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PLAY THERAPY EFFECTIVENESS AND ISSUES

OYUN TERAPİSİNİN ETKİLİLİĞİ VE SORUNLARI

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Abstract

Many children need support with emotional literacy, while others experience behavioural or mental health problems. A number of approaches exist, but not all are suitable for children and adolescents, as their needs differ from those of adults. Play therapy is an effective psychotherapeutic approach for helping children and adolescents. Play is a vital aspect of childhood, with its importance for healthy development being first noted in the writings of Rousseau in the 18th century. Play therapy has now become a leading psychotherapeutic intervention with children and adolescents despite the fact that play was not introduced into a counselling setting until the early 20th century. Play therapy is the most effective means of benefiting children in a counselling relationship, and is undertaken in a nurturing environment in which children play out how they think about themselves, what they need from their life, and what they have experienced, along with their reactions and feelings. Play therapy is an effective method of helping troubled children tackle their distress, enabling them to experience the freedom to explore their emotions and views of themselves, and others, through play. This article will: (1) define play therapy, including its importance in a therapeutic setting; (2) demonstrate the effectiveness of play therapy; (3) explore a number of current issues concerning the use of play therapy.

Özet

Pek çok çocuğun duygusal okuryazarlıkla destek alması gerekirken, diğerleri davranışsal veya zihinsel sağlık problemleri yaşamaktadır. Birtakım yaklaşımlar mevcuttur, ancak bunların hepsi yetişkinlerinkinden farklı olduğundan çocuklar ve ergenler için uygun değildir. Oyun terapisi, çocuklara ve gençlere yardımcı olmak için etkili bir psikoterapötik yaklaşımdır. Oyun, 18. yüzyılda Rousseau'nun yazılarında ilk defa sağlıklı gelişmenin önemini vurgulayan çocukluğun hayati bir yönüdür. Oyun terapisi, oyunun 20. yüzyılın başına kadar bir danışma ortamına girmediği gerçeğine rağmen, çocuklarla ve ergenlerle önde gelen bir psikoterapötik müdahaleye dönüşmüştür. Oyun terapisi, bir danışma ilişkisinde çocukların yararlanmasında en etkili yoldur ve çocukların kendileri hakkında ne düşündüklerini, hayatlarından neye ihtiyaç duyduklarını ve yaşadıklarını,ve birlikte oynadıkları, besleyici bir ortamda duyguları ve reaksiyonlarıyla gerçekleştirilir. Oyun terapisi, sorunlu çocukların zor durumlarıyla başa çıkmalarına yardımcı olmada etkili bir yöntemdir; onların duygularını ve kendilerinin ve diğerlerinin görüşlerini keşfetme özgürlüğünü yaşamalarını sağlar. Bu makalede: (1) terapötik bir ortamın önemini de içeren oyun terapisini tanımlanması; (2) oyun terapisinin etkinliğini gösterilmesi; (3) oyun terapisinin kullanımıyla ilgili bir dizi güncel konuyu araştırılacaktır.

Indroduction

PTUK[1], (2011) defines play as "a physical or mental leisure activity that is undertaken purely for enjoyment or amusement and has no other objective".

The Association for Play Therapy (2003) defines 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 therapy can be defined as a dynamic process. Through their relationship with the therapist, children are able to explore problems at their own pace, and according to their own wishes. Play therapy can thus have a considerable influence on children's current lives, by enabling them to develop and change in a gradual manner. Thus, the role of the therapist is a vital one, due to its role in transforming a child's inner resources, and therefore the therapist should focus on child-centred and play-centred activities, with speech being regarded as secondary (Hooper et al., 2012).

Due to the significance of the relationship between therapist and child, the majority of play therapists employ the child-centred (Landreth, 2002) and non-directive model (Wilson and Ryan, 2005), and will not use play with the aim of making a child talk.

