Therapeutic work with children

Play therapy (PT) has been defined as a method of establishing 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” (Association of Play Therapy, 2014). It is one of a number of interventions used for children who suffer from emotional and behavioural disorders due to its responsiveness to their unique developmental needs (Bratton *et al.,* 2005), such as developing self-awareness, self-monitoring and self-resilience (Paone & Douma, 2009). Numerous tools such as puppets, sand trays and role-play may be employed by therapists to take advantage of a child’s most natural form of expression in order to communicate with them effectively (Mullen *et al.,* 2007). A rise in the popularity and widespread acceptance of PT over the past 70 years has come at a time when societal problems that directly impact children such as fragmented families, substance abuse and media violence have been on the rise (Bratton *et al.,* 2005). However, within the scientific community PT has been less widely accepted due to a lack of sound empirical evidence to support its use (Campbell, 1992).

Accounts of psychotherapy involving children can be found as early as Sigmund Freud and his work with ‘ Little Hans’ (Freud, 1909). However, it is generally acknowledged that the psychoanalysts Anna Freud (1928) and Melanie Klein (1932) pioneered PT as a psychotherapeutic modality (Knell, 1993). From this psychoanalytic perspective, the key principles underpinning PT are the exploration or analysis of transference and resistance by the client (Brandchaft, 2014). Transference refers to the process by which the client transfers their emotions that were originally transferred to the parents

onto the therapist (Tishby & Wiseman, 2014), whereas resistance refers to the repressing of painful experiences by the child into their unconscious in order to bear the stress they may be facing (Scaer, 2014). In this sense, play provides an avenue for decontextualization, allowing them to rid themselves of negative feelings associated with traumatic events (Goldstein, 1994). Importantly, Klein (1932) emphasised the role of play as a substitution for free association used within adult psychoanalysis, and argued that a child's actions during play could reveal underlying thoughts and feelings. The next major development in the field of PT came from the work of Axline (1947). Axline (1947) took the client-centered approaches of Rogers (1951), which placed emphasis on an accepting and empathetic relationship between the therapist and client, and applied them to children to develop non-directive PT. Axline centered this new school of PT on her belief that children have the capacity to resolve their own problems through play, if given the right therapeutic environment (Rasmussen & Cunningham, 1995). These two theories, psychoanalytical and humanistic, exist on the basis that they inform how the therapy is understood, the case is conceptualised and what outcomes would follow through. While they may be in direct contrast with one another, they both engage the same modality of play in order to help children deal with a range of mental health issues. The field of PT has grown dramatically since then as various theorists, academicians, and practitioners have developed specific PT approaches based on their theoretical views and personal experiences with children (Bratton *et al.,* 2005). These approaches include Filial PT (Guerney, 1964), gestalt PT (Oaklander, 1994), Adlerian PT (Kottman, 1995), and ecosystemic PT (O'Connor, 2000), to name a few.

To date, there is a shortage of studies yielding statistically significant results on the efficacy of PT with children. Instead, there exists a wealth of descriptive and theoretical works with inadequate or flawed research design (Bratton *et al.,* 2005). These works often suffer from a reliance on case studies, small samples, and uncontrolled studies, whilst also failing to provide sufficient definitions of what constitutes PT and inadequate or non-measurable determinants of treatment outcome (LeBlanc & Ritchie, 2001). In order to address this, a number of meta-analyses have been carried out (Leblanc & Ritchie, 2001; Bratton *et al.,* 2005; Jenson *et al.* , 2017). The outcomes of these ambitious studies have caused considerable excitement in the field of PT, and are often cited as support for PT's evidence base (Phillips, 2010). They offer some much-needed organisation of remote research endeavours in the field, allowing a glimpse at the entire PT research field (Jenson *et al.,* 2017).

