

Theoretical Orientation and Play Therapy: Examining Therapist Role, Session Structure, and Therapeutic Objectives

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Within the context of play therapy, the author will compare and contrast three important therapeutic dimensions - therapist role, session structure, and therapeutic objective - between three distinct theoretical orientations: 1) child-centered play therapy; 2) Release/Structured play therapy; and 3) Adlerian play therapy. The author will discuss the similarities, differences, and therapeutic implications of each, with the belief that such examination will help counselors remain theoretically grounded in their use of play therapy and perhaps even challenge them to reexamine their beliefs about people and the most effective means of helping.

Working with children in play therapy can be deeply rewarding. Many play therapists will attest to the satisfaction they have gained from helping a troubled young person navigate the increasingly complex waters of childhood. There are, however, a number of theoretical approaches to play therapy, and most approaches differ from one another in several important therapeutic dimensions, including the role of the therapist, degree of session structure, and therapeutic objective.

A detailed examination of these therapeutic dimensions and how they differ in both quality and importance between theoretical orientations is lacking in existing literature.

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Therefore, in this article the author will present an analysis of the similarities, differences, and therapeutic implications of each therapeutic dimension within the contexts of child-centered play therapy, Release/Structured play therapy, and Adlerian play therapy. It is hoped that an exploration of this type will help counselors remain theoretically grounded in their use of play therapy and perhaps even challenge them to reexamine their fundamental beliefs about people, the nature of maladjustment, and the most effective means of helping.

Role of the play therapist

Play is the child's intrinsic form of communication; it is the means through which the child expresses and can resolve emotions and challenges in a developmentally appropriate way (Axline, 1947/1969). The toys the child chooses can be thought of as his or her words; how the child plays with them can be considered the conversation (Landreth, 2002). Perhaps, then, the most fundamental dimension of the play therapy experience is the role of the therapist. What, precisely, is the counselor to do? How is he or she to behave? When is he or she to interact? Not surprisingly, the answers to these basic questions can be distinctly different

depending upon the counselor's theoretical orientation.

Child-centered play therapy. The central tenant of child-centered play therapy, first introduced by Virginia Axline and modeled upon Rogers' person-centered approach (Axline, 1947/1969), is that "individuals have within themselves vast resources for self-understanding and for altering their self-concepts, basic attitudes, and self-directed behavior; these resources can be tapped if a definable climate of facilitative psychological attitudes can be provided" (Rogers, cited in Landreth, 2002, p. 70). Therefore, the role of the child-centered play therapist is to build a therapeutic relationship with, and to maintain an atmosphere of complete acceptance and non-possessive caring for, the child (Landreth, 2002). Within this environment, the child is free to fully express him- or herself without judgment or direction (Axline, 1947/1969). Liberated from the constraints of appraisal or injunction, the child will naturally resume the self-directed and innate striving toward self-actualization and congruence without any further influence from the therapist (Landreth, 2002). The child-centered play therapist trusts that, through the spontaneity of free play, distressing feelings or

situations will be unconsciously manifested without therapist manipulation (Moustakas, 1997). Furthermore, the therapist trusts in the child's own ability to resolve these troubling emotions and to positively integrate experiences and self-concept at his or her own pace without interpretations or interventions from the therapist (Axline, 1947/1969; Moustakas, 1997; Landreth, 2002).

To be most effective, the child-centered play therapist "intently observes, empathetically listens, and encouragingly recognizes not only the child's play but also the child's wants, needs, and feelings" (Landreth, 2002, p. 98). What is emphasized in so doing is "not the therapist's wisdom, but the wisdom of the child; not the therapist's direction, but the child's direction; not the therapist's solution, but the child's creativity" (Landreth, 2002, p. 108). This complete trust in the innate tendency of the child to affect his or her own healing within the genuine, warm, and empathic therapeutic relationship is perhaps the most radical aspect of child-centered therapy.

Release/Structured play therapy. While some consider Release play therapy and Structured play therapy, developed respectively by David Levy (1939) and Gove Hambidge (1955), as distinct

therapies, this author considers them similar enough to be discussed simultaneously here.