Importance of Play Threapy

As stated previously, play has a considerable role in the life of both children and adolescents. It can be fun, educational, creative and stress relieving, giving opportunities for communication and creating beneficial relationships with others. Play has a key role in children's development in a number of ways, including learning to tolerate disappointment and regulate emotions (Schaefer, 2011, p.4). Play can provide opportunities for children to create their own worlds by building, developing and maintaining their sense of self (Schaefer, 2011, p.4). Play can increase children's confidence through developing new skills, improving their physical and mental health, along with self-awareness, self-esteem, and self-respect (Lester and Russell, 2008).

The therapeutic power of play can be placed into 8 categories: (1) communication skills; (2) emotional regulation; (3) consolidation of relationships; (4) ethical judgment; (5) stress management; (6) ego boosting; (7) preparation for life; (8) self-actualisation (Schaefer, 2011, p.4). In addition, play therapy also gives short-term benefits, i.e. improved academic results and the lowering of stress levels for both family and child (PTUK, 2011).

[1] Play Therapy UK

The Therapeutic Power of Play and Play Therapy

Play has been observed in all cultures throughout history. It is a universal expression of children and adolescents, and a common point of different ethnicities, languages and cultures (Drewes, 2006), and is thus critical to a child's development. Play has a significance role in the acquiring of social skills, the creation of social relationships, and the development of thinking (Chaloner, 2001), while at the same time improving children's self-confidence and accomplishments (Drewes, 2005).

Establishing the therapeutic power of play, and play therapy, will demonstrate the effectiveness of play therapy in helping children deal with emotional and behavioural issues (Schaefer, 2011, p.16). Schaefer (1999) describes the therapeutic power of play through the identification of 25 therapeutic factors, including those discussed below.

Self-expression: Some children and adolescents have developmental limitations in language, and so struggle with expressive and receptive language skills, including limited vocabulary and the facility for abstract thinking (Schaefer, 2011, p.17). The primary therapeutic power of play is that of communication (Schaefer, 1993, 1999), enabling children and adolescents to reveal their feelings by means other than words, as they feel comfortable and free in the process of play (Landreth, 1993). It is thus through indirect expression in play that children and adolescents are able to regain memories and begin the process of healing.

Access to the unconscious: through the use of specialised toys, games and materials, unconscious conflicts can be revealed through defence mechanisms (Klein, 1995), thus allowing therapists to gain access to the children's unconscious through play. Within a safe environment, and with the right toys or games, children and adolescents can begin to adapt unconscious wishes and impulses into conscious play and action (Schafer, 1999).

Direct and Indirect Teaching: play is able to teach knowledge and skills by direct instruction. The use of toys, games, or other enjoyable activities, will excite attention, thus improving the ability to learn and remember and improve motivation (Schaefer, 2011, p. 17).

Abreaction: During play therapy, children and adolescents express their stressful and traumatic experiences, awarding them relief, while gaining a sense of power (Schaefer, 1999). Thus, repeated sessions promote the ability to mentally overcome the issue at hand (Waelder, 1932).

Stress inoculation: Play therapy can be beneficial in overcome anticipatory life events, e.g. starting new school, a family move, or the birth of sister or brother (Wohl and Hightower, 2001). By using model coping skills, children and adolescents are able to lessen their fears of anticipatory life events.

Counter-conditioning of negative affects: Play therapy can help to overcome children's fears, e.g. nyctophobia[2] or hospital-specific fears. Rea et al. (1989) found that play therapy helped to diffuse children's fear of hospital in fantasy play with both medical and non-medical materials. Fantasy play also allows the development of defence mechanisms (Schaefer, 1999).

Catharsis: Emotional release is vital in psychotherapy (Ginsberg, 1993), enabling the release of troubled and negative emotion through emotional expression or activity (Schaefer, 1999).

Positive effect: In play, children and adolescents are able to improve their mood and sense of well-being, through their enjoyment and the lessening of stress (Aborn, 1993). Thus, play has a positive effect on both their physical and emotional condition.

Sublimation: Sublimation enables children transform socially unacceptable behaviour to that which considered acceptable (Schaefer, 1999).

