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Correspondence to the Editor should be sent to BAPT, 1, Beacon Mews, South Road, Weybridge, Surrey, KT13 9DZ, England
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BRITISH JOURNAL OF
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Roehampton University, London, England

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# BRITISH JOURNAL OF PLAY THERAPY

## 2010  VOLUME 6  WINTER

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'Small but perfectly-formed'
'Quality not quantity'
'The best things come in small packages'.

...All adages that I hope you will concur apply to this slim but densely-packed sixth volume of the British Journal of Play Therapy. The three articles are as diverse in content as one can get and demonstrate the range and scope of potential contributions to the Journal: from descriptions of pioneering work that challenges our preconceptions of the limits and parameters of play therapy practice (VanFleet & Faa-Thompson, pages 4-18); encompassing University-based research studies, whose findings enhance our understanding of the field (Clack et al., pages 19-34): through to new theoretical papers that have the potential to shape our thinking and our practice (Jennings, pages 35-50). Each in their turn fascinating, informative and thought-provoking. I am grateful to the authors of all three submissions for creating this model of Journal diversity, and fervently hope it will encourage others to contribute examples of their own clinical practice, research or theoretical ideas so that the 2011 edition will be Quality and Quantity!

I am also hugely indebted to the four new members of the Journal Editorial Board whose fresh energies have been absolutely crucial in preparing this issue. Dr Kathryn Hunt and Nora O’Loughlin both from Australia and Dr Sue Pattison and Maggie Robson from the Universities of Newcastle and Keele respectively, all volunteered to join the Board early in the year and were immediately put to work as anonymous referees - and in Nora’s case also somehow squeezing in a valuable review of an important new text on Child-centred Play Therapy (see page 51). Their commitment effectively freed up two other long-standing members of the editorial team, Dr Sue Jennings and Dr Rise VanFleet, to supply their own articles for consideration. A spot of musical chairs on the Editorial Board! I am hoping that for the next issue there will be so many submissions that I will need all members of the Editorial Board back on the reviewing side of the fence. I rely on you to take the plunge, put pen to paper (or fingers to keyboard) and make this happen.

Then this time next year I can turn another old adage on its head and assert - they do ‘make diamonds as big as bricks’.
THE CASE FOR USING ANIMAL ASSISTED
PLAY THERAPY

Risë VanFleet
Family Enhancement & Play Therapy Center, Pennsylvania, USA

Tracie Faa-Thompson
Turn About Pegasus Programme, Northumberland, England

Abstract

Child development research has clearly established the importance of animals in children's lives. Neurobiology has shown that the production of oxytocin in humans is stimulated by interactions with animals, creating the potential for greater relaxation and increased empathy and engagement. The biological and psychosocial benefits of family companion animals have been well documented. Driven by current multidisciplinary theory and research, this article explores the similarities, compatibility, and integration of the fields of Play Therapy and Animal Assisted Therapy for children, adolescents and families. The rationale, basic principles, goal areas, and methods of Animal Assisted Play Therapy are presented, with information about existing research and resources.

Key words Animal assisted play therapy, canine therapy, equine therapy

Essential Features of Play Therapy

One of the advantages of play therapy is that it does not require language or verbalisation from children. Because it capitalises on children's natural inclination to play, children are motivated to express themselves, communicate and resolve problems more readily than through more cognitive or 'talk-oriented' methods designed for adults. The child-focused features of effective play therapy, nondirective and directive alike, suggest that play therapy is often the most developmentally-appropriate intervention to alleviate or eliminate many types of child problems (VanFleet, Sywulak, & Sniscak, 2010). At its core, play therapy brings positive change through the special relationship of attunement, safety, reciprocity and acceptance that play therapists create with children. A meta-analysis of 93 research studies conducted in the United States and that controlled for many common errors and biases in meta-analytic research has clearly demonstrated the efficacy of play therapy when conducted properly (Bratton, Ray, Rhine, & Jones, 2005).

Regardless of the play therapy method used, a hallmark of the approach is the development of a child-focused relationship in which the therapist enters the child's world, considers thoughts, feelings, perceptions and ideas of importance to the child, and through the relationship that ensues, provides an emotionally secure environment in which children can overcome problems, master...
fearful or anxious feelings, and move forward in a psychosocially healthy direction (VanFleet, Sywulak, & Sniscak, 2010). It seems a logical outgrowth of this type of therapeutic relationship that what interests the child should interest the therapist.

The Importance of Animals* to Children

Most parents purchase stuffed toy animals and animal figurines for their children. Similarly, it would be a rare play therapy room that contained no animal toys or images, which often are used to provide safe metaphors for the expression of feelings through items of common child interest. These practices show adult awareness of children's interest in nonhuman animals. One might ask, however, about the extent of children's interest in animals and what roles animals play in children's lives and development.

Fortunately, substantive developmental research has provided some answers to these questions. Developmental psychology research has shown clearly and repeatedly that animals are very important to most children. Children are interested in them, talk about them, approach them readily, and even dream about them (Jalongo, 2004; Jalongo, Astorino, & Bomboy, 2004; Melson, 2001; Melson & Fine, 2006). Jalongo (2004), who has studied the involvement of animals in school classrooms and other settings around the world, has commented, “Companion animals should matter to educators, if for no other reason than that they matter so much to children.” Melson's (2001) book, Why the Wild Things Are, is an authoritative and fascinating compilation of studies of children and animals. Few would argue, either from the research findings or practical experience, with the assertion that animals play a central role in children's development.

Recent research has identified one of the primary biological foundations of the human-animal bond. In her groundbreaking book, Made for Each Other: The Biology of the Human-Animal Bond, Olmert (2009) reveals the role of the neurohormone oxytocin as perhaps the most important influence on our relationships with dogs, horses, cats, and many other animals. (Olmert also served as an advisor to the excellent January 2010 BBC Two Horizon programme, The Secret Life of the Dog, about ways dogs have evolved specifically to engage more fully in relationships with humans.) A series of well-controlled scientific studies have shown that oxytocin, which is well known for its role in mother-infant attachment, is also responsible for the ability of many animals (including humans) to read emotions, to seek physical contact and companionship, and to experience relaxation when in each other's presence (see Olmert, 2009). For example, when people pet their companion dogs, their oxytocin levels rise significantly, as do those of the dogs! It would seem that children's fascination with animals is developmentally profound and biologically based.

Benefits of Family Companion Animals for Children

One thinks first of dogs and cats when considering family companion animals, and they comprise a majority of pets in the United States and the United Kingdom. Depending on their living circumstances, children are exposed at home, on the farm, or in nature to many other animals, including rabbits, guinea pigs, birds, reptiles, horses, cows and a host of other farm animals. In wooded areas, they see deer, squirrels, and foxes. Even very young children usually show immediate interest in the animals they encounter. Anecdotal reports and stories of the benefits of companion animals abound (for example, Herriot, 1986). Studies of families with pets conducted in veterinary colleges and human-animal studies programmes have consistently yielded benefits for human adults and children (Beck & Katcher, 1996; Chandler, 2005; Esteves & Stokes, 2008; Podberscek, Paul, & Serpell, 2000). Frequently cited benefits of family companion animals for children include the following: increased calmness and self-regulation, lowered blood pressure, improved care-giving

*For simplicity the term ‘animals’ in this article refers to nonhuman animals. The terms ‘pets’ and ‘companion animals’ are used interchangeably.
behaviours, development of empathy, increased responsibility, improved sense of security, increased initiation of positive behaviours and social lubricant effects, in which shy or reserved children are more likely to engage with other people in the presence of a pet.

Animal-Assisted Therapy

Growing alongside the field of play therapy at a similar pace has been the field of Animal Assisted Therapy. While several formal definitions exist, they are not used consistently in the literature or in popular practice. In general, nonhuman animals (dogs, cats, rabbits, miniature horses, for example) have visited elderly people in nursing facilities, hospitalised children, and school classes, often for quiet companionship and touch (petting or stroking) as well as simple activities (for example, Burch, 2003; Rivera, 2001, 2004). Specially trained dogs have helped improve children’s motivation and ability to read through Reading to Rover and similar programmes (Jalongo, 2004). Such programmes are often called Animal Assisted Activities or Animal Assisted Interventions. Typically, the term Animal Assisted Therapy (AAT) refers to the work of a specially-trained human-animal team in which the human is a credentialed therapist, such as an occupational therapist, physiotherapist, or mental health therapist, and the nonhuman animal has met specific criteria for participation. The AAT team intervenes in specialised ways to further the attainment of therapeutic goals. Dogs and horses are the nonhuman species engaged most often in AAT work. There are a number of excellent resources on AAT (Chandler, 2005; Fine, 2006; Levinson & Mallon, 1997); O’Connor, 2005; VanFleet, 2008a).

Mental health practitioners use AAT to address a wide range of child and family problems, including developmental, social, emotional, and behavioural concerns. Interventions with horses, dogs and other nonhuman animals have been used with child/family difficulties such as selective mutism, learning disabilities and attention deficit disorder, oppositional behaviours, depression, shyness and social isolation, abuse, anger management, bereavement, domestic violence, bullying, post-disaster and trauma reactions, anxiety, and attachment problems. AAT has been applied in various ways in foster care and residential programmes (for example, www.cbyouthconnect.org, www.greenchimneys.org, and www.playfulpooch.org), as well as in juvenile detention and youth correctional facilities (Bondarenko, 2007; Chandler, 2005; Loar & Colman, 2004).

