A thorough revision of the essential guide to using play therapy in schools

Fully updated and revised, *School-Based Play Therapy, Second Edition* presents an A-to-Z guide for using play therapy in preschool and elementary school settings. Coedited by noted experts in the field, Athena Drewes and Charles Schaefer, the *Second Edition* offers school counselors, psychologists, social workers, and teachers the latest techniques in developing creative approaches to utilize the therapeutic powers of play in schools.

The *Second Edition* includes coverage on how to implement a play therapy program in school settings; play-based prevention programs; individual play therapy approaches as well as group play; and play therapy with special populations, such as selectively mute, homeless, and autistic children. In addition, nine new chapters have been added with new material covering:
- Cognitive-behavioral play therapy
- Trauma-focused group work
- Training teachers to use play therapy

Filled with illustrative case studies and ready-to-use practical techniques and suggestions, *School-Based Play Therapy, Second Edition* is an essential resource for all mental health professionals working in schools.

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School-Based Play Therapy

Second Edition
This book is dedicated to
Scott Richard Drewes Bridges and Seth Andrew Bridges
and
Irene and Eric Schaefer
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Preface

IF EVER WE needed play therapy in the schools, it is now! With the rapid increase in school violence, bullying, homeless children and families, angry and aggressive children, and children exposed to chronic trauma situations, both human-made and by nature, play therapy is needed more than ever in the schools. Schools are the place where children spend a majority of their day, learning, socializing, and having their self-esteem shaped. It makes sense that in this environment, school clinicians would be able to have a significant impact in helping to heal children and adolescents suffering from emotional and behavioral difficulties. The healing powers of play as a treatment modality and play in therapy or counseling can significantly help children and adolescents decrease their emotional and behavioral difficulties. With the growth of play therapy as a respected modality, many school counselors, psychologists, teachers, and social workers have been searching for techniques that could be incorporated into their school settings.

This second edition is born out of our desire to help meet school clinicians’ needs. The invited authors in this text have many years of expertise working in school settings, both in the public and private sectors, and have a broad range of experience with the age groups that they serve. They bring a wealth of knowledge on how to use play therapy to work with children and adolescents in individual and group settings and with a variety of tools.

Two-thirds of the chapters in this volume are new chapters focusing on up-to-date approaches. The remaining one-third are chapters from the first edition that we felt were important to include. These chapters have been updated to include recent developments over the last ten years. This volume is divided into six parts. Part I addresses the therapeutic power of play and offers a review of the outcome research of school-based play therapy. Part II gives the school clinician practical information on how to incorporate play therapy in the schools, along with the concomittant challenges and barriers that are encountered.
Part III addresses play-based assessments for the primary years and for elementary and intermediate school settings. Part IV addresses play-based prevention programs using paraprofessionals and teachers. Part V focuses on individual and group play therapy approaches that specifically target children with autism, anger management difficulties, ADHD, and trauma. Part VI addresses special populations and special issues encountered when using play therapy in the school setting, such as parental alcoholism, selective mutism, homelessness, and bereavement issues. All chapters are meant to be applicable to the school or classroom setting. There are clear descriptions of each approach with suggestions as to how they might be implemented.

We hope that school clinicians and teachers will find this second edition a useful resource for helping the children and adolescents they serve.

Athena A. Drewes
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PART I

PLAY THERAPY: ITS THERAPEUTIC POWER AND RESEARCH EFFECTS
CHAPTER 1

The Therapeutic Powers of Play and Play Therapy

CHARLES E. SCHAEFER and ATHENA A. DREWES

PLAY IS AS natural to children as breathing. It is a universal expression of children, and it can transcend differences in ethnicity, language, or other aspects of culture (Drewes, 2006). Play has been observed in virtually every culture since the beginning of recorded history. It is inextricably linked to how the culture develops poetry, music, dance, philosophy, social structures—all linked through the society’s view of play (Huizinga, 1949). But how play looks and is valued differs across and within cultures (Sutton-Smith, 1974, 1999).