In Release play therapy, the counselor is a master of stagecraft who creates scenarios with playroom toys that simulate as closely as possible the experiences that are deemed to have precipitated the child's distressing reactions (Levy, 1939). The therapeutic relationship is important in Release therapy, but is considered only a precursor to the actual work of the session. Such work is only possible "when the relation with the therapist is, at the least, sufficiently secure for the child to tolerate his [sic] presence in the playroom, to accept his activity in the play to the point of utilizing material and responding to it" (Levy, 1939, p. 718).

Hambidge (1955) elaborated on the role of the play therapist and the therapeutic relationship in his writing on Structured play therapy. In his view, the therapist was to keep the child focused on and increasingly engaged in the play, to provide approval and interpretation of the play, to gather information from the child, and to set limits when needed (Hambidge, 1955). The Structured play therapist was to utilize the therapeutic relationship to assuage the child's potentially overwhelming anxiety when faced with the situations

simulated with the toys (Hambidge, 1955). However, the counselor was cautioned to “keep out of the play except in order to facilitate it, in spite of the fact that the child, for purposes of his [sic] own defenses, will try to draw him into it” (Hambidge, 1955, p. 608).

Adlerian Play Therapy. The application of Adlerian theory to child therapy is a relatively recent development, and can be said to be a utilization of Rogerian interpersonal skills within an Adlerian conceptual framework (Kottman, 1993). In other words, the Adlerian play therapist conceptualizes the child and the child's social environment from the perspective of Adler's Individual Psychology while utilizing a relatively non-directive, genuine, and empathically accepting form of interaction with the child in the playroom (Kottman, 1993).

In traditional Adlerian therapy, the therapist is rather active and directive, serving as much as possible as an equal partner who initiates client insight and encourages client reorientation and growth. Generally speaking, this is a fitting description of the Adlerian play therapist as well (Kottman, 2003). The role of the counselor is rather fluid throughout the course of the therapeutic relationship, changing as the child

progresses through the four phases of Adlerian play therapy: 1) Relationship-building; 2) Lifestyle assessment; 3) Insight; and 4) Reorientation (Kottman, 2003).

In the first phase, the Adlerian play therapist is generally non-directive and allows the child to explore the playroom freely (Kottman, 2003). During the second phase, the play therapist becomes more active and directive, gathering lifestyle information both from the child and from the child's caregivers. By the third phase, the Adlerian play therapist acts as “a partner with essential information to communicate to the child and to the parents” (Kottman, 2003, p. 30). In the fourth and final phase of counseling, the therapist teaches and encourages the child and the child's caregivers to make necessary changes in attitudes, thoughts, and beliefs with the goal of solidifying the gains made in therapy (Kottman, 2003).

Kind, Degree, and Purpose of Session Structure

As the role of the play therapist can vary by theoretical orientation, so too can the kind, degree, and purpose of session structure. A typical play session may last anywhere from thirty to fifty minutes; the course of therapy may be as short as only

a few sessions or can last for potentially many months. The play therapist must, therefore, consider how best to organize that time and to what purpose.

Child-centered play therapy. In child-centered therapy, there is as little pre-determined structure as possible in the session (Landreth, 2002). Since the therapeutic relationship itself is the instrument of growth and change, the child-centered play therapist structures only the broadest parameters of the session: 1) a therapy space with appropriate, easily accessible materials; 2) an atmosphere of freedom, acceptance and tranquility; and 3) an environment of warmth and caring (Moustakas, 1997). From a child-centered perspective, children will direct their own therapy at their own pace and toward their own goals if provided an environment of acceptance, freedom, and permissiveness (Landreth, 2002). Acknowledging that a completely boundless environment is counter-therapeutic and can even be perceived as unsafe by the child, the child-centered play therapist nevertheless believes that structuring a session beyond the barest minimums tends to rob children of opportunities to experience self-determination, self-regulation, and self-affirmation (Landreth, 2002). The challenge, then, is to convey the safety of some

minimal structure in a way does not stifle the child's creativity and exploration.

