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# **Play Therapy**

## **Practice, Issues, and Trends**



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Play therapy is an effective means of responding to the mental health needs of young children and is widely accepted as a valuable and developmentally appropriate intervention. The authors discuss the importance of play in development, the therapeutic benefits of play, the rich history of play therapy, and recent research and current issues and trends in the field, including the need for more mental health professionals trained to work with children.

### **Critical Needs in the Mental Health of Children**

**M**ENTAL HEALTH NEEDS of children in the United States and around the world are urgent and growing to crisis level. In 2001, the U.S. Surgeon General stated that mental illness affects one out of ten children and adolescents, thus continuing a twenty-year trend. According to John R. Weisz and Kristin M. Hawley (1998), those children already diagnosed with a mental illness may have, on average, three-and-a-half diagnoses. Internationally, the need is also great and increasing. In 2005, the World Health Organization stated that 20 percent of children worldwide suffer from disabling mental health problems. There is, in addition, an overwhelming and growing need for mental health professionals with special training to work with children. Largely accepted as the mental health intervention of choice for children, the play therapy field in particular needs more trained practitioners.

## The Importance of Play

Play is the natural world of the child. Children learn about themselves, others, and their world through play. In 1989, the Office of the United Nations High Commissioner for Human Rights identified play as a right for all children everywhere to achieve optimum development, and in 2007, the American Academy of Pediatrics issued a white paper (Ginsberg 2007) on the importance of play for healthy child development.

The 1990s, often called the Decade of the Brain, produced significant research identifying the critical role of play in brain development. This understanding has become so pervasive that the research is reaching the popular press, as demonstrated by articles in *Newsweek* (Begley 1997) and *Time* (Nash 2001). Research in neurobiological development and psychological trauma, as discussed by Phyllis T. Stien and Joshua C. Kendall in 2004 and by Bruce D. Perry and Maia Szalavitz in 2006, has demonstrated how play stimulates the neural structures in the brain and is critical for normal development. Perry (2006) has also discussed children's need for enrichment opportunities, provided in a sequential manner, to address neurological developmental issues. This includes play and play therapy to assist in treating children who experience severe trauma.

Bessel A. Van der Kolk's work on trauma has greatly informed the mental health field, including providing insight into children playing and replaying stressful and traumatic events. Trauma often remains stuck in the nonverbal parts of the brain—amygdala, thalamus, hippocampus, or brain stem. Meanwhile, the ability to think through life events and the ability to process these events takes place in the frontal lobes of the brain. "Fundamentally," says Van der Kolk (1994, 257), "words can't integrate the disorganized sensation and action patterns that form the core imprint of the trauma in the brain. Treatment needs to somehow incorporate the sensations and actions that have become stuck, so that people can regain a sense of familiarity and efficiency in their organism." Play provides physical activity, so that "playing out" the event assists the brain in moving the memory from the nonverbal parts of the brain to the frontal lobes.

## Play as Therapy

Charles E. Schaefer has discussed the therapeutic powers of play in numerous published works (1993, 2003a, and 2003b). He points out that play helps overcome resistance to therapy. In service to involuntary clients, play draws children and adolescents into a working alliance. In this nonthreatening environment, children and adolescents are more willing to engage in the therapeutic process. Play serves as a developmentally appropriate means of communication for children. Half a century ago, Jean Piaget (1951, 166) noted that play “provides the child with the live, dynamic, individual language indispensable for the expression of [the child’s] subjective feelings for which collective language alone is inadequate.” Not long after, Haim G. Ginott (1960, 243) coined the phrase, “toys are the child’s words and play is the child’s language.” Play facilitates the child’s ability to develop mastery that leads to a sense of efficacy and competence. During play, children are self-motivated to satisfy an innate need to explore and master their environment. Play also assists in the development of creative thinking. Creative thinking is the basis for problem-solving skills and the ability to experiment with a variety of options in play without fear of negative consequences. Play also offers a means to discharge strong emotions, bringing relief. Children use a variety of toys and materials to experience a cathartic release of tension and affect. Abreaction, the re-experiencing of previous events, can occur with a child reliving past stressful events and related emotions. During play, children are able to play out negative life experiences by breaking them into smaller parts, releasing feelings that accompany each part, assimilating each experience back into the view they have of themselves, and obtaining a new level of mastery.