Attachment and the enhancement of relationships: Ray, Bratton, Rhine and Jones, (2001) and Van Fleet and Guerney, (2003) have established that play promotes a positive emotional connection between parents and children. Play therapy thus assists parents in developing empathy and improving the family environment, so addressing children's behavioural issues (Rennie and Landreth, 2000).

Moral judgment: In play, children and adolescents follow rules, some of which are decided by their parents, based on the basis of cooperation. Game play experiences allow children and adolescents to advance through the early stages of moral realism (Schaefer, 1999).

Empathy: Role-play enables children and adolescents to improve their understanding of others, and to see things from another's perspective, thus improving altruism (Iannotti, 1978) and empathy (Strayer & Roberts, 1989), along with social competence (Connolly & Doyle, 1984).

Power/control: Play provides children and adolescents with freedom and unlimited power for the duration of the game, enabling them to create new worlds that are subject to their wishes and needs (Schaefer, 1999).

Competence and self-control: There is no limit to creativity during their play, enabling children and adolescents to improve their sense of competence and self-efficacy (Schaefer, 1999), as well as understanding the potential results of behaviours and actions.

Sense of self: In play, children can begin to experience complete permission to be themselves. They can make decisions without any fear of judgment or evaluation (Axline, 1947), along with experiencing the opportunity to understand the power within their own right to think, and to make decisions, for themselves (Winnicott, 1971).

[2] Fear of the dark

Accelerated development: Play assists children to improve and understand the next stage of another's behaviour. Vygotsky (1967) observes that children always act older than their average age, and their daily behaviour, during their play. Play has also been demonstrated to increase the pace of children's development.

Creative problem solving: Feitelson and Ross (1973) and Schaefer (1999) have demonstrated that play helps to increase children's creativity and divergent thinking. It is the process itself that is more important than result, as it enables children to be free to think and create, and to try many different ways and methods without any fear of the consequences (Schaefer, 1999; Sawyers & Horn-Wingerd, 1993).

Fantasy compensation: During play, children directly substitute gratification of their wishes, i.e. a fearful child can be courageous, or a weak child can be strong (Schaefer, 2011, p. 21).

Reality testing: Children are given an opportunity to practice reading social cues, and understand the difference between fantasy and reality in play activities (Drewes and Schaefer, 2010, p.11), thus enabling improved differentiation between reality and fantasy (Singer & Singer, 1990).

Behavioural rehearsal: In the safe environment of play, children and adolescents are able to practice and rehearse socially acceptable behaviours (Schaefer, 2011, p. 21).

Rapport building: The most potent therapeutic power of play concerns the relational component of rapport building (Drewes and Schaefer, 2010, p. 11). Play provides therapists with opportunities for communicating and developing a relationship with the child (Landreth, 1993).

Although, many studies have focussed on the outcomes of play therapy with children, only a small number focus on the process itself. Such process studies have investigated therapeutic factors that have produced a desired change in a child's behaviour, while a play therapist also needs to look at the ways in which changes during play sessions can be optimised, in order to ensure the effectiveness of the treatment (Kaduson, Cangelosi, & Schaefer, 1997).

The Effectiveness of Play Therapy

A number of researchers have employed meticulous research methods to establish the effectiveness of play therapy, including a large number of meta-analytic studies (Schaefer, 2011, p.10). Leblanc and Ritchie (2001) have found the average effect level of play therapy is 0.66, using a meta-analytic approach in a review of 42 published and unpublished studies, thus establishing a significant improvement (Leblanc and Ritchie, 2001). In previous studies, Smith and Glass (1977) reported a mean effect size of 0.68 in meta-analytic studies of non-play based therapeutic interactions with adults and children. However, Casey and Berman (1985) found this effect to be 0.7, with a mean effect of 0.68 when play-based interventions were observed separately from non-play based therapies. These results demonstrate play therapy interventions are equally effective as talk-based therapies.