Zimmerman and Russell-Martin (2008) have noted that AAT with young children makes sense because children and nonhuman animals have much in common: (1) they are dependent upon, or at least mindful of, adult human beings, (2) they exist mostly in the present moment and give honest feedback, (3) their primary form of communication is nonverbal and concrete, and (4) they know how to play naturally and to give freely. These factors, combined with children’s great interest in animals, suggest that AAT is a potentially useful tool in the mental health practitioner’s repertoire.

There are a number of controlled studies that have demonstrated the efficacy of AAT (Bowers & MacDonald, 2001; Trotter, Chandler, Goodwin-Bond, & Casey, 2008). Research studies at the Priory Clinic (www.priorygroup.com) have demonstrated the effectiveness of Equine-Assisted Psychotherapy (EAP) in combination with their 12-Step Programme for clients with addictions. A meta-analysis of 49 controlled AAT studies showed favourable results, especially with dogs and for children with autistic spectrum disorders (Nimer & Lundahl, 2007). Much more research is needed, however. Enthusiastic reports and case studies abound, but more controlled research and programme evaluations are needed to further establish the value of this promising approach.

As studies of the human-animal bond, people-pet interactions, and children’s relationships with nonhuman animals continue to suggest physical, social, and mental health benefits, and as clinical interest and acceptance is on the rise, new methods of responsibly involving nonhuman animals in the practice of mental health therapies are expanding.

Zimmerman and Russell-Martin (2008)
noted the features of AAT that are similar to those of play therapy. Like play therapy, AAT is conducted in a setting that is inviting to children. Both methods help children communicate with others, express feelings, modify behaviours, develop problem solving skills, and learn new ways to relate to others. Play therapy, like AAT, builds on the natural ways that children learn about themselves and their relationships to the world around them. Both approaches can assist children in developing respect for self and others, body awareness, self-esteem, and better recognition and assurance of their own abilities. VanFleet (2008a) has noted the similar trajectories of the fields of AAT and play therapy as well as their developmentally-sensitive approaches for psychotherapeutic work with children, adolescents and families. The developmental, theoretical and clinical similarities have resulted in growing numbers of play therapists incorporating therapy animals in their work. VanFleet (2007) conducted a survey of 83 play therapists in the United States who involved animals with children. Respondents were universally enthusiastic about their clinical results and identified their beliefs that animals could facilitate the accomplishment of a number of therapeutic goals. Full results of this survey are available at http://play-therapy.com/playfulpooch/pets_study.html.

Animal Assisted Play Therapy
Philosophy and Goal Areas

One of the most promising developments in child mental health intervention is the emerging field of Animal Assisted Play Therapy (AAPT). AAPT represents a synthesis of two intervention approaches that focus on the child’s developmental point of view: play therapy and AAT. AAPT has been developing during the past decade and preliminary studies are promising (VanFleet, 2008a; Thompson, 2009).

VanFleet (2008a) has emphasised the involvement of dogs in play therapy and describes Animal Assisted Play Therapy as “the involvement of animals in the context of play therapy, in which appropriately trained therapists and animals engage with children and families primarily through systematic play interventions, with the goal of improving children’s developmental and psychosocial health as well as the animal’s well-being. Play and playfulness are essential ingredients of the interactions and the relationship.” (p. 19).

Faa-Thompson has focused on the involvement of horses in conjunction with play therapy, has established the ‘Turn About Pegasus’ (TAP) programme that is comprised of group and individual Equine Assisted Psychotherapy (EAP) for at-risk children and adolescents, and is in the midst of a year-long research study on the efficacy of the TAP program. VanFleet and Faa-Thompson are both credentialed play therapists in the United States and the United Kingdom respectively, who continue to define and study AAPT, as well as to offer trainings for professionals interested in using AAPT for clinical work or research purposes. A handful of other play therapists have published their work combining AAT and play therapy, including Thompson (2009) in the United States, and Parish-Plass (2008) in Israel. Weiss (2009) has written about the combination of Equine Assisted Therapy and Theraplay. To date, there are approximately 75 professionals trained specifically in AAPT worldwide, with most in the US and the UK. As this pool of individuals grows, methods are refined through qualitative analysis and programme evaluation, and AAPT credentialing processes are developed (VanFleet, 2010), more rigorous research will become possible.

AAPT is used primarily as an adjunct to other therapeutic modalities such as play therapy, Filial Therapy, family therapy, parent education, and cognitive-behavioural therapy, for example. The sections that follow describe guiding principles and goal areas that can be addressed by this approach, some of the methods used, preliminary research findings, case examples, and available resources. Before more controlled research can be conducted on AAPT, it is important that more practitioners become aware of the approach, obtain training in its application, and cooperate with efficacy studies on several levels. Because a background in play therapy is essential for conducting AAPT, this article aims to share basic
premises and xmethods about this emerging intervention with the play therapy community so that the field may develop hand-in-hand with responsible practice and research.

**Philosophy and Guiding Principles of AAPT**

Through the years, ethical questions have been raised about the involvement of animals in therapy work. Can the training and involvement of nonhuman animals be exploitive? As in most human endeavours that involve nonhuman animals, the answer is yes. The authors have seen therapy animals who appear to be exhausted and uninterested during therapy sessions, suggesting that their owners or handlers have focused on the human clients’ needs much more than the therapy animals’ needs. Furthermore, encounters with exhausted animals seem to have little therapeutic value and are likely to be counter-therapeutic. Requiring animals to work until they are exhausted does not represent the humane treatment of animal companions nor does it establish a good model for children. The philosophy of AAPT represents an attempt to rule out such practices that do not serve the best interests of clients or therapy animals alike.

Several guiding principles follow.

To the fullest extent possible, AAPT encourages equal and reciprocal respect for the humans and the animals involved. Human needs are not considered more important than animal needs.

AAPT activities should be safe and enjoyable for all involved. If they are unsafe to any party, they are stopped and a different therapeutic activity is substituted. Furthermore, the child or the therapy animal can ‘opt out’ of any intervention used. For example, if a dog is tired or bored and lies down, this is permitted, and the therapist facilitates the therapeutic process in a manner that the child and the therapist respect the dog’s choice.

AAPT aims to accept the child and the animal for who they are. Therapy animals should not be expected to become so docile or controlled that their individual interests and characteristics are denied. While training for good behaviour and tolerance of children, toys, and movement are important, this is not carried to an extreme. For example, a high-energy dog would not be expected to participate in nondirective play therapy for long periods of time. The dog’s need for action is taken into account so that that particular dog might be involved more frequently in directive play therapy or group interventions.

In AAPT, the focus is not on control, but on relationship. Just as the therapy animal learns how to behave during the sessions, children learn how to behave respectfully and humanely with the animal. The AAPT process helps children build healthy relationships with the therapy animal. This is most easily accomplished by the emphasis on fun, playful activities that are motivating and enjoyable for all involved. A good play therapist employing AAPT is able to use many types of interactions and moments to work toward therapeutic outcomes.

Like play therapy, the process in AAPT is of much greater importance than completing any task. Sometimes children or groups of children take several sessions to complete a given task. As in play therapy, the mantra is always ‘trust the process.’

AAPT is grounded in solid child-developmental, child-clinical, and humane animal-handling principles. Only positive, relationship-building interactions that are compatible with current best practices on all these dimensions are used.

**Goal Areas of AAPT**

There are five major goal areas that can readily be addressed through the use of AAPT, often simultaneously (VanFleet, 2008b, 2009). These are described below.

**Self-Efficacy.** AAPT aims to develop children’s capabilities, including their ability to protect themselves and keep themselves safe. They also develop competencies in animal welfare and handling, with the expectation that these in turn build self-confidence. For example, all children learn how to meet the animals, how to approach or touch them to avoid bites, kicks, or scratches, and how to handle them properly, such as how to train a dog using positive methods or how to touch the
horse to avoid alarming it. Even though therapy animals usually present very little risk to children, AAPT promotes child behaviours and competencies that will work with other animals they might encounter, including those that pose potential dangers. For example, even though a therapy dog accepts children’s arms encircling its neck, most dogs do not like this. To avoid possible facial bites from an unfamiliar dog or a friend’s pet dog, children learn to avoid this way of touching dogs and to scratch their chests only after they’ve received permission from the owner.

**Attachment/Relationship.** Through their interactions with the animals in AAPT, children can learn healthier relationship behaviours and patterns. They can also experience the animal’s caring for them. This is especially valuable for children with maltreatment histories and disrupted human attachments. Often, they learn to trust the therapy animals before they can trust humans. When a therapy dog searches for a child in a simple hide-and-seek game and greets the child with licks and low relaxed tail wags, the child can feel valued in a way not experienced fully before. Gonski (1985) found that the simple presence of a dog helped children in foster care quickly drop their hostility and resistant defences and engage more readily and eagerly with others.