According to Schaefer, using pretend play during role-playing allows children to try on different roles and try out alternative behaviors. Role-playing provides children with the ability to develop empathy as an attempt to understand other people in their lives. Use of fantasy in play allows children to learn more about themselves and their view of the world. Fantasy play gives children a sense of power and mastery that is not possible in their real world, resulting in an increased ability to regulate affect, reduce aggression, and generate positive feelings. Developing themes and metaphors in play gives meaning to life by shaping the child’s belief systems. Metaphors enrich, structure, and energize childhood experiences.

Schaefer has also discussed the development of attachment in therapeutic

relationships. The physical and sensorimotor play within the therapeutic relationship provides corrective emotional experiences, leading to new attachment formations. With strong attachment, children are able to enhance relationships. In these relationships, children learn to accept and solidify their sense of self. Reenacting distressing life experiences in play helps master fears. Through play, learning new, more functional and adaptive responses, incompatible with previous responses, weakens the stimulus-anxiety connections. For older children, adolescents, and adults, game play is a more developmentally advanced form of play. Game play—learning to play by the rules, take turns, and be a gracious winner or loser—is a primary means of socialization. Following the rules and pacing required of playing a game with others helps distractible children and teens focus and sustain attention. Finally, Schaefer has reminded us that enjoying play is also therapeutic. Participating in a pleasurable and fun activity contributes to a sense of well-being, provides an antidote to the stress of living, and uplifts and restores the spirit.

Occupational therapists, child-life specialists, speech therapists, physical therapists, and many other human service providers use therapeutic play with toys and games to facilitate treatment goals respective to their disciplines. Such play engages children and helps prepare them for surgical procedures, encourages verbalization, and aids the development of gross and fine motor skills, among other benefits.

## **The Practice of Play Therapy**

Play therapists are mental health professionals trained specifically to use children's play as the basis of therapeutic interaction. It is within play—children's natural form of communication—that the dynamic of therapy occurs. Children's play is a symbolic expression of their world. By the age of two to three, children are typically able to imbue symbolic meaning onto their play. For example, in a play therapy session, a child may use a dinosaur to represent his aggressive father. During such a symbolic play scene, the child may add growls and emotional expressions while involving the dinosaur-father in interactions with other animal-family toys. Symbolic play allows children to express the unmanageable in manageable ways. In this example, it could be frightening for a child to talk about the anger his father expresses. However, playing provides the emotional distance necessary for communication.

The Association for Play Therapy (2008) has defined play therapy as “the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development.” Play therapists watch for patterns and themes in children’s play in order to make responses that produce therapeutic movement and ultimately catharsis (Landreth 2002). As John A. B. Allan (1997) has noted, the difference between play and therapy is the therapist’s ability to think analytically about everything that is going on in the session verbally, nonverbally, and symbolically in the child’s play and artwork.

Toys allow for creative and emotional expression, testing of limits, and role-playing reality, and play therapists have a sound theoretical rationale for selecting and placing toys and materials in a play therapy playroom. Types of toys include, but are not limited to, dolls and dollhouses, play kitchens, building blocks, farm and wild animals, toy knives and swords, dress-up costumes, art supplies, musical instruments, and puppets (Landreth 2002; Kottman 2003; O’Connor 1991). Some therapists may include games that facilitate discussion and social skills development. Each play therapist’s theoretical orientation dictates whether play with the toys and games is child directed or directed by the professional.

Play therapy has a rich history of practice and research. The development of play therapy paralleled the development of the mental health field in general. During the zeitgeist of the early twentieth century, Anna Freud (1928) and Melanie Klein (1932) wrote about applying psychoanalysis to children, and Margaret Lowenfeld (1935) wrote about allowing children to use play to teach her how to understand their world. Since that early work, play therapy has integrated most of the leading counseling theories. Virginia M. Axline (1947), one of the most well-known figures in the field, adapted Carl Rogers’s person-centered theory into child-centered play therapy. Louise Guerney (1983) and Garry L. Landreth (2002) have continued to popularize child-centered play therapy. Working at approximately the same time as Axline, Clark Moustakas (1959), the existential theorist, developed and discussed extending that theory to children and called it relationship play therapy. Allan (1997), noted above, provided the field with seminal work in Jungian-based play therapy, while Violet Oaklander (1988; 2006) did the same for gestalt-based play therapy. In today’s mental health environment, cognitive behavioral therapy (CBT) is

popular. Susan M. Knell (1993) has been especially influential in this arena. Terry Kottman (2003) has brought Adlerian individual psychology play therapy to us, and object relations play therapy, as articulated by Helen E. Benedict (2006) has helped the field understand how to work with damaged relationships and attachments from its perspective.