Bratton and Collagenous (2005) found a large mean effect size of 0.80 during their recent studies focussing on the meta-analytic approach of play therapy interventions. Overall, these meta-analyses demonstrated the importance of parents' cooperation, due to the improved outcomes when parents were trained to act as co-therapists (Bratton et al., 2005; Leblanc and Ricthie, 2001).

PTUK (2011) investigated both the referrer's and the parents' observation of changes in children directly after therapy. A large number of children (3702 Cases) participated in this research, with 74% of children being observed to experience a positive change, 18% a negative change, and 8% no change. Overall, PTUK (2011) established that the simple answer to the question 'How effective is play therapy?' is that between 74% and 83% of children demonstrate a positive change, with the level of improvement depending on the depth of the children's problems. In this study, the majority of children experiencing severe problems show a positive change, i.e. 74% of those with slight/moderate problems, and 83% of those with severe problems. Furthermore, age also has an effect on the level of improvement. Generally speaking, younger children experience greater levels of positive change (PTUK, 2011) (i.e. 80% at age 6 and 71% at age 12). The other factor relates to gender, with 71% of girls aged 12 demonstrating higher levels of improvement than boys (PTUK, 2011).

The PTUK (2011) study also focused on children with severe problems. Between 1st January 2008 to 30th June 2011, 56 children were observed by referrers, and 89 by parents. 83% of these children were observed to experience positive change, 10% had no change and 8% had a negative change.

As noted above, the effectiveness of play therapy can be influenced by age. The average age of children was 7, years, and 6.7 years when play therapy was provided by professionals. In the research undertaken by Weisz et al. (1987), Kazdin et al. (1990) and Casey and Berman (1985), almost 2 out of 3 of children were male and play therapy was found to be equally effective for both genders and all ages. However, earlier studies on the effectiveness of child therapy found mixed results in relation to the impact of both age and gender. Weisz et al. (1987) reported play therapy having a greater effect on girls than boys, while Casey and Bernan (1985) reported no difference between genders, but that play therapy proved more effective for younger children. Leblanc and Ritchie (2001) reported play therapy to be significantly effective, with no difference observed between genders, or age groups. As part of the PTUK (2011) research, 1871 cases were observed between the period 1st January 2008 to 30th June 2011. The data revealed a slight decrease in the rate of positive change in relation to an increase in age (see Table 1).

ge		% Showing a positive change

	11	73
	15	80
	80	78
	75	76
	32	74
0	76	74
1	23	76
2	59	71
	871	

Table.1- Positive change by age

PTUK (2011) notes that the effectiveness of play therapy does not depend on gender. Table 2 demonstrates the results of observations of changes in children post therapy according to gender. A slight difference was found, with 79% of girls, and 73% of boys, showing positive change.

	Boys		Girls	
	N	%		%
Negative change	2	1		1

	77	9%	02	5%
No change	115	8%	3	6%
Positive change	1086	73%	35	79%
	1478	100%	80	100%

Table 2 – Changes Observed Post Therapy by Gender

PTUK (2011) has undertaken studies in the UK, along with countries such as Malaysia, Australia and Ethiopia. Positive change was observed after play therapy, as follows: 61% in Australia, 69% in Malaysia and 90% in Ethiopia. These numbers reveal a positive change after play therapy, regardless of ethnicity.

A review by Ray, Bratton, Rhine and Jones (2005) of 93 play therapy outcome studies has established the positive effect of play therapy for children with emotional and behavioural difficulties. Those given play therapy demonstrated a 0.80 positive change in comparison to those who were not given the treatment (Ray, Bratton, Rhine and Jones, 2005). Further analysis has also revealed that play therapy is effective across setting, gender, age and clinical, and nonclinical, populations. The importance of the findings of Ray, Bratton, Rhine and Jones (2005) concerns the fact that play therapy is an effective intervention for children's issues, and has a considerable effect on children's behaviour, social interactions and personality. When children are unable to socially adapt their behaviour, both they, and their parents, can be negatively affected. Current research supports the conclusion that play therapy has the power to influence behaviour.