Because the qualities of healthy human-animal relationships are much the same as healthy human-human relationships, AAPT can help children learn to relate to another, learn about the give-and-take of relationships, and consider and adjust to the animal’s needs and desires. Practitioners of AAPT have reported that social lubricant effects seem to occur in the therapy setting as well: children and adolescents warm up to the therapist and the therapy process more readily because of the animal’s involvement. One 16-year-old foster girl wrote retrospectively in her journal and gave permission for the following comment to be shared with other therapists:

“I wasn’t ready to trust one more adult who would let me down like all the others. But when I met Kirrie (dog), I thought that this might be different. Any therapist who would share her own dog with me might be different. It was easier for me to talk with her (therapist) and trust her because of this. Plus, it helped me feel better when Kirrie licked my tears away.”

**Empathy.** AAPT has the potential to develop children’s ability to recognise others’ feelings, act upon that knowledge appropriately, and offer care-giving behaviours. Therapists can help children learn about animals’ emotions and communication signals and provide opportunities for children to take kind and humane actions based upon that increased awareness. This often happens spontaneously, such as when one boy noticed a small spot of blood on a dog’s lip during a ball game and brought it to his therapist’s attention, or when a girl realised that her angry shouting was causing a horse to turn away from her and immediately began speaking in a quieter, gentler tone of voice. Sometimes this can be facilitated by the therapist who encourages children to feed or water the animals, teaches about animal communication signals, prompts children to focus on the animals’ feelings and reactions, or shows children how to touch, groom, or massage the animal, such as with Tellington Touch (www.lindatellingtonjones.com). There is some evidence that when children develop more humane attitudes toward animals, they can be generalised to humans (Ascione, 1992; Ascione & Weber, 1996).

**Self-regulation.** AAPT can be applied to help children develop greater self-regulation, both of emotions and behaviours. Children learn to remain calm with therapy animals and to have patience. When animals do not behave in ways the children desire, they must sometimes adjust their expectations and plans, and at other times, learn to persevere. If teaching new behaviours to a therapy dog is part of the child’s treatment plan, for example, it is a process that cannot be hurried. The child learns to reinforce the dog for small gains toward a larger goal, a skill that might serve the child well in the future when applied to him- or herself. As children learn to communicate, often nonverbally, with animals during AAPT, they begin to understand the animals better and how their own
behaviours are affecting their relationships, positively and negatively. Therapists can also help children develop better control of their arousal levels and agitated feelings through a series of activities with the therapy animals. For example, children greatly enjoy playing rope-tug with dogs (using a long rope for safety), and as the play intensifies children can choose to ‘let the dog win’ by releasing the rope or asking the dog to “Drop it”, a behaviour previously taught to the dog. If a horse walks away because a child is angrily stamping her foot, a suggested activity might be for the child to help the horse feel safe enough to approach her again (often accomplished with calmer attitudes and behaviours).

**Problem-resolution.** The resolution of many specific problems can be facilitated through the use of AAPT. Children have been helped with anger and aggression, anxiety, frustration tolerance, hyperactivity, depression, trauma reactions, feelings of isolation and many others. A foster boy who stole money from his mother’s purse refused to talk about it directly with adults, most likely because he had been cajoled and threatened to ‘admit it’ by his parents and grandparents. When asked to give advice to a therapy dog who had stolen some food from the counter, he readily suggested ways of planning ahead, respecting others, distracting oneself from the desired but forbidden item by focusing on a different activity, or asking for the item first. A kindergarten girl learned about making friends by dictating and illustrating a short book to help shy dogs. Some of the challenges of complex trauma and attachment problems have been addressed with clinical success through AAPT as well (Parish-Plass, 2008; VanFleet, 2008a).

In addition, live therapy animals can assist the treatment of animal-specific problems, such as loss of a family companion animal, overcoming the trauma of an animal bite or other injury, resolving fears of dogs, and eliminating animal cruelty behaviours. In these cases, too, AAPT is one piece of the treatment plan that often includes other forms of play therapy, Filial Therapy, or other family therapy interventions, but it is an important one.

**Methods of Animal Assisted Play Therapy**

Considering the philosophy and goal areas described above, therapists using AAPT employ a variety of actual methods. Because AAPT practitioners are usually play therapists, they draw upon that background, training and experience to enhance the use of AAPT. Some of the key approaches and methods used with dogs and horses are included here.

**Canines in Play Therapy**

VanFleet (2008a) has described the involvement of dogs in nondirective and directive play therapy in detail. A few methods are described here to provide readers with a general idea of how AAPT can work with dogs.

To participate in nondirective play therapy, a dog must have the temperament and training to lie in the corner of the room quietly when the child chooses to play with other items and to participate in various activities or roles chosen by the child when asked. The therapist provides minimal cueing to help the dog follow the child’s lead or establishes limits if the child engages in potentially harmful behaviours. For example, a 14-year-old boy hid behind the puppet theatre, telling the therapist to have the therapy dog find him. When the child whispered, “Okay, now!” to the therapist, she simply said to the dog, “Go find Brian!” The dog, being very child-oriented, moved through the room and found the boy behind the theatre. The boy, who had experienced over 15 foster placements and two failed adoptions, was so delighted with the dog’s finding him that he frequently asked for the dog to play with him this way. It seemed clear that he was playing out themes related to his abandonment and experiencing the novel feeling of being ‘wanted’ enough that the dog would search for him. In another example, a 6 year-old boy with little self-regulation tried twice to strike the therapy dog when she failed to do what he wanted. The therapist set a limit, “You may not hit or swing at Kirrie, but you can do just about anything else here.” The dog’s involvement was ended through a
three-step limit-setting procedure during the boy’s second AAPT session because he could not control his desire to hit her. The boy showed much greater restraint and more patience during his third and subsequent AAPT sessions. He was motivated to control his own behaviour in ways he had not been heretofore. Eventually, he developed a kind and enjoyable relationship with the dog.

Not all dogs have the temperament for nondirective play therapy work. Some canines are very active or energetic and enjoy working, for example. It seems disingenuous to expect them to be something other than what they are, even if training might eventually help them become more docile. In these cases, the dogs might be involved in the more directive play therapy approaches that can be beneficial for children as well. In such cases, nondirective play therapy or Filial Therapy play sessions might occur during the first half of an hour-long session, and the more directive interventions and AAPT provided during the last half. If two therapists are involved, one might provide Filial Therapy feedback to the parents while the AAPT therapist works with the child and dog.

In more directive forms of AAPT, the therapist continues to focus solidly on the child’s needs and provides as little direction as is needed. (In this article, directive play therapy refers to play-based interventions that the therapist suggests or sets up to accomplish specific therapeutic goals.) As in most forms of play therapy, the human AAPT therapist uses observations much more than questions to allow children to develop understandings of themselves and their relationships with the animal. For example, the therapist might comment, “When you pointed that sword at Corky, she turned her head away from you and then walked away.” The child might become more aware of his/her behaviour and its impact on the dog. Of course, if needed, the therapist sets a limit to maintain the safety of all involved. For some children, it might be necessary to draw their attention more fully to the animal by a well-placed, “How do you think Corky is feeling about that sword?”. This would occur only during directive play interventions, as questions are leading and not to be used in this way during nondirective play therapy.

Astute and well-trained AAPT therapists can use moments that occur between child and dog to facilitate the child’s discovery of self, and they can also engage dogs in creative ways that use the individual animal’s unique characteristics. Two examples of this follow.

Heebie Jeebie (Jeebie for short) was an energetic but well-behaved play therapy dog. Although she did well when interacting with the children, she barked whenever children and the therapist departed the room leaving her behind. The therapist decided to involve a particular child client in training Jeebie to stay quietly in the room by herself. Carrie was 10 years old and struggled with the effects of Attention Deficit Hyperactivity Disorder. She often resorted to troublemaking behaviours when she had to wait for events to happen. Jeebie’s training took place in a playroom and a private adjoining hallway. Keeping the tone playful and game-like (which was important for both child and dog), the therapist showed Carrie how to ask Jeebie to Sit-Stay while they left the room. Armed with treats, Carrie and the therapist left, closed the door, and waited outside the door for just 3 seconds of quiet dog behaviour before re-entering the room and giving the treats to Jeebie. They then repeated the ‘game’, waiting 5 seconds, which they playfully counted off together with hand gestures outside the door. This process became part of each of the subsequent four sessions. By the end, Jeebie was able to wait quietly for 8 minutes. Also by the end, Carrie was able to wait quietly for 8 minutes. The playful atmosphere was important for maintaining Carrie’s interest. When Carrie demonstrated this activity for her parents during her fifth AAPT session, she proudly told them that she thought she could wait better too, if she had something fun to do. The parents were able to follow through on this idea with her and they soon reported that they were having many fewer problems waiting and that they planned to share this way of structuring wait-times with Carrie’s teacher.