When looking at PT as one therapeutic approach, in all of its forms, the results have been mixed, and have divided clinicians and researchers with regards to its effectiveness. There appears to be a discrepancy between the theoretical plausibility of PTs use as the natural mode of expression for children, and its performance when assessed by researchers. In their seminal meta-analysis LeBlanc & Ritchie (2001) found an overall effect size (ES) of 0. 66, and similarly Bratton *et al.* (2005) in their following meta-analysis, which included almost double the number of studies, found an overall ES of 0. 80. These findings indicate that PT is considerably better than nothing, and that it is better to about the same degree as most other forms of child psychotherapy. However, these findings were in contrast to Jenson *et al.'s*

(2017) later meta-analysis which found a far more modest overall ES of 0. 44, no longer comparable to the outcomes of other child-focussed treatments. Phillips (2010) argues that these differences are due to the coding categories used to evaluate the individual studies and the rigor to which they were upheld. While compiling individual studies and determining overall ESs may be beneficial in comparing therapeutic interventions and gaining a grand picture of the field, this may come at a cost to the smaller picture, such as the influence of different variables. As such, the different variables in the delivery of PT will be discussed in relation to their benefits and limitations.

The first variable in the use of PT which will be discussed is the treatment modality used; non-directive or directive. Theoretically, a non-directive approach has the advantage of allowing the child autonomy over their actions, as well as enabling the treatment provider a window into their mind, free from external motivation or teaching (Swan & Ray, 2014). This may be particularly beneficial for children with non-pathological speech disorders, such as selective mutism (Moustakas, 1951). In these conditions where an underlying anxiety disorder or social phobia may be present, a non-directive approach may relieve some of the pressure felt by the child to speak or act in a certain way (Wilson & Ryan, 2006). In this sense, non-directive PT may be beneficial as an anxiety reducing device (Mollamohammadi & Yazdkhasti, 2017). This is further supported by Bratton *et al.'s* (2005) meta-analysis which found that while both treatment modalities can be considered effective, non-directive interventions had a greater ES (0. 93), than directive interventions (0. 71). However, these ESs may reflect the difference in the

number of studies for each modality, with Bratton *et al.* (2005) including six times as many nondirective PT studies in their meta-analysis. Bratton *et al.* (2005) also acknowledged both the shortage of clearly articulated interventions and the mixing of approaches within the same treatment protocols. This further evidences the issues that still exist within PT research, even with the use meta-analyses. While the available scientific evidence in favour of non-directive over directive PT is persuasive, directive PT has been shown to be effective with trauma victims (Ryan & Needham, 2001). In challenging cases such as these, therapists are able to prepare for the session thereby enabling selection of specific activities appropriate to the goal of therapy (Tennessen & Strand, 1998). Additionally, a directive approach allows the therapist to walk through the child's emotions with them, which may be particularly valuable in the first few sessions (Andrews, 2010). However, offsetting these benefits is the risk that the therapist will externally influence the child and stall the development of their independence and self-coping mechanisms (Phillip, 2010). It is clear that both modalities have benefits if adopted appropriately according to the child's condition, however the results from meta-analyses may mask some of these more specific benefits such as the impact of directive PT with trauma victims.

An equally significant variable in the effective delivery of PT is the treatment provider. LeBlanc & Ritchie (2001) revealed that PT delivered by a paraprofessional had a larger ES (1. 05) than delivery by a mental health professional (0. 72). Furthermore, Bratton *et al.* (2005) noted that the majority of paraprofessional studies involved parents (22 of 26 studies), and

so when recalculating for parent-only filial studies, found an increased ES of 1. 15. Use of paraprofessionals in therapy may both elevate some of the stresses of a shortage of mental health professionals (Jenson *et al,* 2017), as well as benefit the child in the short and long term (Bratton, 2010). Filial therapy enables parents to connect with their child and gain a greater understanding of their feelings, motives and behaviours (Ginsburg, 2007), as well as arming them with techniques they can use to more effectively respond to their children at home (Paone & Douma, 2009). However, while there is consensus in the PT literature regarding the efficacy of paraprofessional delivery (Bratton *et al.,* 2005), ESs may be inflated due to its reliance on self-reporting (Phillips, 2010). In all of the studies included in Bratton et al.'s (2005) study in which parents provided treatment, parents were also a source of the outcome measure. Certainly, parents who are willing to invest themselves fully in their child's therapy are likely to see greater benefits in their child than those who are ambivalent about the therapeutic process (Guerney, 1997). In addition, the results may be reflective of paraprofessionals being matched to children appropriate to their skill level, and professionals being assigned more difficult cases (Bratton *et al.,* 2005). In light of this, the benefits and limitations of therapist-delivered and parent-delivered therapy need to be explored further.