Other models of play therapy have also assisted mental health work with children. Ann M. Jernberg's book *Theraplay* (1979) and Viola A. Brody's book *The Dialogue of Touch: Developmental Play Therapy* (1993) provided models for working with children who have attachment issues. Kevin O'Connor's ecosystemic play therapy (1991) has assisted play therapists in understanding the impact of the variety of systems that affect children's functioning. Schaefer (2003b), cited above, articulated prescriptive play therapy, a framework of integrating a variety of play therapy theories and techniques to develop individualized plans of intervention. In *Experiential Play Therapy* (1997), Carol C. Norton and Byron E. Norton posited that play therapy best intervenes with children in the mode in which children function—that is, in experiential rather than cognitive ways.

Using play to engage the entire family in mental health services may be a preferred mode of intervention. Schaefer, Eliana Gil (1994), and Lois J. Carey (1998) have written extensively on family play therapy, and Steve Harvey (2006) has developed what he calls dynamic family play therapy, an action-oriented intervention that uses play to activate the creativity of family members and help them adapt to conflicts.

Involving parents in the therapeutic process has proven very effective. Several different approaches rely on the strength of the parent-child relationship as a significant factor in healing. Research has supported the effectiveness of therapeutic approaches involving parents from many backgrounds, ethnicities, and mental health problems. After a decade of research and practice, Bernard G. Guerney and Louise F. Guerney described their development of filial therapy in 1964. Filial therapy trains parents in basic child-centered play therapy skills and procedures. Parents learn to follow the child's lead, reflect the child's feelings, describe the content of the play, and set limits. Landreth later introduced a ten-session model based on the Guerneys' work, and in 2006, answering the call in the mental health field for more manualized treatments, he and Sue C. Bratton formally developed a protocol for this ten-session model known as child-parent relationship therapy (CPRT). In both the Guerney and the Landreth/

Bratton models, a mental health professional trains and supervises parents in weekly parent-child play sessions to reduce children's behavioral problems and strengthen the parent-child relationship.

In addition to her aforementioned contributions to play therapy for children, Jernberg (1979) has described the use of touch to connect the parent and child in a closer and more secure relationship. The parent and therapist work together with the child as the parent learns to respond more empathetically and to understand the child's nonverbal communication through a playful approach. Children who have attachment difficulties can benefit from this model. Research studies conducted in Germany and Finland have also found promising results for this therapeutic approach (Wettig, Franke, and Fjordbak 2006).

Parent-child interaction therapy (PCIT), developed chiefly by clinical psychologist Sheila M. Eyberg, is an evidence-based treatment for disruptive behavior in preschoolers (Brinkmeyer and Eyberg 2003). PCIT focuses on improving the parent-child relationship by changing the parent-child interaction pattern. Drawing on both attachment and social learning theory, PCIT uses two phases of treatment to teach parents new ways of interacting with their child. In phase one, parents learn to give attention to the child's positive behaviors while the child plays. In phase two, therapists coach parents in parent-child sessions to praise appropriate play behaviors and ignore inappropriate play behaviors.

Sandtray therapy, a form of play using miniature figures and a tray of sand, has become an important approach with adolescents, adults, couples, and families. Dora Klaff, a Jungian therapist influenced by Eastern mysticism, advanced this therapy in Switzerland in the 1950s and 1960s. She called it Sandplay, and it became popular worldwide. Lois Carey, a long-time proponent of the Klaffian approach, described it in detail in 1998, and that same year, play therapists and counseling educators Linda E. Homeyer and Daniel Sweeney discussed it from a theoretically inclusive approach. Sandtray therapy gives children opportunities to speak through scenes they build in the sand, much the way Lowenfeld (1935) indicated clients "speak with their hands."

Two recent research projects explored treatment effectiveness of group sandtray therapy. In 2007, Mon-hsin Wang Flahive and Dee C. Ray determined that group sandplay is an effective treatment intervention for preadolescents with behavior problems. The following year Yu-Pei Shen and Stephen A. Armstrong showed how group sandplay with seventh-grade girls improved

self-esteem in areas of academic competence, physical appearance, and global self-worth.