Kirrie is a play therapy dog who is a Border Collie cross. Typical of that breed, she is intelligent and learns very quickly. When her human companion and play therapist encountered a 7-year-
old, Jason, with fear of the dark, she thought of a way to involve Kirrie. Using an easy targeting technique common in the training of service dogs, the therapist taught Kirrie to push a battery-operated closet light on and off with her foot. During the AAPT session, Jason learned the cues to give Kirrie to perform this task (On Light; Off Light). Then, dressed in a cape and king’s hat, Jason became the ‘King of the Lights’, telling Kirrie to turn the light on and off. The King of the Lights also told the therapist when she could dim the lights in the room more and more. Over the course of several sessions, this AAPT desensitisation procedure allowed Jason to turn the lights off completely in the therapy room while playing the game with Kirrie. Kirrie eventually ‘wrote’ him a special congratulatory letter in which she thanked him for helping her learn the Light Game and mentioned that he might like to keep one of the lights they had practiced with (she would keep the other one). Jason’s mother reported that they stuck the light to his bed headboard so that he had easy control over the light in his room, and he soon was sleeping peacefully. Although Filial Therapy was also used successfully with this family to address other concerns, Jason’s mother thought that his work with Kirrie had been the most helpful intervention for helping him sleep at night.

There are countless ways in which canines can be involved in AAPT. Many, but not all, dogs are well-suited to play therapy work because they are active and playful, are social animals who enjoy people and children, are often expressive of their emotions in ways that children can understand, live in the here-and-now, and are incapable of deceit (VanFleet, 2008a). Play therapists who can apply the empathy, attunement, child-centred focus and playfulness they use in their usual play therapy work can create numerous ways to help children by involving a canine co-therapist.

**Equines in Play Therapy**

During the 1970s, horses began to take the role of co-therapist, and today more and more people are recognising the unique properties that horses bring to the psychotherapy process. As with canines, new methods are being developed and refined in North America and Europe, and Equine Assisted Therapy has become a viable subgroup of AAT. Therapeutic riding programmes are well-known and valuable, but they typically serve as a separate adjunctive activity to psychotherapy and are somewhat different from AAPT approaches. Most forms of Equine Assisted Psychotherapy (EAP) currently used in conjunction with play therapy focus on ground work, although some therapeutic riding modalities can easily be incorporated.

One approach particularly well-suited for combination with play therapy is the Equine Assisted Growth and Learning Association’s (EAGALA) model (www.eagala.org). The EAGALA model was developed by licenced clinical social worker Lynn Thomas and Greg Kersten, starting in the United States in 1999 and in the United Kingdom in 2003. EAGALA has a large worldwide membership and the model emphasises the importance of the qualifications and contributions of the mental health specialist.

Most play therapists are aware of and utilise Sand Tray therapies in their work, understanding the importance of the deep metaphorical learning possible for children and adults alike. Typically, therapists can provide sand trays and miniatures for clients to use as they see fit (nondirective play therapy) or suggest ways for clients to use the sand trays for certain bits of work needed. Equine assisted therapy that uses the EAGALA model is sand tray therapy magnified!

Instead of being outside the sand tray looking in, the clients and therapists are actually in the sand-based arena. Just as in traditional play therapy, there is a range of tools the clients can use with the unique difference being that the horses are not considered therapeutic tools, but as equal co-therapists. Upon entering the arena, children usually like the feel of the deep sand and its malleable texture. Horses seem to like it too, for when they enter the arena they often lie down and roll in the sand, kicking their legs up in the air. Children are often quick to imitate this horse-modelled behaviour, and the children’s joy of rolling and kicking in deep, firm sand provides a sense of
freedom and thrill, but is also paradoxically relaxing. A similar phenomenon in traditional play therapy work is when children spontaneously remove their shoes and socks in order to stand barefoot in the sand tray. In an arena, the whole body is engaged. When children watch horses rolling with abandon first, they seem to lose their self-consciousness about engaging in this full sensory experience.

Equine Assisted Psychotherapy components include this unique environmental setting, a human-equine team approach toward treatment, and structured experiential problem-solving activities reminiscent of some forms of group play therapy (Ashby, Kottman, & DeGraaf, 2008; VanFleet, 2006). Benefits are immediate and process- or solution-focused rather than problem oriented. As with other animals in AAPT, the involvement of equines in play therapy and other mental health work has a strong sensory component, permitting touch experiences that could not be appropriately offered by a human therapist. Taylor (2001) has suggested that the process of (mild) risk taking in equine work tends to produce deeper therapy than working in traditional room-based counselling settings.

The EAGALA model of equine mental health work is very compatible with play therapy, and it is also practical as the mental health specialist need not own a horse. EAGALA advocates the use of a therapeutic team comprised of a licenced mental health specialist, an equine specialist, and of course, at least one horse. Horses are viewed as part of the team because of their reported ability to respond to humans’ internalisation of feelings. The role of the mental health specialist is to oversee treatment, attending to the emotional aspects and verbal and nonverbal responses of the clients toward the horse(s). Counsellors also help construct the metaphor for change. The equine specialist attends more to the behaviours and reactions of the horses involved, sharing observations of the horses’ responses to the human clients. Together this team assists clients as they discover more about themselves through the metaphors and the overall process, all the while creating a nonthreatening and nonjudgmental therapeutic atmosphere. Once again, play therapists’ understanding of children as well as their ability to empathise and create emotional safety serve them well as a mental health specialist on an EAGALA team. While play therapists sometimes share their lives with horses, equine specialists almost always do, so having a horse in one’s garden or flat is not a requirement for this work. The collaborative nature of EAGALA teams makes many things possible.

AAPT that incorporates horses is experiential in nature. Participants learn about themselves and others by participating in activities with the horses and then processing their thoughts and feelings with the team immediately afterwards, in the here-and-now. Involving horses makes the process dynamic. Horses are large and powerful, and this creates a natural opportunity for some children, adolescents and families to overcome fear and develop confidence. The size and power of the horse are intimidating to many people. Accomplishing a task involving the horse, in spite of those fears, creates confidence and provides for rich metaphors for dealing with other intimidating and challenging situations in life. In many cases, children readily see the parallels of their emotional reactions, behaviours and patterns in AAPT to similar situations in daily life.

Horses are similar to humans in that they are social animals. They have defined roles within their herds. They would rather be with their peers. They have distinct personalities, attitudes and moods. An approach that seems to work with one horse does not necessarily work with another. At times, they seem stubborn and defiant. They like to have fun. As such, horses provide vast opportunities for metaphorical learning and therapeutic growth. The therapist’s effective use of metaphors, in discussion and/or activity, is an effective technique when working with even the most challenging individuals or groups. An example of the involvement of horses by a play therapist-equine team follow.

Faa-Thompson (2010) describes her ‘Safe Touch’ intervention when working with a sexually abused girl who was endangering herself with risky behaviours. Through playful intervention with horses and playing ‘games’ over a 10 week period, the child developed body awareness by learning
about her own and the other's (horse's) body. The therapist used a sensory model much like play therapy, focusing on the texture, feel, smell and sounds of the horse.

Cattanach (1992) believed that play therapy gives children the space to come to terms as best as possible with the multiple losses incurred when one is sexually abused. She stressed the importance of assisting children to repossess their bodies and find an identity other than one bound up in the past abuse. This applies to teenagers as well, but it is sometimes difficult to engage them in play therapy because they perceive it as too childish. Involving horses to replicate safe touch, trusting relationships and caring overcomes resistance and helps reframe an identity not defined by the abuse. In her keynote address at the British Association of Play Therapists conference in June 2010, Eliana Gil mentioned how the work of noted psychiatrist and neuroscience and child trauma expert Bruce Perry uses three key modalities: play therapy, Equine Assisted Therapy, and gentle holding and rocking of the child. It could be argued that the Safe Touch intervention mentioned above and detailed below incorporates all three modalities in one intervention. It is playful and led by the young person; it involves horses; and it provides a gentle rocking motion as the horse walks and the child rides bareback behind the therapist.

Melinda was a 14-year-old girl who was believed to have suffered severe and chronic sexual abuse by many family members of both genders. She had been in a therapeutic unit for 8 years and at the time of therapy was in a foster placement waiting for a place in a residential school. Melinda was referred for life story work and play therapy, but it soon became evident that her risky behaviour with teen males was adversely affecting her peer relationships, leading to further rejection and placing her at risk of further sexual abuse. Because of the urgency of the situation, priority was placed on AAPT involving horses.

The therapist invited Melinda to get to know a few horses in the sand-based arena over a period of time. Melinda wanted to groom them and get acquainted. The therapist laid out a variety of tools, any of which Melinda could use if she wanted to. As Melinda touched the horses in sensitive places, they reacted by swishing their tails and making "faces that conveyed ‘Get off me!". Melinda was able to make the link between these reactions and the horses’ unfamiliarity with her and her own unfamiliarity with them.

Over the course of 10 sessions, Melinda progressed to riding a horse bareback behind the therapist. This provided her with an experience of safe closeness with both therapist and horse. As they rode, Melinda envisioned a course and directed the therapist to steer the three of them through it. The activity involved much laughter, fun and frustration, especially when the therapist did not properly follow Melinda’s instructions. After the third bareback riding session, Melinda disclosed more about her intra-familial sexual abuse. By the end of the 10 sessions, Melinda’s risky behaviour had diminished dramatically, her peer relationships had become more interactive and normal, and she had gained in self-esteem. Through this rich and living AAPT experience, Melinda learned about the importance of trust and relationship in touch, reducing the likelihood that she would blindly succumb to others’ unwanted contacts. Her positive changes have been maintained for over 5 years.

