC, RPT

"Clinical Theory explains the 'why' while play expresses the 'how' of a child's worldview."
Sarah Stauffer, PhD, LP (Switzerland), LPC, NCC, RPT-S

"Theory tells you what to do when you don't know what to do."
Jodi Crane, PhD, LPCC, RPT-S

"Theories are the roots that ground and guide us. Without them, we might be susceptible to external variables. The best creativity emerges from solid grounding."
Eliana Gil, PhD, LMFT, RPT-S

"A clinical theory provides the road map for myself and the client on the journey toward health."
Linda Homeyer, PhD, LPCS, RPT-S

"Theory grounds us and guides us; it is the foundation of all clinical practice."
Galina Kadosh Tobin, LPC, RPT, NCC

"Theory is the foundation of practice."
Joyce C. Mills, Ph.D. LMFT, LLC

"Counseling without theory is like navigating without GPS, you'll surely get lost without it."
Christina Villarreal-Davis, Ph.D., LPC-S, RPT-S, NCC

"Theory centered client driven."
John Burr, LCSW, RPT-S

A Senior Therapist's Observations and Concerns

CLINICAL EDITOR'S COMMENTS:
The author urges play therapists to (re-)consider their motivations for practice.

| ELIANA GIL, PHD, LMFT, RPT-S

When I started my professional career, my primary inspiration was a desire to be of service to others, plain and simple. That desire burned in my heart from the time I was a young child. These days, we talk about teaching children empathy. When I was a child, no one mentioned the word but, somehow, I learned it through my father's example. I do not remember much about him anymore, and I rarely mention him, but what I learned from him was to have tremendous compassion towards others. Clear memories include watching him give his sandwich to a poor person sitting on the sidewalk and give his umbrella to a woman and a child getting soaked by the rain. He treated everyone around him with respect and tenderness, and I am so grateful to have seen the things he held dear to his generous heart.

From Humble Beginnings: Volunteering

I also had a Catholic upbringing, and those Christian principles resonated with me. Like my father, I was constantly aware of those who were struggling around me. As soon as I could, I volunteered to do community work on the weekends. I looked forward to this more than most things in my youth. The nuns accompanied a handful of students into the poor sections of Washington, DC. They would go into the houses to speak with the parents or caretakers and we stayed outside playing with the children. We did very simple things: threw balls, drew on the streets with chalk, played hopscotch, blew bubbles, ate snacks, listened to music and danced, sang funny made-up songs, and jumped rope. I was oblivious to all the stressors in these children's lives, and I was disinterested in what the nuns were doing inside. I was just content to be present with these little ones, to enjoy each other's company, and to participate in a little laughter and fun.

This is where I first knew that I wanted to work with children and that I wanted to be of service to them and their families. I had no concept of what shape that would take or that my chosen profession would value play as much as I did. My career has been completely gratifying.

As I sit back and watch a new crop of professionals finding the work they love, I find myself beset with pleasure and pride. I have had so many students eager to learn, passionate, in fact, to give the best of themselves to others. I hear amazing stories from therapists all the time that demonstrate how invested they are in helping, how much they worry about doing everything they can to make a positive difference. I feel that there is an army of warriors equipped with love and willingness to connect with and provide to others. I am so proud to be a play therapist and to belong to the Association for Play Therapy! And, from my vantage point, I see other trends developing that cause me concern and a desire to ask people to pause and rethink some new trends that are emerging.

Concerning Trends: A Shift in Motivation

I see a rush to self-promote, to "brand," to set one person apart from another. I see models and certifications popping up everywhere, actually diluting the very meaning of these distinctions. Individuals are now certifying people in their often new and untested models. Certification always has been something that demonstrates that someone has obtained additional knowledge and experience in a specific area, but also that someone has been accountable through a process of supervision. Certificates are conferred by formal entities that set standards and regulations and enforce those.

As Registered Play Therapist/Supervisors (RPT/S), we became eligible for the credential through the Association for Play Therapy (APT) only after obtaining a master's-level degree in a mental health field and a mental health license to practice independently, documenting specialized play therapy and child development instructional and practical requirements, amassing thousands of play therapy clinical hours under a licensed mental health professional's supervision, and receiving play therapy-specific supervision. We understood that were accountable to others, and we got the guidance we needed after we learned the basics.

Many current offerings of individual certifications are usually didactic (without experience or supervision requirements). There is little

accountability, and the inferred expertise may or may not be properly transmitted, received, or verified. The more individuals certify others, the less significant certifications become and the more pressure new professionals feel to keep up with the sheer quantity of certifications they can put behind their names.

We are at a stage in the development in the play therapy field where very few original theories will be created: Most approaches will fall under a seminal or historically significant theory that already exists. Models are best proffered after they have been established for a substantial amount of time, and after the approaches have been tested with hundreds of clients, not just a few.

> ***I also remain convinced that our peers are quite generous in their receptivity of original and creative work, and they are quite willing to applaud those whose notoriety is well-earned and deserved.***

A few years back, I read an article on "branding," and the author rightfully encouraged therapists to become more business-minded. Mental health programs do not typically offer courses on how to run private practices and/or how to market ourselves in our communities. Yet, my observation is that social media has created opportunities for some to simply flood the air space with self-promotion, and this is very unbecoming in those who have not yet earned the right to promote themselves so aggressively. When I see posts not-so-cleverly designed to promote something personal, like a product of some kind, I notice how turned upside-down marketing and promotion has become. In the past, people set out to help others and, sometimes, if they were believable, credible, and had something worthy to say, others took notice of their work and inquired about it. Now, it seems, tooting one's own horn creates enough noise so that the real questions are not asked:

- Is your primary goal to be of service to others?
- Are you giving yourself enough time to test your hypotheses and approaches with a substantial number of clients?
- Although many of us are not in academic settings where we can do formal research, is there some way that you collect data about how people progress as a result of receiving your services?