Such play interventions with older children and adolescents often have the goal of using play to help them feel more comfortable and, therefore, more willing to talk about feelings and experiences (Gallo-Lopez and Schaefer 2005). S. R. Slavson first considered the need for specialized treatment attending to the developmental needs of preadolescents in 1945. More recently, Jill Packman and Bratton (2003) found an activity-based approach effective with preadolescent learning-disabled students who exhibited behavioral problems at home and school. Such play-based interventions often involve the use of symbolic expression to help adolescents express themselves and allow clients to have a safe distance between themselves and reality (Bratton and Ferebee 1999; Malchiodi 2005). In 2003, Schaefer promoted play therapy across the life span to encourage the use of the language and benefits of play for a wide age range.

### **Issues in Play Therapy**

The play therapy field faces a number of issues. Among the most important is the critical need for an increase in the number of mental health professionals trained in play therapy. Play therapy presentations at professional conferences and other continuing education opportunities are in growing demand, and graduate schools need to offer more play therapy course work and clinical supervision opportunities.

The Association for Play Therapy (APT) maintains a directory of universities in the United States that offer graduate-level play therapy courses, clinical practica, and internship experiences. In 1989, 33 universities offered course work in play therapy (Landreth 2002); by 2004, that number had grown to 104. In the last four years, it has increased 40 percent, to 146 universities. Of this total, 99 of these universities offer clinical experiences. This increase in graduate-level training is immensely encouraging. To promote continued growth, APT is working with play therapy faculty members at doctorate-granting institutions to develop programs similar to the Center for Play Therapy at the University of North Texas. Centers such as this will train future play therapy faculty, generate play therapy research, and provide additional graduate-level course work and continuing education opportunities.



The growth of national professional associations is also helping meet the international mental health needs of children. The APT emerged in the United States in 1982, followed by the Canadian Association of Child and Play Therapy (CACPT) in 1987 and the British Association of Play Therapists (BAPT) in 1992. The last five years have brought exponential growth in national associations—including organizations in Argentina, Australia, Taiwan, Mexico (two organizations), Hong Kong, Ireland, Israel, Japan, Malaysia, and South Korea. Other countries have active play therapy communities as well. A crucial component to the development of adequately trained play therapists is each country's national professional association establishing minimum training standards. APT, CACPT, and BAPT have also created minimum training and supervisory standards leading to a specific play therapy credential for their respective countries. These credentials professionalize the play therapy field and protect client welfare.

Play therapists must be responsive to their clients' culture, and as the field grows globally, the application of Western play therapy theories and practices in other cultures is another area of concern. Several play therapy trainers who provide instruction in a wide variety of countries have noted that the dynamics of issues—such as sexual abuse, family violence, and alcoholic parents—dealt with in therapy there are very similar to those in the United States. Nevertheless, individuals who either provide training in other countries or cultures or return to their own after training abroad must consider cultural differences. While some cultural adjustments—like types of toys and materials—are easily accomplished, others are difficult to identify.

Several recent works have addressed cultural considerations in play therapy broadly (Gil and Drewes 2005; Schaefer, McCormick, and Ohnogi 2005), or have specifically illustrated the need for concern. In 2001, Shu-Chen Kao and Landreth described how helping children grow and develop within the belief system of their particular culture may mean changing how play therapists work with them. For example, "returning responsibility" is a common therapeutic response used by play therapists, as in, "You can choose," or "That's something you can decide." This helps children develop, among other things, individualism. However, individualism is a Western value, and so Kao and Landreth suggested rephrasing these facilitative responses in ways that would help Chinese children learn to rely on self in relationship to others. Another example is the participation of extended family members in the therapy. Traditional Hispanic families may have in the family system many adults who expect to be involved in meetings with the play therapist, both in consultations and in therapy.

Clear, intentional, and thoughtful application of cultural considerations to foundational play therapy skills, procedures, and philosophy is important to develop culturally sensitive play therapists throughout the world. Equally important, the cultural dimensions of play therapy beg for additional research to inform best practices.

Play therapy supervision is another critical component in developing well-trained, competent play therapists. As play therapy's popularity increases, the lack of literature written specifically on play therapy supervision has become apparent. Bratton, Landreth, and Homeyer first wrote about the importance of play therapy supervision and discussed an intensive supervision model in 1993. In 2004 and 2006, Ray differentiated between basic and more advanced play therapy skills and provided information about how supervisors can work more effectively with supervisees.

Given the nonverbal nature of play therapy, supervisees may benefit from exploring supervision issues through nonverbal means. Perhaps supervision experiences that use symbolism, metaphoric play, and art would be appropriate, if not the standard. Children are unpredictable and, in the safety of the playroom, may interact with the therapist in any number of ways. For example, children may be aggressive toward the therapist, demonstrate intense repetitive play, or express themselves symbolically and metaphorically. The play therapist must understand these dynamics. Experiencing these same dynamics in the supervision process would lead supervisees to a greater depth of understanding than they could get from words alone (Morrison and Homeyer forthcoming 2008).