This and similar approaches that incorporate horses into play therapy relationships can easily be applied to children and families with attachment difficulties or those struggling with physical boundaries and recognising their own and others’ personal space. Faa-Thompson has described her integration of Equine Assisted Therapy and the EAGALA model with play therapy in two forthcoming chapters (in progress).

**Indications and Contraindications for AAPT**

Because AAPT is in its infancy and so little controlled research has been completed on it, there is little empirical information about the types of problems where it can be usefully applied or when it should not be considered. Clinical experience, however, suggests considerable applicability as an adjunct to play therapy and family therapy for a wide range of presenting problems, including...
clinical and developmental difficulties. Because AAPT is a relationship-focused and process-oriented approach, its potential power resides in the socialisation, skill-building and confidence-building experiences it affords children. Furthermore, its flexibility provides play therapists with many avenues to apply their creativity in involving animals to meet children’s, adolescents’, and families’ therapeutic goals. As the field develops and more therapists are properly trained in its principles and methods, more research will become possible to ascertain its most useful applications.

Similarly, the current state of development of AAPT means that one must rely on clinical experience and judgment when ruling out its use. AAPT would not be appropriate for children terrified of the animals involved, unless, of course, the therapist was using a systematic desensitisation programme to overcome those fears. AAPT should be used only by trained play therapists and their animal co-therapists who have received the proper training in AAPT. Therapists must also have basic competencies in animal training, understanding animal communication signals and positive animal handling methods.

**Risks and Cautions**

The practice of AAPT is not without its difficulties. There are practical and logistical aspects that must be worked out. These include where the animal will stay when not being involved in sessions, how to set up a playroom when dogs are part of the process, how much work to expect from the animals, where and when animals go for elimination and how to obtain consent from parents and/or the organisations involved. Not all animals are suitable for this work, and AAPT training programmes highlight essential selection, training and safety features. There are also risks of injury to children, such as scratches, kicks, or bites and injuries to the animals if children try to strike or kick them, feed them unhealthy food items or write on them with coloured markers. Some children are allergic to animals, and there are diseases that can be passed between humans and dogs. Potential risks and ways to minimise them are detailed in other resources (Chandler, 2005; VanFleet, 2008a) and during live workshops on AAPT. While there usually are ways to resolve possible problems, therapists must be aware of the risks and plan for them. It is also critical for therapists to supervise children, teens, and animals continuously whenever they are together.

**Research and Resources**

To date, there is little research conducted specifically on AAPT, although some preliminary studies exist and show promise (Parish-Plass, 2008; Thompson, 2009; Weiss, 2009). Some details about the most relevant and best controlled studies follow.

Trotter, Chandler, Goodwin-Bond, and Casey (2008) compared 12 weeks of Equine Assisted Counselling (EAC) with the empirically-supported, award-winning Kid’s Connection classroom counselling intervention, using 164 at-risk children and adolescents. They used a pre-test-post-test experimental-comparison group design. The EAC group demonstrated statistically significant increases in positive behaviours and decreases in negative behaviours on well-established measures. Furthermore, the EAC group made statistically significant improvements in 17 behavioural areas whereas the comparison group programme resulted in statistically significant improvements in 5 behavioural areas. The study represents one of the best designed studies in this field and demonstrated the efficacy of EAC.

Thompson (2009), in a repeated-measures (ABAB) design using subjects as their own controls, found that the presence of a therapy dog in nondirective play therapy sessions with anxious children improved mood, facilitated rapport between therapist and child, increased the occurrence of thematic play, and reduced aggressive and disruptive behaviours in session. VanFleet (2008a) used post-therapy sandtray creations to demonstrate that nearly all children involved in AAPT placed a dog figurine in their final sandtray depicting their perceptions of the important parts of the therapy experience, while children without the AAPT experience did so significantly less often.
These studies offer tantalising suggestions about the potential usefulness of AAPT, but they represent only a beginning. Now that more therapists are using AAPT, there are greater opportunities unfolding for data collection and more rigorous research.

For clinical practice and research to move forward, training is needed. Related training and information for interested play therapists can be found at www.playfulpooch.org, www.eagala.org, www.scas.org.uk, www.taoofequus.com, and www.thekennelclub.org.uk/dogtraining (Good Citizen Dog Scheme). The reference list includes useful resources, and the authors of this contribution may be contacted for further lists of resources.

**Conclusion**

Animal Assisted Play Therapy combines two promising therapeutic approaches for working with children, adolescents and families: play therapy and animal assisted therapy. The living presence of nonhuman animals as therapeutic partners offers children new avenues for reducing defences, expressing their feelings, building healthy relationships, and overcoming problems. The experience can reshape children’s views of themselves and empower them while offering them new understandings of their relationships with other animals and ultimately, other humans. The field of AAPT has grown substantially, and it is hoped that further training and use of AAPT will lead to increased process and outcome research. Woof!

**REFERENCES**


Introduction

Play therapy aims to help children and young people suffering from a range of psychological difficulties including depression, anxiety and aggression. It is often used to help children and young people resolve difficult life experiences such as a family breakdown, abuse, trauma, grief and domestic violence. The aims of play therapy include helping children and young people to modify their behaviours, build healthy relationships and clarify their self-concept. In play therapy, the relationship between a child and a therapist is regarded as paramount in helping to explore, express and make sense of complex and distressing experiences (British Association of Play Therapists, 2010).

The foundations of play therapy can be seen in the work of Freud (1928) and Klein (1932) who used play as a substitute for verbal responses in their efforts to apply analytic techniques to their work.
with children. Another milestone in the development in play therapy occurred when Axline (1947) developed a non-directive model of play therapy (later referred to as Child-Centred Play Therapy) based on the Rogerian model of psychotherapy. Over the years, play therapy continued to develop in the UK and internationally to include a cluster of treatment models, approaches and theoretical schools of thought. These include humanistic (Axline, 1947, Rogers, 1976), behavioural (Knell, 1995), gestalt (Oaklander, 1994) and psychoanalytical (Freud, 1928; Klein, 1932). During the 1980s and 1990s a wide range of specific play therapy models emerged, based on practitioners' theoretical views and personal experiences of working with children. These included gestalt play therapy (Oaklander, 1994), Adlerian play therapy (Kottman, 1995), prescriptive play therapy (Schaefer, 2001) and ecosystemic play therapy (O'Connor, 1999) to highlight a few. In the UK, Jennings (1990, 1999) and Cattanach (1992, 1994,) integrated elements of non directive Play Therapy to formulate a British Play Therapy movement. Whilst the various models and approaches may differ philosophically and in their technical application, they all recognise and value the therapeutic and developmental aspects of play in helping children to resolve past psychological difficulties to achieve healing and emotional wellbeing.

It is important to differentiate play therapy from other specialisms that make use of play methods. These include therapeutic play, where the objectives are to increase the emotional wellbeing of a child or young person. This differs from play therapy in that it is used to treat mild, or recently emerging emotional or psychological difficulties from becoming more entrenched. Play therapy can also be differentiated from the work of hospital play specialists who use free or directed play methods. Their goals are to help children prepare and cope with anxieties and feelings associated with hospital procedures as well as supporting a child or young person’s family and contributing to clinical judgements through play based observations (Hubbuck, 2009).

There is a sizeable body of research on outcomes of play therapy, indicating that this approach can be used to help children suffering from a variety of problems (e.g. Bratton, Ray, Rhine & Jones, 2005; Dougherty and Ray, 2007). However there appears to be less emphasis on play therapists, clients and particularly childcare professionals’ perceptions of this relatively new (in the UK) therapeutic approach. Bratton and Ray (2000) carried out a review of eighty-two play therapy research studies from 1942 to 2000. They identified the 1970’s as the height of play therapy research with studies focussing mainly on children’s difficulties with social adjustment and the self. Prior to this, research in this field focused primarily around intelligence and school achievement. More recently, there has been a shift in research focusing on social problems such as domestic violence, drug and sexual abuse as well as diagnoses such as depression and conduct disorder amongst children.

There has been a small amount of research looking at the issue of play therapists’ experiences and perceptions of play therapy. Examples include a study by Phillips and Landreth (1988), who surveyed 1166 American play therapists on their perceptions of the effectiveness of play therapy, and issues such as their referral criteria and their views on which disorders were most amenable to play therapy. This study found that the therapists believed that 80% of their cases had a successful outcome, and that for the majority of the therapists, type of disorder and the age of the child were the key criteria for referral. A more recent study reported by Nalavany, Ryan, Gomory and Lacasse (2005) investigated American play therapists’ views of the qualities, competencies and skills of an effective play therapist. Each therapist was asked to identify 3 qualities of a ‘good’ therapist, and the responses were collated and organised into 7 clusters. The therapists were then asked to rate the ease of acquisition of each cluster of abilities, and the importance of each to their practice. Sensitivity and responsiveness to the child were rated as being most important, and theoretical knowledge and skills with family were rated as being most difficult to acquire.