The child-centered play therapist begins structuring the session the moment the child enters the playroom, utilizing subtle but precisely chosen words and behaviors (Landreth, 2002). As the session begins, the therapist "might say something like, 'Melissa, this is our playroom, and this is a place where you can play with the toys in a lot of the ways you would like to'" (Landreth, 2002, p. 183). The phrase "in a lot of the ways" - as opposed to "in any way you want" - conveys some limits on behavior; however, the statement's main thrust remains that the child has freedom and choice in the playroom (Landreth, 2002).

After this initial statement, the therapist acts in ways that communicate freedom while conveying to the child that he or she is safe and attended-to fully (Landreth, 2002). First, the counselor sits down in a neutral area of the room, avoiding any suggestion of which toys the child should play with or how. Secondly, the counselor makes sure that his or her entire body remains square with the child as the child moves about the playroom. By sitting down, the therapist communicates that the child is in the lead; by squaring the body (rather than just turning the head),

the therapist conveys that the full attention of the therapist is on the child at all times (Landreth, 2002). Reflecting the content of the child's play and his or her feelings during the session is another powerful means of communicating the safety inherent in the therapist's attention and acceptance while simultaneously encouraging the child's freedom and exploration (Landreth, 2002).

After a play session in which only minimal structure has been set, the therapist is active in structuring the session's conclusion, again utilizing specifically chosen words and behaviors (Landreth, 2002). For example, the therapist may announce when five minutes remain in the play session, then two minutes, and then one minute. Finally, he or she will likely rise from the chair and state confidently but compassionately, "Our time in the playroom is up for today" (Landreth, 2002, p. 290). If the child is reluctant to leave the playroom, the therapist should continue taking steps toward the door and, while acknowledging the child's desire to stay, warmly but firmly repeat, "I know you want to stay for as long as you decide, but time is up" (Landreth, 2002, p. 290). Structure of this type is an important part of the therapeutic process, for it offers the child an

opportunity to practice self-control and self-regulation (Landreth, 2002).

Release/Structured Play Therapy. As its name might suggest, there is significantly more structure in the sessions of a Release/Structured play therapist. This structure is directly related to the nature of the therapy, in which the therapist selects toys and creates scenes that he or she determines resemble stressors in the child's life (Levy, 1939). Many Release/Structured play therapists utilize a bit of free play in the beginning of a session early in the therapeutic relationship, but only as a precursor to the true work of the session (Levy, 1939). When the relationship is developed to the point that the child can accept being in the playroom, the therapist directs the child to certain prearranged toys and "the child is encouraged to work with the plot selected, add whatever other actors or scenes he wishes, and keep the play going" (Levy, 1939, p. 717).

Rather than allowing the child to spend a significant part of the session in free play, the Release/Structured play therapist encourages extended play only within the scenarios that are determined to have a direct bearing upon the child's presenting problem (Hambidge, 1955). The therapist, however, likely does not view such control on the play as therapeutic

rigidity, as there is no prescribed regime of scenarios that all children must play through. Scenes that precipitate anxiety or distress in one child will not necessarily do so for another; therefore, the scenarios the therapist depicts in the toys will vary from one child to another (Hambidge, 1955). Furthermore, the Release/Structured play therapist continually assesses the pace of the play and actively “keep[s] the play moving whenever possible to its natural dramatic crescendo... until the child has apparently finished a cycle of activity” (Levy, 1939, p. 717). With concern for the child's capacity to handle the release of affect in structured play, the therapist is also responsible for stopping the play if it provokes either intolerable anxiety or disinterest in the child (Levy, 1939).

The therapist must consider three variables when structuring the play experience: 1) the child's integrative capacity; 2) the nature of the play; and 3) the capacity of the people in the child's environment to cope with the effects of the therapy (Hambidge, 1955). In other words, the Release/Structured play therapist chooses the scenarios to be depicted and directs the course of therapy based largely upon his or her assessment of the child's (and of the child's caregiver's) capacity to deal with the emotions released and the child's

resultant attitudinal and behavioral changes (Hambidge, 1955).