Another issue is play therapists' personal problems, which may cause difficulty in therapeutic relationships. Quality play therapy supervision includes working with therapists who have personal issues and difficulties and must prevent those from affecting their counseling. Gil and Lawrence C. Rubin (2005) have suggested that countertransference issues are more frequent in therapeutic relationships involving children. Children bring their entire system—self, parents, siblings, agencies, schools, physicians, psychiatrists, and others—to therapy, thereby providing many different aspects of themselves to which the therapists may react. The supervisory process must address play therapists' reactions. Unfortunately, there is a lack of experienced play therapists, well grounded in theory, with training in supervisory skills, to mentor the growing numbers of new professionals. This is particularly true in international settings. Additionally, some countries do not have well-defined parameters or

expectations for supervised experiences during the training of mental health professionals.

## Trends

Several important trends also characterize play therapy today. One of the most significant is disaster relief for children. Immediately after a disaster, children benefit from play interventions, with play therapy coming later as a follow-up intervention where and when available. In personal communication with the authors in 2007, Jennifer N. Baggerly referred to this type of play therapy as “psychological first aid.” Psychological first aid differs from traditional play therapy in that it is an immediate intervention designed to attend to the child’s most urgent psychological need, perhaps in only a single session. Previously, Baggerly and Nadine D. Mescia (as cited in Baggerly 2006) developed a model, Child C<sup>3</sup>ARE, to train play therapists to provide individual interventions to children in disaster response situations. Elsewhere, Janine S. Shelby has worked with the National Center for Child Traumatic Stress and Operation USA, a disaster relief and development organization, to include play-based crisis interventions in a *Psychological First Aid (PFA) Field Operations Guide*. A number of other professionals, representing APT, have served on a task force to incorporate play-based interventions further in this type of crisis work for children. Teams of mental health professionals used these interventions in Sri Lanka after the Indian Ocean tsunami of 2004.

These are tremendous accomplishments and significant steps forward, but the need continues for crisis organizations, such as the American Red Cross and others, to do more to provide developmentally appropriate mental health interventions for children during times of disaster response. Children’s services must be standard procedure, and play therapy responders must be ready to assist when called. Baggerly recommended that play therapists receive in-depth training in disaster response principles and procedures, join emergency relief organizations, and continue to research developmentally appropriate disaster relief interventions for children.

An unrelated but equally important trend in play therapy is the adaptation of filial therapy into prekindergarten and elementary classroom settings. Though launched twenty years ago, filial therapy remains an active growth area and is an appropriate intervention to meet the New Freedom Commission

on Mental Health's 2003 call for prevention and early intervention services to young children. Research has shown successful use of the child-parent relationship training (CPRT) model noted above in working with preschool teachers whose students are hard of hearing and deaf (Smith and Landreth 2004). In an innovative study in 2002, Leslie Jones, Tammy J. Rhine, and Bratton investigated the effects of CPRT with high school mentors to determine the impact on the behavior of four- and five-year-olds referred for school adjustment problems. In similar studies in 2003, Christopher J. Brown, working both alone and in partnership with Jodi M. Crane, investigated the effects of CPRT with undergraduate students enrolled in human services classes. These studies revealed positive outcomes in child-behavior changes and the teachers' ability to learn and use therapeutic skills.

Another trend based on principles and procedures similar to CPRT but additionally influenced by Alfred Adler is kinder training. JoAnna White, Mary Flynt, and Kay Draper designed it in 1997 to train kindergarten teachers as therapeutic agents. It helps teachers generalize filial therapeutic skills to the classroom setting. Several recent studies indicate promising results from it (Post et al. 2004; Draper et al. forthcoming; White and Wynne forthcoming). While the absence of random assignment and control groups limits the strength of these studies, they reveal increases in teachers' empathic interactions with students, decreases in child behavior problems, and improvement in early literacy skills.

Similarly, a twenty-week version of child-teacher relationship training (CTRT), developed by Mary O. Morrison in 2007, has extended CTRT to the training and supervision of Head Start teachers and classroom aid teams. In addition to adapting the CTRT manual for their classrooms, participants in Morrison's study received ten additional weeks of training. The results suggest that CTRT is an effective, developmentally responsive intervention for use with young, at-risk children to ameliorate their behavioral difficulties. In a 2007 research study, Wendy P. Helker found that teachers and aides who participated in the CTRT program increased their use of play therapy skills in the classroom and maintained them during follow-up. Further, there was a statistically significant relationship between teachers' and aides' higher use of play therapy skills and a decrease in students' externalizing behaviors at post testing. These studies confirm the effectiveness of training teachers to use play therapy skills to address the behavioral difficulties of young children in a school setting.