The use of fantasy, symbolic play, and make-believe is a developmentally natural activity in children’s play (Russ, 2007). Play is not only central but critical to childhood development (Roopnarine & Johnson, 1994). For a variety of species, including humans, play can be nearly as important as food and sleep. The intense sensory and physical stimulation that comes with playing helps to form the brain’s circuits and prevents loss of neurons (Perry, 1997). Play is so critical to a child’s development that it is promoted by the United Nations 1989 Convention on the Rights of the Child, Article 31.1, which recognizes “the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts.” Play is perhaps the most developmentally appropriate and powerful medium for young children to build adult-child relationships, develop cause-effect thinking critical to impulse control, process stressful experiences, and learn social skills (Chaloner,
Play can provide a child the sense of power and control that comes from solving problems and mastering new experiences, ideas, and concerns. As a result, it can help build feelings of confidence and accomplishment (Drewes, 2005). Through play and play-based interventions children can communicate nonverbally, symbolically, and in an action-oriented manner.

Play is not only essential for promoting normal child development, but it has many therapeutic powers as well. All therapies require, among other factors, the formation of a therapeutic relationship, along with the use of a medium of exchange (Drewes, 2001). The use of play helps establish a working relationship with children, especially those who lack verbal self-expression, and even with older children who show resistance or an inability to articulate their feelings and issues (Haworth, 1964). The presence of toys and play materials in the room sends a message to the child that this space and time is different from all others. It indicates to the child that they are given permission to be children and to feel free to be fully themselves (Landreth, 1993).

Play is used in therapy by play therapists and child clinicians as a means of helping children deal with emotional and behavioral issues. Play therapy and the use of play-based interventions is by no means a new school of thought (Drewes, 2006). The use of play to treat children dates back to the 1930s to Hermione Hug-Hellmuth, Anna Freud, and Melanie Klein. Several adult therapies have since been adapted for use with children, such as child-centered play therapy adapted by Virginia Axline (1947), sandplay therapy evolving out of Jungian theory through Margaret Lowenfeld (1979) and Dora Kalff (1980), and cognitive-behavioral play therapy by Susan Knell (1993).

In the safe, emotionally supportive setting of a therapy room, the child can play out concerns and issues, which may be too horrific or anxiety producing to directly confront or talk about in the presence of a therapist who can help them feel heard and understood. The toys become the child’s words and play becomes his or her language (Landreth, 1991), which the therapist then reflects back to the child to foster greater understanding.

**CURATIVE FACTORS OF PLAY**

Therapists from differing theoretical orientations have long been interested in the healing or curative factors of psychotherapy. It is
only over the past 25 years that child clinicians and researchers have looked more closely at the specific qualities inherent in play behavior that makes it a therapeutic agent for change (Russ, 2004). The goal is to understand what invisible but powerful forces resulting from the therapist-client play interactions are successful in helping the client overcome and heal psychosocial difficulties. A greater understanding of these change mechanisms enables the clinician to apply them more effectively to meet the particular needs of a client (Schaefer, 1999).

Freud wrote of insight, facilitated by the therapist’s interpretations and analysis of transference (Schaefer, 1999), as the key component toward curing a client in psychoanalysis.

Yalom (1985) wrote about “therapeutic factors” or change mechanisms that he believed were inherent in group psychotherapy (Schaefer, 1999). They included acceptance, altruism, catharsis, instillation of hope, interpersonal learning, self-disclosure, self-understanding, universality, vicarious learning, and guidance (Schaefer, 1999). Bergin and Strupp (1972) offered critical factors that transcended theoretical schools of thought: counterconditioning, extinction, cognitive learning, reward and punishment, transfer and generalization, imitation and identification, persuasion, empathy, warmth, and interpretation (Schaefer, 1999).

Schaefer (1999) was the first to describe the therapeutic powers of play. Based upon a review of the literature, he identified 25 therapeutic factors that will be discussed below.

SELF-EXPRESSION

Developmental limitations in expressive and receptive language skills, limited vocabulary repertoire, and limitations in abstract thinking ability contribute to young children’s difficulty in communicating effectively. Perhaps the major therapeutic power of play that has been described in the literature (Schaefer, 1995, 1999) is its communication power. In play, children are able to express their conscious thoughts and feelings better through play activities than by words alone. Children are naturally comfortable with expression through concrete play activities and materials (Landreth, 1995). Use of symbolic representation and expression through dolls and puppets provides emotional distance from emotionally charged experiences, thoughts, and feelings. Through indirect expression in play the child can gain awareness of troublesome affects and memories and begin the process of healing.
ACCESS TO THE UNCONSCIOUS

Through the specially chosen toys, games, and materials for their therapeutic and neutral stimulus qualities, the child can reveal unconscious conflicts via the defense mechanisms of projection, displacement, and symbolization (Klein, 1955). With the support of the play therapist in a safe environment, the child can begin to transform and integrate unconscious wishes and impulses into conscious play and actions (Schaefer, 1999).