And, I guess I just have to ask: Whatever happened to humility? Whatever happened to earning your right to be heard? Where is this "rush to fame" coming from? And can we reverse these trends before it becomes intolerable? These trends range from off-putting to downright dangerous, and I hope we can all pause and consider the basic question of why we do what we do!

A Cautionary Account

Play therapists whose major motivation is to become a presence in the field of play therapy by presenting, traveling nationally or internationally, or writing books in the hopes that they are widely cited, may have mistaken goals in striving for this popularity. I have seen literally thousands of clients, and I feel confident that I can share my experiences with the caveat that all children are unique and what works for one child or family may not work with others. I hold myself to a high ethical standard: I will not give speeches on a topic I have not worked directly on for a minimum of five years; I will not write on a topic unless I have had direct and substantive experience in the topic area.

Many people have asked me how I got where I am today, and this question feels uncomfortable to me when it seems to come from a place of vertical striving, or trying to get ahead for the sake of personal notoriety and/or financial gain, rather than horizontal striving, or sharing acquired knowledge with others so that the whole profession advances as a result of the conversation. This question, and the concern I have over the recent trends I have noticed, inspired me to write this piece as a cautionary account.

Personally, I just wanted to help children and their parents. That's all I set out to do. The rest just followed. I was really lucky in that I enjoyed talking about my work and people seemed to find what I said useful. I never set a goal to be a speaker or a writer or a big deal in any field. I set out to help kids, and that remains my goal to this day.

I realize that some people may be offended by something I have said here. Although it is not my intent to offend, condemn, or pass judgment on anyone, it is simply my goal to encourage reflection on these topics, and to share my discomfort with the individualized trend of shifting towards "what the field can do for me," rather than the collective spirit of, "What can I offer others to help them?" I originally titled this "Musings from a Cranky Old Lady," but in re-reading it, I felt that I needed to document legitimate concerns I have about the profession I love and value greatly.

I also remain convinced that our peers are quite generous in their receptivity of original and creative work, and they are quite willing to applaud those whose notoriety is well-earned and deserved. They are most eager to praise, applaud, and elevate their peers. Maybe trusting that recognition will happen rather than trying to create it, would be a more simple and earnest goal to which to aspire. I hope that the legacy each of us leaves is one of pride in what we do for others instead of pride in our individual accomplishments.

ABOUT THE AUTHOR

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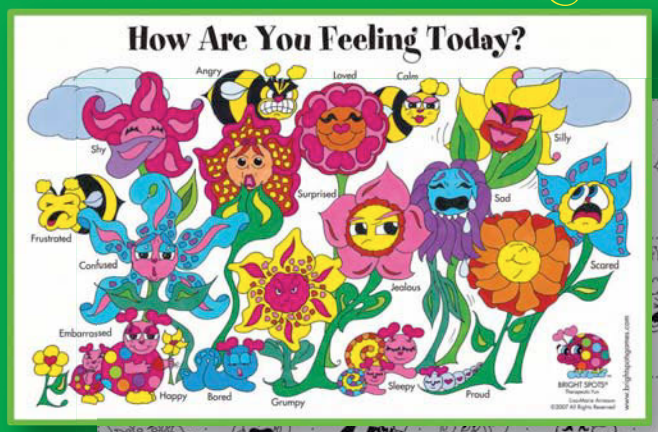

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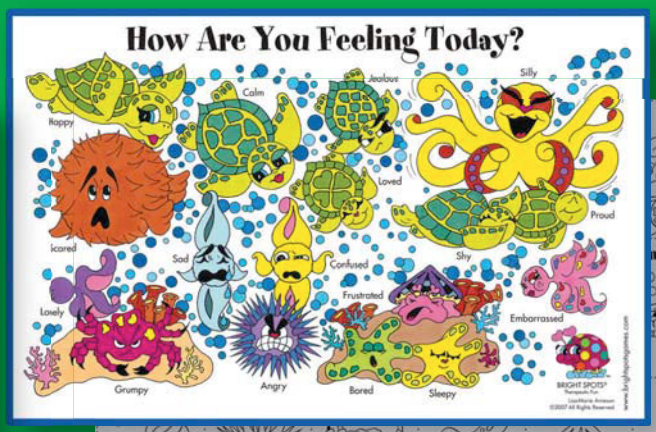

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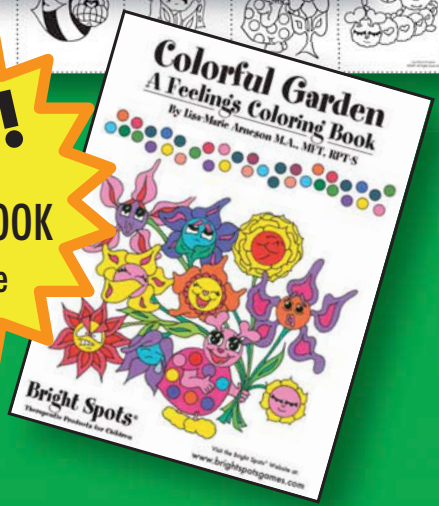

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