Ray, Bratton, Rhine and Jones (2005) found that involving children's parents fully in therapy is not necessarily an effective alternative, but provides structured, and supervised, experiences for parents to practice their skills with their children. Play therapy can be conducted by both professionals or parents, with Ray, Bratton, Rhine and Jones (2005) finding a medium effect when play therapy was conducted by a professionals, but a much greater one when it was undertaken by parents.

A number of studies have focussed on play therapy conducted by professionals and paraprofessionals. Ray, Bratton, Rhine and Jones (2005) define 'paraprofessionals' as parents or teachers, trained by a professional. The results of their study demonstrate that the effectiveness of play therapy is moderate to large (i.e. 0.72) when conducted by professionals, but very large (i.e. 1.05), when delivered by paraprofessionals.

Many studies have examined the effectiveness of play therapy in two categories: humanistic–nondirective, or nonhumanistic– directive. Ray, Bratton, Rhine and Jones (2005) are of the opinion that play therapy is effective regardless of approach, but humanistic treatment has demonstrated a large degree of effectiveness, while non-humanistic treatments have demonstrated a moderate degree.

Ray, Bratton, Rhine and Jones (2005) have demonstrated no influence exerted by setting or location. Many of the studies have been carried out either in a clinic or a school, and they found that found play therapy conducted in a critical incident or residential setting had a greater effect than when conducted in a clinic or school. Casey and Berman (1985) report that setting is not an influential factor in the effectiveness of play therapy.

Ray, Bratton, Rhine and Jones (2005) have established that individual play therapy sessions given by a paraprofessional are significantly more effective than either group or individual play

therapy undertaken by a professional. In addition, when conducted by professionals, both individual and group play therapy had similar effects. Both formats are effective with effect sizes of 0.79 and 0.82, respectively. However, Weisz et al. (1995) report that individual play therapy sessions had a greater effect than that of group therapy. The studies of Casey and Berman (1985), Weisz et al. (1987), and LeBlanc and Ritchie (2001) reveal no significant differences between the effectiveness of individual and group treatments.

One significant factor in the effectiveness of play therapy concerns the number of sessions. LeBlanc and Ritchie (2001) found that a greater effect resulted from between 30 and 35 sessions, although Casey and Berman (1985) found the duration of treatment had a negative correlation with outcomes. Weisz et al. (1987, 1995) and Kazdin et al. (1990) argue a lack of any correlation between the effectiveness of play therapy and the length of treatment.

Both clinicians and researchers have attempted to establish an answer to this issue. Ray, Bratton, Rhine and Jones (2005) have found no important differences, revealing that play therapy has a positive effective, regardless of whether undertaken for behavioural issues or other identified concerns. Casey and Berman's (1985) study has demonstrated a difference in relation to the target problem, although Weisz et al. (1987) note no significant difference, but report a significant correlation between training and problem type. In a more recent review, Weisz et al. (1995) found no difference in treatment effect by problem type, but established significant interaction between problem type, the age of the child, and the training of the therapist.

Issues in Play Therapy

Play therapy raises a number of questions in relation to the procedures and processes of other therapeutic methods. Although the play therapist may not anticipate all of the issues arising in the playroom (Landreth, 2012), the researcher and therapists need to investigate therapists' positions on these issues.

Young children may not worry about the issue of confidentiality, but older children are more socially aware, and may have concerns that the therapist might pass on information (Landreth, 2012). This can prove a particularly sensitive issue with children who have experienced abuse. Therapists need to provide confidentiality, unless it is an issue of safety:

In this special time, what you say or do is private. I will not tell your parents or teacher, or anyone, unless it is necessary to keep you safe. If you want them to know what you do here, you can tell them. That will be fine. You can decide. (Landreth, 2012)

A further issue concerning confidentially relates to parents, who are responsible for their children, and will want to know how they can help them and how the sessions are progressing. It is a

problematic to determine the limits, but the primary concern of therapists should be to protect the children.