DIRECT AND INDIRECT TEACHING

Play allows you to overcome knowledge and skills deficits in clients by direct instruction. For example, when you teach social skills to children using dolls, puppets, and role-plays, the children are more likely to learn and remember the lessons. The use of fun and games captures children’s attention and increases their motivation to learn.

Story telling and the use of play narratives allow the child to join in interactive fantasy play with the therapist (Schaefer, 1999). This in turn can result in the child learning a lesson or solution to his or her problem (Gardner, 1971). This is a gradually paced, indirect method with room for repetition that allows for less emotional arousal than direct confrontation (Frey, 1993). Play narratives enable clients to organize their fragmented memories and experiences into a cohesive, meaningful story (Pennebaker, 2002).

ABREACTION

Through the use of play, children reenact and relive stressful and traumatic experiences and thus gain a sense of power and control over them (Schaefer, 1999). Through repetitive play reenactments, the child is able to gradually mentally digest and gain mastery over horrific thoughts and feelings (Wedler, 1932). Children show a natural tendency to cope with external events and traumas through play. After the horror of 9/11, many children were observed building towers with blocks and crashing toy airplanes into them. “Post-traumatic play can be effectively used therapeutically. It is, in fact, the most potent way to effect internal change in young traumatized children” (Terr, 1990, p. 299).

STRESS INOCULATION

The anticipatory anxiety of upcoming stressful life events, such as a family move, starting school, birth of a sibling, or visit to a doctor or
dentist, can be lessened by playing out the event in advance (Wohl & Hightower, 2001). By playing out with miniature toys exactly what to expect and using a doll to model coping skills, the strange can be made familiar and less scary to the child.

**Counterconditioning of Negative Affect**

Two mutually exclusive internal states are not able to simultaneously co-exist, such as anxiety and relaxation or depression and playfulness (Schaefer, 1999). Thus, allowing a child to play hide-and-seek in a darkened room can help in conquering fear of the dark. Or dramatic play with hospital-related toys can help to significantly reduce hospital-specific fears. Rea et al. (1989) found hospitalized children’s adjustment was significantly improved (anxiety significantly reduced) for the randomly assigned group that was encouraged to engage in fantasy play with both medical and non-medical materials.

Fantasy play allows the child to move from a passive to an active role; for example, the child can role-play giving an injection to a doll patient. Fantasy play also facilitates the expression of several defense mechanisms such as projection, displacement, repetition, and identification (Schaefer, 1999).

**Catharsis**

Catharsis allows for the release and completion of previously restrained or interrupted affective release via emotional expression (e.g., crying) or activity (e.g., bursting balloons, pounding clay, or punching an inflated punching bag) (Schaefer, 1999). Emotional release is a critical element in psychotherapy (Ginsberg, 1993).

**Positive Affect**

While involved in play, children tend to feel less anxious or depressed. Enjoyable activities contribute to a greater sense of well-being and to less distress (Aborn, 1993). In play, both children and adults are likely to elevate their mood and sense of well-being (Schaefer, 1999). Sustained high levels of the stress hormone cortisol can damage the hippocampus, an area of the brain responsible for learning and memory, which results in cognitive deficits that can continue into adulthood (Middlebrooks & Audage, 2008). Laughter and positive affects help to create the opposite effect, releasing mood-boosting hormones or
endorphins, lowering serum cortisol levels, and stimulating the immune system (Berk, 1989). Play and playfulness and its potential for mirth and laughter become an antidote to negative affects such as anxiety and depression (Schaefer, 1999).

**SUBLIMATION**

Sublimation allows the channeling of unacceptable impulses into substitute activities that are socially acceptable (Schaefer, 1999). The child who physically hits another may be re-directed, helped to practice and learn through repetition alternative means of expressing negative feelings by using “warlike” board games (chess, checkers), card games (War), or competitive sports activities (Fine, 1956; Schaefer, 1999).