Adlerian Play Therapy. In Adlerian play therapy, session structure can be fluid; “sometimes the client leads while the therapist follows and sometimes the therapist leads while the client follows” (Kottman, 1993, p. 166). When allowing the child to lead in the play session, the Adlerian therapist, similar to the child-centered therapist, verbally tracks the child's actions, reflects feeling and content, and creates an atmosphere of trust and safety (Kottman, 2003). However, when taking the lead, he or she interprets the themes expressed in the child's play and structures the plan of how best to intervene by utilizing an Adlerian model of personality development (Kottman, 2003).

Play sessions, interpretations, and interventions are structured around Adler's goal-oriented conception of behavior (Kottman, 2003). For an Adlerian, regardless of whether it is conscious or non-conscious, there is always a purpose behind human action (Dreikurs & Soltz, cited in Kottman, 1993). Therefore, the Adlerian play therapist always considers the potential goal the child may be endeavoring to meet through the conduct: attention, power,

revenge, or withdrawal (Dreikurs & Soltz, in Kottman, 1993). The Adlerian play therapist is also cognizant of the child's inherent social-embeddedness (Kottman, 1993). Sessions can therefore be structured to include the child, his or her caregiver(s), teachers, friends, or significant others in the child's life (Kottman, 1993).

Goals of Play Therapy

Therapeutic objectives are often linked closely to the play therapist's view of the nature of adjustment and maladjustment and to his or her beliefs about people and their capacity for change. Therefore, if therapist role and session structure are as diverse across theoretical orientations as has been described, it follows that the goals and objectives of play therapy would be equally disparate.

Child-centered play therapy. The objective of child-centered play therapy is no less than to free the child to resume his innately motivated, self-paced, and self-directed journey toward self-actualization; it is not a problem-focused therapy but rather a person-focused one (Landreth, 2002). In this orientation, the child's presenting problems are considered to be the symptoms of an underlying incongruence in the personhood of the child rather than as the focus of therapeutic concern

themselves. Instead of utilizing techniques to minimize the problem (usually identified, ironically, by the child's caregivers or teachers), the child-centered play therapist attends to and prizes the entire person of the child with the belief that this unconditional acceptance will free the child to reconnect with his or her intrinsic ability to resolve such incongruence. With increased congruence, the child's problematic symptoms will abate of themselves (Landreth, 2002).

Within this perhaps dauntingly broad objective are a number of specific goals to be potentially met (Landreth, 2002). Through the therapeutic relationship, the child-centered play therapist facilitates the child's development of: 1) a more positive self-concept; 2) greater self-responsibility; 3) increased self-direction; 4) more self-acceptance; 5) increased self-reliance; 6) greater self-determined decision making; 7) an enhanced feeling of control; 8) sensitivity to the coping process; 9) an internal source of evaluation; and 10) greater trust of self (Landreth, 2002). By engaging in non-directive free-play within the safety and warmth of the therapeutic relationship, the child

brings [feelings] out into the open, faces them, learns to control them, or abandons them... He [sic] begins to

realize the power within himself to be an individual in his own right, to think for himself, to make his own decisions, to become psychologically more mature, and by so doing, to realize selfhood (Axline, 1947/1969, p. 16).

The child's experience of the therapist's acceptance and understanding during free-play will, sometimes relatively quickly but other times only after an extended period of therapy, reawaken the dormant ability of the child to self-direct and self-evaluate (Moustakas, 1997). Furthermore, the child will not only discover his or her own way of dealing with the stressors that preceded therapy but will find internal means of coping with potentially distressing emotions and situations in the future (Moustakas, 1997).

Release/Structured play therapy. The goal of Release/Structured play therapy is to minimize the child's maladaptive symptoms by using the acting-out principle of play in a structured setting (Levy, 1939). By engaging in structured play, the child is encouraged to release and master repressed emotions that were found to be the underlying cause of his or her affective or behavioral disturbance (Hambidge, 1955). From this orientation, the child's emotional catharsis leads to a

reduction in anxiety symptoms and problematic behavior (Levy, 1939; Hambidge, 1955).