Another significant advantage of PT is that it can be delivered effectively to individuals, as well as groups (Jenson *et al.* , 2017). While having a significant monetary benefit (Ginott, 1994), group PT also has a number of other benefits. The group nature allows children to build relationships outside the therapist-child one and utilises play as the means through which children

learn perspective taking, language skills, problem solving and an awareness of the needs of others (Davidson, 1998). Additionally, it may be used by therapists to provide valuable observation time in order to secure diagnostic formulations (Jenson *et al.,* 2017). Conversely, group PT may be unsuccessful or even damning for children with attention issues or social phobias (Casey & Berman, 1985). Perhaps in these cases, group PT would be better utilised as a tool for enhancing skills learnt in previous individual therapy (Phillips, 2010). In order for therapists to get the most beneficial results from group PT, careful selection of the group so as to select children who would benefit from this format as well as matching developmental ages is of paramount importance (Ginott, 1994).

Another factor that may impact the benefits of PT as a therapeutic approach is it's duration. LeBlanc & Ritchie (2001) looked closely at this variable and found that the optimum number of treatment sessions was between 30 and 35. Bratton *et al.* (2005) speculated that this finding was due to intensified problem behaviours at the onset of therapy. Yet, often due to financial and resource constraints, 30 sessions is not feasible (Cummings, 1977). Clearly, in these cases other therapeutic interventions would be more beneficial, exhibiting a considerable limitation of PT. However, Bratton *et al.* (2005) identified an intriguing subgroup of children who responded more quickly to PT intervention. The study noted an inverse relationship between children in the critical-incident category (i. e. hospitals, prisons) and the number of sessions. These results are promising and indicate that children in crisis may respond more readily to treatment at that time. Evidently, the benefits and

indeed limitations of PT are subject to the right approach taken with the right child.

The final variable and the one that shows the most variance in the benefits and limitations of PT is the characteristics of the child, namely their age, personality and target problem (Ray, 2008). PT is inherently developmentally sensitive and therefore can be used with children younger than those targeted by more traditional talk therapies (Bratton *et al.,* 2005). In 1962, Piaget proposed a theory of cognitive development, laid out in a serious of stages. In the pre-operational stage (three-six years) symbolic play dominates, whereas in the later, concrete operational stage (seven years and older) socialising becomes a far more central component of play, and the use of games and rules feature (Piaget & Inhelder, 1969). Dougherty & Ray (2007) investigated this further and concluded that PT was effective at both stages, given the right therapeutic environment. This was supported by Leblanc and Ritchie (2001) who noted that neither age nor gender were significant predictors of treatment outcome. Clearly, PT is beneficial in that it is uniquely responsive to boy's and girl's developmental needs from 3-to-12-years old.

Another important child characteristic is their personality (LeBlanc & Ritchie, 1999). Some children, such as Dibs, the young boy discussed in Axline's accounts, are charismatic and have protective factors present within themselves (Axline, 1964). Therefore, they are more predisposed to benefit from PT. However, children may be very resistant to therapy, feeling forced to be there against their will, which may lead to poorer outcomes (Fall *et al.,* 1999). Additionally, if the child's methods of coping with certain triggers or

memories are held rigidly, PT may be limited in its ability to teach them more adaptive ones (Danger & Landreth, 2005). In these children, as well as ones with extremely severe target problems such as post-traumatic stress disorder (PTSD), a more targeted intervention, such as directive PT or another therapeutic intervention may be far more successful (Vickerman & Margolin, 2007). This is supported by a systematic review (Gillies, 2016) that found that in reducing PTSD symptoms in the short term, CBT was favoured over play therapy.