**ATTACHMENT AND RELATIONSHIP ENHANCEMENT**

Play has been found to facilitate the positive emotional bond between parent and child. Studies of filial therapy (Ray, Bratton, Rhine, & Jones, 2001; Van Fleet & Guerney, 2003), Theraplay, and Parent-Child Interaction Therapy (Brinkmeyer & Eyberg, 2003; Hood & Eyberg, 2003) have shown success in promoting parent-child attachment and relationship enhancement (Drewes, 2006). Through step-by-step, live-coached sessions, the parent/caregiver and child create positive affective experiences, such as playing together, which results in a secure, nurturing relationship. Gains are reflected, via research, in improvements in parental empathy, increased perception of positive changes in the family environment, self-esteem, perception of child-adjustment, perception of the child’s behavioral problems, along with the child’s self-concept, and changes in the child’s play behavior (Rennie & Landreth, 2000).

**MORAL JUDGMENT**

Piaget (1932) first asserted that children’s spontaneous rule-making and rule-enforcing play in informal and unsupervised play situations was a critical experience for the development of mature moral judgment. Game play experiences help children move beyond the early stage of moral realism, in which rules are seen as external restrictions arbitrarily imposed by adults in authority, to the concept of morality that is based on the principles of cooperation and consent among equals (Schaefer, 1999).
EMPATHY

Through role-play, children are able to develop their capacity for empathy, the ability to see things from another’s perspective. Role-playing different characters in social play has been found to increase altruism (Iannotti, 1978) and empathy (Strayer & Roberts, 1989), as well as social competence (Connolly & Doyle, 1984).

POWER/CONTROL

Children feel powerful and in control during their play. They can make the play world conform to their wishes and needs (Schaefer, 1999). In marked contrast with the sense of helplessness children experience during a disaster, play affords them a strong sense of power and control. The child towers over the play materials and determines what and how to play during the therapy session. Eventually, this competing response (power) helps overcome the child’s feelings of insecurity and vulnerability.

COMPETENCE AND SELF-CONTROL

Play provides children with unlimited opportunities to create, such as through stories, worlds constructed in a sandtray, or drawings, whereby they can gain a sense of competence and self-efficacy that boosts their self-esteem (Schaefer, 1999). In addition, by engaging in activities such as game playing or construction play, children can learn self-control through thought and behavior stopping that can help them to stop and think and plan ahead. As a result the child can anticipate the consequences of various potential behaviors and actions. These skills can be mastered through practice opportunities and positive reinforcement and can consequently then generalize into any number of settings (e.g., school, home, social settings).

SENSE OF SELF

Through the play and child therapist’s use of a child-led, child-centered approach (Axline, 1947), a child can begin to experience complete acceptance and permission to be himself without the fear of judgment, evaluation, or pressure to change. Through a commentary on the child’s play, the therapist provides a mirror, figuratively speaking, by which the child can understand inner thoughts and feelings and
develop an inner self-awareness (Schaefer, 1999). Play can also provide
the opportunity for the child to realize the power within to be an
individual in one’s own right, to think for oneself, make one’s own
decisions, and discover oneself (Winnicott, 1971). Since this is often a
unique experience, Meares (1993) noted that the field of play is where,
to a large extent, a sense of self is generated. He concluded that play
with an attuned adult present is where experiences are generated that
become the core of what we mean by personal selves (Schaefer, 1999).

ACCELERATED DEVELOPMENT

Preschool children’s levels of development can advance in play beyond
the ordinary accomplishments of their age period and function at a
level of thinking that will only become characteristic later on (Schaefer,
1999). Vygotsky (1967) observed that children at play are always above
their average age and their daily behavior.