Both Levy (1939) and Hambidge (1955) were generally respectful of the child's innate resilience and the role of free-play in relieving anxiety and tension. Therefore, Release/Structured therapy was contraindicated if the child's anxiety and distress could be alleviated extra-therapeutically through either free-play or verbal interactions with others (Levy, 1939; Hambidge, 1955). There is, however, an unspoken assumption in Release/Structured therapy that the child's resources are inevitably limited. Rather than using the word *if*, Levy (1939) wrote that "when the child's method of dealing with anxiety is unsuccessful, symptoms indicating the presence... of the disturbance are at hand" (Levy, 1939, p. 713).

The Release/Structured therapist believes that, to be most effective, the innate healing power of play should be studied, distilled to its essence, and then reintroduced to the child in a controlled setting for specific therapeutic purposes (Levy, 1939). He viewed his work with child's play much as an immunologist might view the development of a vaccine by first studying "the organism's own methods of protection" (Levy, 1939,

p.713). Similarly, Hambidge (1955), likening the Structured play therapist to “the skilled surgeon [who] knows when, where, how, and how much to use the scalpel,” cautioned that “the medical psychotherapist [must] know when, where, how, and how much to use Structured play therapy” (p. 607).

Adlerian play therapy. The goals of Adlerian therapy, regardless of whether it is conducted with children or adults, are to help clients (a) enhance their social interest; (b) overcome or reduce their feelings of inferiority; and (c) make changes in their life goals and mistaken beliefs about self, others, and the world (Mosak, cited in Kottman, 2003).

In adapting Adler's insight-oriented model to children, who usually do not operate on the same level of cognitive development as adults, Kottman (2003) encouraged the Adlerian play therapist to strive to engender insight and reorientation in the child as much as developmentally possible. However, the therapist was additionally advised to work with significant adults in the child's familial and social environment to foster their insight and reorientation as well (Kottman, 2003).

The Adlerian play therapist gathers information from the child's caregivers about the family constellation, the general atmosphere of familial values and attitudes, and the perception of the child's place within the family structure (Kottman, 1993). With this information, the therapist teaches the family new communication and discipline skills and works to reorient family values, attitudes, and beliefs. In so doing, the therapist endeavors to institute change in the family system so that the child's therapeutic gains can be reinforced and maintained over time (Kottman, 2003).

Discussion

As has been shown, the role of the play therapist, the kind, degree, and purpose of session structure, and the therapeutic objectives pursued in session are all greatly influenced by theoretical orientation. To summarize, the child-centered play therapist is an empathic adult who enters into an authentic, accepting relationship with the child, provides only minimal structure, and trusts in the self-actualizing tendency of the child to reach child-determined goals. The Structural/Release play therapist is a shifter of scenes who carefully creates play experiences through which the child can

release bypassed affect, thereby diminishing maladaptive symptoms and behavior. The Adlerian play therapist is a partner, teacher, and encourager who utilizes free-play within an Adlerian conception of psychological development and family constellation to nurture social interest, relieve inferiority feelings, and reframe maladaptive cognitions and life goals.

It is interesting to note that, although a therapeutic relationship of safety and genuineness is important in all three of the theoretical models investigated here, the relationship is seen as the very instrument of healing in Child-Centered play therapy but as merely the vehicle through which the therapist may cultivate either affective release or cognitive insight in Release/Structured and Adlerian play therapy, respectively. In other words, the relationship is necessary and sufficient in the child-centered play therapy, necessary but not sufficient in Release/Structured and Adlerian play therapy.

Also of interest is the fact that session structure in Child-Centered play therapy is minimal, done only to facilitate freedom, safety, and self-control, whereas structure in Release therapy is purposeful and therapist-directed toward the resolution of problems. If such a conceptualization is accurate, then Adlerian play therapy may

be thought of as a middle way in conceiving session structure. Adlerian play sessions are themselves relatively free of direction; however the interpretation of the play behavior, the session formats (e.g., individual, group, or family), and session objectives (e.g., relationship-building, assessment, consultation, psycho-education), are structured upon the Adlerian model of personality development.