Another trend is an increase in play therapy publication and research. Professional play therapy literature has been rapidly expanding its rich sixty-year accumulation due to global growth of the field, increased graduate-level academic opportunities, and greater focus on research. For example, the Center for Play Therapy, which collects and houses all play therapy literature in its archives, identified approximately 575 play therapy books, chapters, dissertations, and journal articles published in the last five years. Additionally, as Ray found in a comprehensive analysis of peer-reviewed journals and reported personally to the authors, counselor educators publish more frequently in the *International Journal of Play Therapy* than anywhere except in the journals of the various divisions of the American Counseling Association. In 2008, the *International Journal of Play Therapy* moved from a semiannual to quarterly status, thereby providing additional opportunities in a play-therapy-specific venue. However, additional play therapy articles remain needed in a wide variety of professional journals to increase other mental health professionals' awareness and credibility of the field.

At the same time that play therapy literature has been expanding, the quality and rigor of research standards have been changing. Broad-based research projects using poorly defined and convenient samples without comparison groups, and treating global problem behaviors without clearly specified protocols or approaches, no longer meet the demands of the current mental health environment. Quality research—such as between-group design experiments, random assignment of subjects, use of treatment manuals and protocols, clearly defined client samples (gender, age, race, and other)—and appropriate analyses of data are required, as are single-case designs that meet rigorous research standards. All such research must meet current standards.

Meanwhile, there is ongoing debate regarding empirical or evidence-based treatments, including their categorization as “best support” and “promising” (Ray 2006) or “well-established” and “probably efficacious” (Chambless and Hollon 1998). Both Ray and T. Kerby Neill (2006) have compared research in highly controlled laboratory settings with research in professional practice, or real-world, settings. Quality is, of course, essential in both. Ray urged researchers to use clearly defined, manualized treatment and provide detailed reporting of sample population demographics, including using specific categories such as anxious, hyperactive, or depressive problems rather than generic terms such as “acting out” or “problem behaviors.” Ray also encouraged the field to replicate studies, while adhering to the same protocols with specific presenting problems,

in specific settings with independent researchers. When this occurs, a variety of play therapy treatment protocols will be acknowledged as “evidence based.”

Neill reminded us of philosophical questions in the therapeutic process, asking whether it is the theory and protocol, or some other factor in the therapeutic experience, that produces effective treatment outcomes. He also suggested researching common factors in play therapy. In this, he cited the work of Bruce E. Wampold, who suggested that effective psychotherapy is due to the common factors of a working alliance between client and therapist, the therapist’s competence and belief in the intervention, and the importance of the client’s hope and expectations.

Recent meta-analyses of research about play therapy outcomes also support the importance of continuing study. A 2001 meta-analysis (Leblanc and Richie) revealed a moderate effect size ( $ES = .55$ ) regarding play therapy’s success with children. In the largest meta-analysis to date, performed in 2005 by Bratton, Ray, Rhine, and Jones, a collection of ninety-three research studies conducted between 1953 and 2000 revealed a larger treatment effect size ( $ES = .80$ ) and indicated that play therapy was effective across a variety of presenting issues. Those studies using humanistic approaches to play therapy—primarily child-centered play therapy and nondirective play therapy—showed a still larger treatment effect ( $ES = .92$ ). Play therapy approaches involving paraprofessionals (parents and other significant adults in children’s lives, such as teachers) found an even greater effect size ( $ES = 1.05$ ). The authors concluded, therefore, that filial therapy—play therapy involving a child’s parent or teacher—is an effective modality for intervening in young children’s problems and provided the added benefit of potentially preventing the onset of more costly and serious problems across the lifespan.

## Conclusion

Play therapy is a dynamic, growing field. National associations comprised of culturally unique communities of play therapy advocates are establishing standards and are demanding clinical publications and training to help inform their practices. The number of university programs preparing play therapy supervisors, faculty, and researchers is rising. Treatment protocols and manualization are being refined and new ones developed, professional literature is mushrooming, and research is increasing. Moving forward, all these must continue, and

all who are in the field must be more vocal in educating professionals and the public about what is necessary to make play therapy available to all children in need of services.

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