Ethical and legal issues are also very important in counselling, and therapists need to bear a number of these in mind, particularly in relation to children, who are a dependent sector of the population (Landreth, 2012). Professional organisations advise play therapists to follow ethical guidelines and standards of practice, and legal and ethical considerations specify that parents should be involved when their children are undertaking play therapy (Landreth, 2012) as children do not have a legal capacity to refuse a service or protect themselves. During play therapy, a legal guardian should be present, in most cases this would be a parent.

Therapists need to understand how to involve children in therapy, and a child-centred play therapist should believe in a child's capacity for self-direction and avoid any intrusion of her own personality into the child's play (Landreth, 2012). Therapy sessions are a special time of freedom for the child, in which they can make their own decisions and direct their own life. Some children do not wish to have a playmate, and so the therapist needs to wait for their permission to join in their play. Thus the therapist needs to understand her role during play therapy, and help the child to hear, see, and understand herself (Landreth, 2012), and at the start of therapy, in particular, the most effective approach is to create a non-playing, or limited play, relationship. The role of therapists can change, depending on therapy sections, and the nature of the child or situation, and thus for each case, the therapist needs to have a full understanding of her role (Landreth, 2012).

At the end of each session, the therapist generally gives a child a sweet or chocolate, or happy face sticker, as children understand that the purpose of gifts is to reward good behaviour (Landreth, 2012). Play is rewarding for children, so they have no need of a reward, (Landreth, 2012), but a memento at the termination of the play therapy relationship can give the child something to remember the therapist and the experience. Thus, therapists should be aware of the issues of "do they need to give" or "what do they need to give" (Landreth, 2012).

Some children can be disorganised and messy during a play session, leading to the issue of whether "these children be asked to clean up" (Landreth, 2012). Some therapists believe children can leave a session without tidying away their toys, but others may ask them to put them away (Trotter, 2012). There is no direct answer for this question, as it depends on individual child's behaviour and the nature of their problem, which can result in being asked to tidy up becoming an issue.

During play therapy, some therapists inform children of the specific reason they are there, believing that children should understand in order for behaviour change to occur (Landreth, 2012). However, this method is focused more on the problem rather than the child. Therapists note that play gives children a free and safe environment, and such intervention can damage the nature of this play environment.

Some play therapists forbid children to bring a friend to the playroom during a play therapy session (e), although others do allow friends to be present (Ginott, 1994). Axline (1969) notes that if the therapist is conducting group therapy, a group chosen by the children is more effective than one chosen by therapist. Dorfman (1951) states that therapy can be more effective when it is not taking place between two individuals, and thus allows children to bring a friend to their play therapy sessions.

However, play therapists experience a number of issues in relation to their training and profession. Over the past decade, play therapy training has still been a relatively new training, with a great deal of innovation taking place (Cattanach, 2003). The lack of high quality training has affected the effectiveness of play therapy, due to the key role played by the therapist in a play therapy setting. There has been an attempt to resolve these issues through establishing a number of hours of supervised practice (Cattanach, 2003), and the education of play therapists still requires further development.

Conclusion

To conclude: the role of play is an indisputable factor in the life of children, having many positive effects, such as self-confidence, self-esteem, and self-respect. This results in the important effect of play therapy. Schaefer (1999), for example, reports the therapeutic power of play in 25 therapeutic factors, including Direct and Indirect Teaching, Abreaction, etc.

Play therapy is more effective with children and adolescents than other kinds of therapies, as they feel more comfortable and free in playroom environments. In addition, evidence provided by many researchers, from a considerable number of cases, has demonstrated the positive effect of play therapy on children and adolescents, regardless of the following: the treatment modality/theoretical model used; the treatment provider, setting, duration, and format (i.e. group vs. individual); the target problem behaviour; gender and age; and the ethnicity of participants.

Despite the existence of a great many positive effects of play therapy, like other therapeutic methods, it also has a number of issues. Thus, both researchers and play therapists need investigate these issues further.

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