Free play is utilized in all of the theoretical orientations, but with differing therapeutic emphasis. The child-centered play therapist trusts that, within a genuine, warm, and empathic relationship, the child will satisfactorily resolve challenges through self-direction and self-evaluation. The Release/Structured therapist might allow the child a bit of free play, but only in preparation for the actual working phase of the session. Curiously, if Levy (1939) minimized the therapeutic importance of free-play, Hambidge (1955) went so far as to disparage it, describing the therapist who encourages it as “indulging in hours of diffuse, therapeutically unremunerative activity” (Hambidge, 1955, p. 605). “The therapist”, he continued, “does not, simply out of a compulsion for thoroughness or fear of incompleteness, use forms of play manifestly

unrelated to the patient's problem" (Hambidge, 1955, p. 606).

Levy's (1939) and Hambidge's (1955) views, however, are certainly not without counter. Axline (1947/1969), perhaps with Release/Structural therapy in mind, recalled the account of another therapist, who, feeling "that her [play] group had problems centering around their family relationships, placed the doll house and family in the very center of the room and put everything else out of the way" (Axline, 1947/1969, p. 119). Axline then described the response of the children, who "came in, immediately saw the pre-arranged set-up, and then sat down in idleness and asked how long they had to stay and would they have to come back again" (Axline, 1947/1969, p. 120). As can be seen, the value of free play has been one of many points of contention among play therapists.

Unspoken in both the Adlerian and Release/Structured models is the assumption that the child's caregivers are accurate in their definition of the child's problem and that the therapist has the knowledge and ability to resolve it. In the child-centered model, conversely, not only is the child's problem rarely if ever addressed, but the therapist assumes no special knowledge or expertise in how to treat it.

Landreth (2002), despite his years of training and experience, admits "I know so little about the complex intricacies of childhood; therefore I will allow children to teach me" (Landreth, 2002, p. 6). This attitude of wonder and awe toward the precious and never-completely-knowable personhood of the child is one shared by child-centered therapists and greatly informs the conceptualization and treatment of their clients.

One final and perhaps most telling note is that, whereas all of the models described here acknowledge that children have an innate capacity for resilience and self-healing, only the child-centered play therapist relies upon and strives to reawaken this inborn tendency exclusively. Levy (1939) and Hambidge (1955), both medical doctors, understandably relied upon the proper diagnosis of observable symptoms and the application of prescribed courses of treatment when, as is implicitly inevitable, some stressors are beyond the child's capacity to cope. Similarly, Kottman (1993; 2003) trusted the child's innate capacity to a point but then focused her therapeutic attention upon challenging the child's mistaken beliefs and reorienting the child and the child's caregivers to maintain these new, presumably more adaptive, cognitions.

Implications for counseling

Therapist role, session structure, and therapeutic objectives are but a few of the dimensions a play therapist must consider when working with children. To deal with the therapeutic dilemmas inherent in each dimension, the play therapist must first thoroughly investigate his or her own beliefs and attitudes about the nature of people, the course of personality development, the causes of maladjustment, and the most effective means of facilitating growth and change.

Counseling students should be encouraged to be theoretically consistent in their work with clients, regardless of whether those clients are children or adults. A student who reports being person-centered with children but Adlerian with adults would likely be challenged to investigate more thoroughly his or her beliefs and attitudes about people in general. For example, if the counselor-trainee endorses the unlimited potential of children to reconnect with their self-actualizing tendency and that this inherent tendency is sufficient for growth, the student might be encouraged to explore his or her reluctance to trust this same inborn potential when working with adults. Conversely, if the counselor firmly believes that familial values and attitudes,

mistaken beliefs, and fictional life goals from childhood can lead to adult maladjustment, he or she might examine why a client's play sessions would be limited to non-directive free play that does not include or consider the influence of the child's cognitions or environment.

Therapists who wish to work with children can greatly benefit from a careful consideration of their fundamental attitudes and beliefs about people in general and how these beliefs inform their choice of theoretical orientation. An investigation of this type will likely reap rewards for all the therapist's clients, whether child, adolescent, or adult, and is likely to be fruitful ground for continued counselor self-discovery.

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