A number of studies have examined perceptions of play therapy from the point of view
of the child. Axline (1950) carried out follow-up interviews with 22 American children who had received either individual or group play therapy which was deemed to be successful. The children were aged between 4 and 14 years at the time of therapy and the interviews were conducted up to five years after the final therapy session. The aim of the study was to gain some insight into children's perceptions of their experiences and their interpretation and memory of the process of therapy. Overall, the study found that the experience of play therapy was a positive one for the children and all of the children remembered their experiences vividly.

A recurring theme was the children's growing awareness of their thoughts and feelings and positive changes arising from this. The children also commented favourably on their relationship with their therapist and their freedom to act spontaneously and direct the sessions. The children also reported the therapeutic sessions to be 'fun'.

More recently, Carroll (2002) interviewed fourteen English children aged between 9 and 14, as well as their therapists, to gain an awareness of the children's perceptions of the Play Therapy experience. As with Axline's (1950) sample, all of these cases were deemed to be successful. The results were similar to those of Axline in that many of the children regarded the intervention as fun. The therapists however, tended to ascribe more meaning to the play. For the children, having fun in the context of the therapeutic relationship appeared to be the most significant aspect of the therapeutic process. The children talked about the warmth of their therapist as well as their therapists' willingness to help and act as an advocate for them and in ensuring that they felt comfortable and safe.

Green and Christensen (2006) interviewed 7 American children on their experiences of counselling with school counsellors who employed play therapy techniques. The children valued the therapeutic relationship as providing them with empathy and acceptance as well as collaborative problem solving and being given the freedom direct the sessions. The participants also indicated that the therapeutic relationship was important in helping to bring about change as their behaviours and feelings became more positive.

Jager and Ryan (2007) investigated the use of play-based techniques to investigate the views of 12 English children who were participating in a school-based NSPCC therapeutic programme and found that these techniques revealed both positive and negative views among the children receiving therapy; the therapist was then able to use this information to adapt and modify the therapeutic approach. Jager and Ryan argue that play-based methods are ideal for evaluating child therapy generally as they provide a highly suitable means for children to express themselves.

Siu (2009) evaluated the effectiveness of Theraplay in reducing internalising problems in a group of Hong Kong children, from the point of view of the children and their parents. The findings demonstrated that among the children who participated in a Theraplay intervention, internalising problems had decreased compared to a control group of children who received no intervention. Follow-up interviews showed that Theraplay received positive evaluations from both the parents and the children. Parents were asked to rate their satisfaction with the programme and the likelihood that they would recommend the programme to other parents. The majority of the parents described themselves as being ‘very satisfied’ with the programme and that they would recommend the programme to others. In addition, parents reported that they had fun with their children during the intervention. Among the children, most perceived the activities to be “fun” and said that they were happy playing games with their parent.

While there is some very positive research on perceptions of play therapy from the point of view of the child and the therapist, another important issue relates to knowledge and perceptions of play therapy in the wider population, and particularly among childcare practitioners. It is clear from the studies reviewed above that play therapy can be a beneficial intervention for children, but children can only benefit if parents, carers and professionals engaged with working with the child are aware of this approach and are willing to consider play therapy as an option. Practitioners working in health, education, social care and childcare are in an
ideal position to identify children with difficulties that may benefit from a play therapy intervention. However there are questions as to what extent workers in these areas are aware of the value and relevance of play therapy. If they have heard of play therapy, do they know what it is about? Do they see play therapy as distinct from other forms of play specialisms such as therapeutic play and playwork? The current study is exploratory in nature and seeks the views of childcare practitioners working in the fields of health, education, social care and childcare. Although there are different approaches to play therapy, this research did not distinguish between these as the study was primarily concerned with general awareness of this form of therapy.

Research Methodology

In order to investigate this issue, two approaches – quantitative and qualitative – were used. The quantitative aspect took the form of a questionnaire study in which participants were asked a series of basic questions about play therapy, and the numbers of participants making particular responses to each question were analysed. In this way, some basic quantitative information could be obtained on issues such as the percentage of participants who had heard of play therapy, the various sources of awareness, and knowledge of aspects of play therapy. However while such quantitative information is very useful, it is also interesting to understand the factors that may underlie responses to questionnaire items. For this reason, the quantitative questionnaire study was followed by a small-scale qualitative interview study. Qualitative data can be useful supplements to quantitative data, as they can “...help the account ‘live’ and communicate to the reader through the telling quotation or apt example” (Robson, 1993, p.371). Therefore it was decided to follow up four of the participants in the questionnaire study and conduct interviews that would allow them the opportunity to expand on the responses given on the questionnaires.

Questionnaire Study

Participants

The sample consisted of 65 childcare professionals from four sectors including health, social care, education and child care. The sample consisted of nineteen participants working in social care including social workers, children's charity project workers and project co-ordinators as well as youth workers and a parent therapist. Twenty participants were working in education, these included class teachers, teaching assistants, SENCOs, educational psychologists and a head teacher. Eighteen of the participants were working in the health sector, including staff nurses, senior staff nurses, a speciality registrar, a paediatrician and a junior doctor. The remaining eight participants worked in child care and included nursery officers and a nursery manager.

The sample comprised ten males and fifty-five females. The participants ranged in age from under 25 years to over 60 years of age. The participants can be regarded as a convenience sample in that they were workers approached by the first author who were available and willing to participate in the study.

Questionnaire

A brief questionnaire was constructed in order to investigate participants’ knowledge and perceptions of play therapy. This consisted mainly of closed questions, where participants were asked to select the options which related to their knowledge and perceptions of play therapy. Some questions required simple ‘yes/no’ answers, such as Have you heard of play therapy prior to this study? Other questions required the participant to select what they felt was the most appropriate response or responses from a list (e.g. What do you believe play therapists do?). Where a list of responses was provided, these also included an ‘other’ response in order not to constrain the respondents and miss out on useful information. The questions were generated by the first author, drawing upon her own
experience of working as a child care practitioner. The questionnaire was also piloted on two child care professionals, one working in education and one in social care, who were not participating in the study. This was to ensure that the questions were well understood. Participants responded to the questionnaire in their own time and in a location convenient for them. All participants were assured that the questionnaire was for research purposes only and all responses were anonymous and confidential. Participants were also asked to indicate if they would be willing to take part in a follow-up interview if required and to provide a means of contact for this. Prior to conducting the study, approval was sought and gained from the ethics panel of the University of Glamorgan’s Psychology Department. The research was also conducted within the BAPT ethical framework.

Findings

The first question asked simply if the participants had heard of play therapy. The responses organised by sector of employment are displayed in Figure 1. This chart and all subsequent charts display responses to questionnaire items in terms of the percentage of participants responding in a particular way.

![Figure 1: Awareness of play therapy by sector.](image)

Awareness was highest among the healthcare workers (100%), followed by social care and child care workers (90% and 88% respectively). Awareness was lowest amongst the education workers with 75% of this group reporting that they had heard of play therapy. Taking the sample of participants as a whole, the majority have heard of play therapy (88% of the entire sample), but a minority had never heard of this approach (12% of the total sample).

Participants were also asked if they had heard about other forms of therapeutic intervention. Responses are displayed in figure 2.

In general, there appears to be a high degree of awareness of other forms of therapeutic intervention. Awareness was lowest in the case of drama therapy (44% of participants had heard of this) and attachment therapy (52%). Regarding other forms of therapy, awareness rates in excess of 80% were reported.
The next question of interest concerned the participants who had heard of play therapy and asked for the specific source of awareness. The results are presented in Figure 3.

The above chart shows that by far the greatest source was hearing via a colleague or another agency. Research papers were another important source, with 21% of participants hearing about play therapy through this channel. The media was the source of awareness for 10% of respondents. Responses classified as ‘other’ included hearing about play therapy through participation on training courses, modules taken at university, or working with a child who had been through play therapy.

![Figure 2: Awareness of other forms of therapy](image1)

![Figure 3: Sources of awareness of play therapy](image2)
The participants who were aware of play therapy were then asked if they knew the route of referral for play therapy. The responses to this question are presented in figure 4.

![Figure 4: Participants' knowledge of the route of referral](image)

It can be seen that despite the fact that these participants were aware of play therapy, the vast majority (83% of respondents) did not know the route of referral to a play therapist.

Following the questions on basic awareness of play therapy, there then followed a series of questions relating to participant's perceptions of play therapy. For each of these questions, participants were free to choose as many responses from a list as they felt were appropriate.

Firstly, participants were asked what type of intervention they perceived play therapy to be. The responses are displayed in figure 5.

![Figure 5: Perceptions of type of intervention](image)

It can be seen that the majority of participants correctly perceived play therapy as an intervention for dealing with emotional and...
behavioural difficulties (92% and 80% respectively). However, 32% of participants also believed that play therapy also involved simple provision of play opportunities, indicating perhaps a degree of confusion of play therapy with other forms of play work. A considerable number of participants (57%) thought that play therapy could also be used as an intervention for physical difficulties, again perhaps indicating confusion with other interventions where play may be used as part of a wider set of techniques, such as the work of occupational therapists.

Participants were next asked what they thought play therapists do in their therapeutic work. The responses are displayed in figure 6.