CREATIVE PROBLEM SOLVING

Numerous studies have demonstrated that play and playfulness are
associated with increased creativity and divergent thinking in children
(Feitelson & Ross, 1973; Schaefer, 1999). Since in play the process is
more important than the end product, children can freely, without
fear of consequences, come up with novel combinations and discoveries
that can aid them in solving their own problems and social problems
(Schaefer, 1999; Sawyers & Horn-Wingerd, 1993). Indeed there is
“something about play itself that acts as a vehicle for change” (Russ,
2007, p. 15). Divergent thinking has been thought to be a mediating link
between pretend play and coping strategies (Russ, 2007), whereby
children who are good at pretend play (use of affect and fantasy) are
better divergent thinkers, have more coping strategies, and could more
readily shift from one strategy to another (Christiano & Russ, 1996).
Goldstein and Russ (2009) found in a study with first grade children that
there was a positive and significant relationship between imagination in
play and the frequency of coping responses and variety of strategies
used, even when the sample was controlled for IQ. Russ (2007) and
Singer (1995) speculate that it is divergent thinking that underlies
children’s pretend play, a notion that has received empirical support.
Being able to think up and find different uses for objects (e.g., clay,
blocks), to create different endings to stories, or to devise scenarios of
action can increase divergent thinking (Dansky, 1999).
Fantasy Compensation

In play, children can get immediate substitute gratification of their wishes. A fearful child can be courageous, or a weak child can be strong. Robinson (1970) saw play as essentially a compensatory mechanism operating much like a daydream. Impulses and needs that cannot find expression in real life find an outlet through fantasy.

Reality Testing

Play experiences allow children to practice reading cues in social situations and can help differentiate fantasy from reality. In social pretend play, children often switch back and forth between the roles they are playing and their real selves (Schaefer, 1999). Frequent engagement in pretend play allows for better discrimination between reality and fantasy (Singer & Singer, 1990).

Behavioral Rehearsal

In the safe environment of play, socially acceptable behaviors, such as assertiveness versus aggressiveness, can be rehearsed and practiced. The play and child therapist can model in play new behaviors that are more adaptive for the child through use of puppets and role-play, which the child can then repeatedly practice to ensure skill development and mastery (Schaefer, 1999; Jones, Ollendick, & Shenskl, 1989).

Rapport Building

One of the most potent therapeutic powers of play is the relational component of rapport building. This occurs when the client responds positively to the playful and fun-loving therapist. Since most children do not come willingly to therapy, they need to be initially engaged in the process through therapist/child play interactions. Also, since “play is the language of the child,” it provides a natural medium for communicating with, and establishing a relationship with, the child (Landreth, 1983, p. 202).

Prescriptive Play Therapy

Each of the well-known schools of play therapy (e.g., client-centered, cognitive-behavioral, and psychodynamic) emphasizes one or more of the curative powers of play. The prescriptive eclectic approach
(Kaduson, Cangelosi, & Schaefer, 1997) advocates that play therapists become skilled in numerous therapeutic powers and differentially apply them to meet the individual needs of clients. The prescriptive approach is based on the individualized, differential, and focused matching of curative powers to the specific causative forces underlying the problem of a client (Kaduson, Cangelosi, & Schaefer, 1997). When therapists have a greater understanding of these change mechanisms, they can then become more effective in meeting the particular needs of the client.

Norcross (2002) also advocates a prescriptive approach to treatment whereby techniques are modified to match the client’s diagnosis or presenting problem. Moreover, therapists should change their interpersonal style of interaction to match the client’s style in order to improve treatment outcome.

FUTURE RESEARCH

Although there are numerous outcome studies now attesting to the efficacy of play therapy with children, there are few, if any, process studies of play therapy. Process studies seek to identify the specific mediators, that is, the therapeutic factors that produced the desired change in the clients’ behavior. Play therapists also need to look at which change agents in play can be combined to optimize treatment effectiveness. A clearer knowledge of the array of therapeutic factors underlying play therapy will allow child clinicians to borrow flexibly from available theoretical positions to tailor their treatment to a particular child (Kaduson, Cangelosi, & Schaefer, 1997).

CONCLUSION

This chapter has briefly highlighted the various therapeutic change mechanisms within play that can help clients overcome their psychosocial difficulties. The therapeutic factors within play should not be viewed as mysterious but as capable of being understood, altered, and even fully controlled. The use of individualized treatment goals facilitates and guides the therapist in deciding which therapeutic powers to apply. Further research is needed to elucidate the specific therapeutic powers of play that are most effective with the specific presenting problems of clients.

This prescriptive matching of change agents with underlying causes will result in the most cost-effective play interventions.