The efficacy of PT has been studied with a wide array of different conditions (Shirk & Karver, 2003). However, a few stand out in the literature, including in treatment of speech difficulties (Danger & Landreth, 2005), in children facing medical procedures (Phillips, 2010) and for children displaying aggressive behaviour (Shaefer & Mattei, 2005). Historical literature demonstrates a long-established link between the development of play behaviours and the acquisition of language (O'Brien *et al.* 1987). Some findings suggest that children with an impairment in the ability to play, almost always have difficulty in learning to talk (Mundy *et al.,* 1987). Martin (1981) furthers this that " play is an essential precursor to language". Today, PT is recognised as useful in improving receptive and expressive language skills of children with speech difficulties (Danger & Landreth, 2005). PT has also been shown to be useful in aiding the development of language for children with autism spectrum disorder (Hebert *et al.* 2014).

Clearly, the benefits of PT can extend to children with a variety of mental health needs. Another well-documented use of PT is for children facing medical procedures (Phillips, 2010). Many Italian hospital programs

encourage the young patients to attend PT sessions in order to help them overcome the fear of invasive and painful medical procedures and to improve treatment compliance (Scarponi, 2016). PT is also an ideal opportunity for suffering children to act out characters, share experiences, and discuss the fears of being patients (Scarponi, 2016). However, the effectiveness of PT in treatment of aggressive behaviours is not so clear cut. Landreth (2002) argues that through the expression of aggressive feelings or behaviours in the playroom, but most importantly in the presence of an empathic and understanding adult, a child will learn to meet self-needs in a socially appropriate manner. Dollard *et al.* (1939) stated that " the occurrence of any act of aggression is assumed to reduce the instigation of aggression". According to this supposition, one aggressive act can serve as a substitute for another in reducing the aggressive drive. In this sense aggressive urges tend to build up and the child needs to release them in a safe environment, such as a playroom. Without this release, the pressure will mount until the point at which the aggressive impulses will erupt in real life aggressive behaviour that could be harmful to both self and others (Schaefer & Mattei, 2005). In light of the above, play therapists often grant children the opportunity to play aggressively by supplying them with toys such as guns (Laue, 2015). However, citing social learning theory[1]as an explanation, critics of allowing aggressive behaviours in the playroom claim that freedom of aggressive play will reinforce, and therefore increase aggression in children (Drewes, 2008; Schaefer & Mattei, 2005). Some play therapists have reported the need to " tame" children by " blocking" aggressive behaviour (Crenshaw & Mordock, 2005).

Discussion of the efficacy of PT is challenging due to the combinatorial quality of its different modalities. It is most beneficial when the correct combination of variables are used in order to address the specific needs of the child (Shirk & Karver, 2003). Therefore, perhaps PT's benefits like in its versatility, and as such is best used in association with other treatments. A number of studies point to the efficacy of play therapy in combination with cognitive behavioural therapy in the treatment of aggression (Badamian & Ebrahimi Moghaddam, 2017).

While adults use language to communicate with one another, children use play as their primary medium of expression (Trotter, Eshelman, & Landreth, 2003). Play allows them to express their feelings in a comfortable way, by bridging concrete experience with abstract thought (Kot, Landreth, & Giordano, 1998). However, while the theory behind PT seems secure, the research to support its efficacy is not. The field is characterized by a disparate array of studies that often do not build incrementally or theoretically on previous work. However, by untangling the current research, a number of interesting benefits emerge, particularly its success with language difficulties and its use before medical procedures as well as its success in group settings and its ability to be paraprofessionally delivered. However, a number of limitations also arise, specifically its use with more severe psychological trauma and its extended optimum duration.

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[1]The theory that people learn from one another via observation, imitation, and modelling (Bandura, 1978)