The responses to this question did indicate a degree of confusion about the nature of play therapy. While many participants accurately perceived play therapists as working with families as a whole (55%) and working with children on a 1:1 basis (68%), there also is some indication of confusion with other forms of therapy. For example, 48% of the participants also thought that play therapy involves the therapist talking with children about difficulties indicating perhaps a general perception of therapy as a ‘talking’ process, and 37% of participants viewed play therapy as playing with children and having fun, again perhaps indicating confusion with other forms of play work. This generally confused view of play therapy can also be seen by the fact that 83% of participants saw play therapists using play methods as part of the intervention and only 25% of participants accurately saw play therapy as solely involving play methods.

Finally, participants who were aware of play therapy were asked if they had ever been involved in referring a child to play therapy, or were aware of a child who had been referred to play therapy. A minority of these individuals (29%) answered yes to this question. These participants were then asked to report the outcome of the referral. The responses are displayed in figure 7.

None of the respondents reported the outcome to be unsuccessful, however only a minority (22%) reported the outcome as successful and the majority (78%) reported the outcome as partially successful.
Summary of Questionnaire Findings

Although the questionnaire was of an exploratory nature, some potentially interesting findings have emerged which would be worthy of further investigation. Most of the participants have heard of play therapy, and there seems to be a generally high level of awareness of the various forms of therapeutic intervention. However, while participants are aware of the existence of play therapy, the majority would not know how to refer a child to a play therapist. Participants appear to be aware that play therapy can be used as an intervention for children with emotional and behavioural difficulties, but some participants (including some of those who accurately identified play therapy as an intervention for emotional and behavioural problems) also see a role for therapists as simply providing an opportunity for children to play. This may indicate confusion of the work of play therapists with other specialists such as play workers or perhaps a view that play therapists provide play opportunities alongside therapeutic services. Some participants also saw play therapists as working with children with physical disabilities. This may be seen as a further example of play therapy being confounded with other forms of work involving the use of play, such as the work of occupational therapists with physically disabled children. Evidence of confusion can also be seen in their responses to the question of what play therapists do within their interventions. The responses here seem to indicate that many workers still see play therapy as just another form of ‘talking therapy’ where play is simply used to facilitate communication. Just 25% of participants seemed to be aware that in play therapy, play is the form of communication, rather than just a means to an end.

Interview Study

Participants

In order to build on the information gained from the questionnaires, follow up interviews were conducted with 4 participants who had also taken part in the questionnaire study, one from each of the four sectors sampled. The following individuals agreed to take part in an interview:

Participant A: A 35 year old female working as a Nursery Officer.

Participant B: A 55 year old male who works as a Manager for a charity which runs youth projects as well as providing services for vulnerable women and their children.
Participant C: A 24 year old female working as a Junior Doctor. At the time of interview she was coming to the end of a four month placement in the Paediatrics ward of a large hospital.

Participant D: A 56 year old female working as a year 4 class teacher in a Primary school.

Interview Schedule

The interviews were semi-structured in nature. The interview schedule consisted of eight main questions which were designed to be answered in a flexible manner or reframed by the participants. The questions were generated by the first author who also conducted the interviews, and explored participants’ knowledge of play therapy, their understanding of the distinction between play therapy, therapeutic play and other play specialisms and their views on referring children for therapeutic interventions. The interview schedules were piloted to the same two childcare professionals as with the questionnaire. This was to ensure that the context, phrasing and order of the questions were logical and well understood. A digital dictaphone was used to record the interviews. Ethical issues were also addressed including participants’ anonymity, their right to decline answering any questions which they did not want to, their right to end the interview at any point and their right to withdraw from the study. All participants gave consent for their responses to be used for publication, including the use of anonymous verbatim quotes.

Interview Findings

All 4 participants reported that they encountered children suffering from emotional, behavioural and social difficulties during the course of their work. The 4 participants were all aware of the existence of play therapy, but their knowledge appeared to be limited. For example, when asked for her understanding of play therapy, participant A responded:

“Play therapy is where you have a child and they have experienced or are about to experience a certain difficulty and you work out a way of preventing that from happening to the child and it’s like there is thought gone into it.”

This example also illustrates some confusion around the difference between Play Therapy and other play based interventions as participant A’s definition is more akin to the work of hospital play specialists. Indeed participant A revealed that she had previously worked in a hospital alongside play specialists:

“I worked in a hospital for a couple of years before I was here and I did play therapy there with the hospital specialists.”

This reinforces the impression that this participant regards the work of hospital play specialists as synonymous with play therapy.

This confusion was also evident in the responses of other participants. Participant C admitted that she was confused around the different roles of play workers, play therapists and hospital play specialists:

“…quite often they introduce themselves as ‘I’m a play assistant’, ‘I’m a play worker’, ‘I’m a play specialist’ and they all obviously know their roles but to us it’s difficult to distinguish.”

Despite this confusion however, it was participant C who provided the best description of play therapy, using her perception of therapies in general as a concept:

“In my understanding of it, play therapy sounds more like a treatment program rather than just play specialists. Play therapy sounds more like there is a goal towards the end of it, you’re looking to achieve something out of the play therapy itself.”

Participants were generally unsure of the distinction between play therapy and therapeutic play. For example, when asked if he understood the distinction participant B responded:

“Well…no, but I’m sure there is, or that people say there is and can perhaps quantify that”.

Participant A also was also unsure about the
distinction between play therapy and therapeutic play and when asked what she understood by the term therapeutic play, gave the following answer:

“…therapeutic play could range from a play where you’re dressing up with scarves and it’s therapeutic, the child is comfortable, it’s relaxing. You could have child playing with a tray full of shaving foam and it’s therapeutic.”

There was also a mixed knowledge of the difference between play work and play therapy. Play therapy also tended to be viewed as rather adult led as opposed to play work. According to participant D:

“I guess I see play work as any situation which allows a child to play and interact with others. I see this as free play and giving children the opportunity to express themselves. Where as I think Play Therapy is probably very structured, where the therapist is either trying to understand or get children to express their difficulties or trying to give them an outlet in order to express those difficulties and then be worked on.”

In addition to the confusion as to the exact nature of play therapy, there was also evidence of some suspicion about this approach to therapy. When asked to describe the difference between play work and Play Therapy, participant B reframed the question and put forward a rather negative perception of Play Therapy:

“Well I think it’s a difficult thing. I’ve always been nervous about moving something that’s very normal and very everyday into the area of therapy. Parents have been playing with their children for ten thousand years so I’m always a bit nervous when an everyday thing such as swimming becomes swimming therapy.”

Later, when asked about the distinction between play therapy and therapeutic play, participant B made the following observation:

“I remember going to *** Hospital and watching some different interventions. Some of them were really nutty and it just seemed like people had read a bit of a book and had a new idea…clients were just doing everyday things such as swimming but professionals were convinced it was therapy.”

Another issue probed in the interviews was practitioners’ views relating to identifying children with problems and referring to play therapy and other interventions. A theme which flowed through all four interviews was a general lack of clarity around child care professionals’ roles and responsibilities for referring children and young people to play therapy. None of the participants saw making referrals for children with emotional, behavioural or social difficulties as part of their role:

“I think we would probably ask the educational psychologist or social services perhaps for their input on different interventions and also how to refer.”

(Participant D)

“We wouldn’t really have to consider that (making referrals) because it would be totally out of our hands.”

(Participant A)

Participant A also appears to not see herself as part of a wider team in being responsible for ensuring that a child is referred to the most appropriate intervention and that input is given by all agencies working with a child.

All of the participants believed that it is difficult for child care professionals to distinguish between the different therapeutic interventions and treatments available to treat children and young people with difficulties. Participant B demonstrates this in his response but also suggests that this may also be due to child care professionals having reservations around referring to newer therapeutic interventions such as play therapy:

“Yes, I think it is exceptionally difficult. From my experience I think that practitioners often stick to what they know and are often nervous of new things.”

When questioned about this issue, participant D made the point:

“I think it’s quite easy to identify
In addition to a lack of certainty about appropriate types of intervention, participants also believed it to be difficult for practitioners to know the route for referral for different therapeutic interventions and treatments:

“Yeah, I think that’s a really big problem. Partly because from our medical training, I know you have to find things out for yourself sometimes, but we’ve never really been made aware of the different options available for different things. Also we move around hospitals so much, the services available and the referral routes differ so much from hospital to hospital and you can’t keep up with it.” (Participant C)

There also seemed to be a lack of awareness around what happens and the outcome when a child is referred for a specific intervention or therapy:

“So they come in (CAMHS) and they will decide which services are appropriate and we never find out why and we never find out where CAMHS have sent them and whether it was appropriate.” (Participant C)

**Summary of Interview Findings**

The follow-up interviews further confirmed the findings from the questionnaires in that child care professionals’ knowledge of play therapy was somewhat limited. There was much confusion amongst the four interviewees around the difference between play therapy and other play based interventions, such as therapeutic play, which were largely viewed as the same. The follow-up interviews also highlighted some confusion around the different roles and responsibilities of play workers, play therapists and hospital play specialists. This confirms the finding from the questionnaires where some of the child care professionals viewed play therapy as providing play opportunities to children and young people, therefore confusing play therapy with play work. These findings help to demonstrate the need for child care professionals to have an awareness of other professionals’ roles and responsibilities in order to be able to work in a multi-agency context and to be able to make sense of referrals in general.

In addition, all four interviewees believed it to be difficult for child care professionals to distinguish between the different therapeutic interventions and treatments available to treat children and young people with difficulties. These findings help to build on those from the questionnaires, in that the majority of child care professionals did not know the route for referral for play therapy and possibly other therapeutic interventions. This highlights a training need amongst child care professionals around gaining an awareness and basic knowledge of the different therapeutic interventions available to treat children and young people including the criteria and route of referral.

The follow-up interviews also showed that there appeared to be a general lack of clarity around child care professionals’ roles and responsibilities for referring children and young people to play therapy. None of the interviewees saw making referrals to play therapy or any other therapeutic interventions as part of their role and were quite protective with firm boundaries around their role.

There also appeared to be a lack of awareness around what happens and the outcome when a child is referred for a specific intervention or therapy. This does not necessarily reflect a failing on the part of the childcare workers and may simply reflect the fact that these workers do not have the time to follow up referrals and may also indicate a need for more feedback from therapy providers.

These findings suggest that many child care professionals may work in quite a disjointed manner, meaning that it may be possible for children and young people to miss out on being referred to therapeutic interventions or when a child is referred, there is a lack of communication regarding the outcome of the referral.
Implications for Practice

This study was exploratory in nature, and focussed on the knowledge and perceptions of a small sample of childcare practitioners. It must also be acknowledged that the participants were all based in one geographic region (South Wales) and it would be interesting to see if similar findings would be observed in a larger scale study involving workers based in other regions. However if the responses of the participants in this study are indicative of childcare practitioners in general, then the results may be a cause of concern to the play therapy profession. While there is a high degree of awareness of the existence of play therapy (as well as other forms of intervention generally), participants’ specific knowledge of play therapy is limited and in some cases incorrect. While many practitioners recognise that play therapy can be an effective tool for treating emotional and behavioural disorders in children, there also appears to be confusion between play therapy and other forms of intervention using play methods, and indeed some participants may view any form of work involving play as ‘doing therapy’. This is very much demonstrated by interview participant A when commenting on her experience of working alongside hospital play specialists. This confusion in the case of hospital play specialists has also been noted by Hubbuck (2009) who reports that play specialists are often mistakenly labelled by patients, families and colleagues as ‘the play therapist’. She points out that this can also cause problems for play specialists themselves, as use of the term ‘therapist’ may lead to incorrect expectations of their role and the services they can provide for patients.

It was also the case that the majority of participants reported that they do not know the referral route for play therapy, and most do not see it as their role anyway. This has implications for the ability of practitioners to identify and refer children for play therapy. The main settings for play therapy in the public sector are health (Child and Adolescent Mental Health Service - CAMHS), social services and education. Access to play therapy via CAMHS can be made via a referral from GP’s, Health Visitors, Social Services and other relevant child care support agencies. However, in the third author's experience as a practicing Play Therapist, there is no direct route for referring children for play therapy within the UK. Individual agencies and professionals offering play therapy have their own specific referral processes. In the third author’s experience in private practice, the majority of children receiving play therapy are referred via Social Services, the Health Service, via the Court or via self-referral from the child’s parent or caregiver. It is therefore important for Play Therapists to adopt a proactive role in educating and advising other professionals on how to access therapeutic work for children. Cattanach states “the teaching role of the Play Therapist is an important way to help other professionals understand what play therapy is about and how to use play within other professional areas” (Cattanach, 2003, p.86)

Another key role of Play Therapists is to explain their work to parents and carers prior to undertaking Play Therapy sessions with their child. Another potential finding of concern is the responses in the questionnaire study of participants who had referred or were aware of a child referred to play therapy regarding the outcome of therapy. While none of these participants reported the outcome as unsuccessful, most regarded the outcome as ‘partially successful’. A limitation of the current study is that participants’ views as to what constitutes a ‘partially successful’ outcome was not probed further. However if professionals are going to make use of play therapy, they must be confident that it is an effective approach, and perhaps the views of professionals who have made referrals to play therapy could be explored in further research, particularly around their expectations of play therapy and their views of outcomes.

In addition to a rather mixed view of the efficacy of play therapy, another issue relates to general attitudes to play therapy, and whether or not it is perceived as a credible approach to therapy. The views expressed by participant B in the interviews relating to “moving something that is very normal and very everyday into therapy” illustrate this concern. There is also the general issue highlighted by participants of the difficulty in distinguishing
between the different therapeutic approaches. Again, all of these factors could have a negative effect on willingness to refer a child for play therapy.

The results of this study therefore suggest that members of the play therapy profession may need to give thought to educating childcare practitioners and the wider public about the nature of play therapy, and correct any misconceptions about this therapeutic approach. There are a number of possible steps that could be taken here. BAPT members could offer short information sessions about play therapy to local agencies, for example, Social Services, Health and Education in order to increase professional understanding throughout the UK. Another useful step would be the development of a database of qualified and experienced Play Therapists throughout the UK who would be able to respond to requests from the media on children’s emotional wellbeing and the value of play therapy as an effective intervention. Consideration may also be given to the provision by the BAPT of media training courses for play therapists along the lines of the type of courses provided by the British Psychological Society for members of the Psychology profession. In the current study, the media was a source of awareness for only 10% of the workers and effective use of the media could help to raise the profile of play therapy among childcare workers and the wider public.

Regarding raising the public profile of play therapy, another useful step would be to investigate sources of awareness of other forms of therapy. The results of the questionnaire study reported in this paper indicate high levels of awareness of other therapeutic approaches. However the question of how participants came to hear of these approaches was not examined in this research and this issue could be explored in a future study. This might provide information that can be used by the play therapy profession to consider ways in which play therapy could be better publicised.

It is clear from the current study that participants are unsure of the distinction between play therapy, other forms of therapy and other forms of work involving play, and indeed some participants may have reservations about play therapy generally. A potentially important step that could be taken to improve this situation would be to make ‘play therapist’ a protected title with the Health Professions Council (HPC). There is currently no safeguard in place to prevent other professionals stating they are play therapists. This is a common problem throughout the UK and claims made by other professionals are often done so with limited on no professional training in play therapy. The profession of Arts Therapist (encompassing the titles of Art Psychotherapist, Art Therapist, Drama Therapist and Music Therapist) is currently HPC protected (Health Professions Council, 2010). Serious consideration should be given by the play therapy profession to following this trend. The title of Play Therapist could then only be used by graduates of properly accredited training courses and this would eliminate the inappropriate use of the term and reduce confusion that can be caused by this.

Continued research into play therapy practice as well as outcomes of therapy will continue to enhance the image of play therapy, particularly among childcare professionals. An important future direction for research in play therapy is suggested by Geidner (2008), who argues that rather than focussing on outcomes, the emphasis should move toward developmental and clinical processes – in effect, demonstrating not only that play therapy is effective, but also clearly indicating how play therapy is effective. This would clearly ground play therapy practices and approaches within the wider field of research on child development and enhance its credibility as an evidence-based approach to therapy.

There is no doubt that play therapy is an effective and child-friendly approach to therapy, and many children have benefitted to this approach. However it is important that play therapists concern themselves not just with therapeutic work, but also working together as a group of professionals in order to educate and increase professional understanding of the effectiveness of play therapy as an intervention for children and young people. It is important that childcare practitioners as well as parents and carers are aware of the nature of play therapy.
therapy, and see it as a credible, evidence-based approach delivered by appropriately trained therapists who are accountable to a professional body. This will ensure that parents, carers and other professionals are able to make informed choices before referring children and young people to play therapy.

REFERENCES


NEURO-DRAMATIC-PLAY AND ATTACHMENT

Sue Jennings
Glastonbury, England

Abstract

Neuro-Dramatic-Play is a new synthesis of recent neuroscientific discoveries, play therapy and dramatherapy practice, and current thinking on childhood attachment. Neuro-Dramatic-Play is focused on the 6 months before and the 6 months after birth, and the development of secure attachments. In the early playfulness between mother and infant, the sensory, rhythmic and dramatic play form the basis of playful attachment and contribute to the growth of secure identity, the capacity for empathy and healthy social relationships.

Neuro-Dramatic-Play (NDP) is described as preceding the developmental paradigm of Embodiment-Projection-Role (EPR) that charts the infant's dramatic development between birth and seven years. Building on NDP and EPR, it can be shown that appropriate play therapy and dramatherapy interventions can be planned in order to focus on the specific attachment and emotional needs of the child. Once these stages have been successfully navigated, then a third stage becomes possible, namely Theatre of Resilience (ToR), through which a child is able to contribute to and learn from their own culture, including theatre, ritual and stories.

This essay focuses primarily on Neuro-Dramatic-Play and its application as assessment and therapy with children who are troubled, lost and unhappy. It is still work in progress.

Key words: Embodiment-Projection-Role, attachment, brain development, sensory, rhythmic and dramatic play

Background

For the past 25 years I have been developing the theory and practice of ‘Embodiment-Projection-Role’ (EPR), a developmental paradigm which charts a child’s dramatic development from birth to 7 years (Jennings, 1990, 1994). As EPR became more refined, and the transitional events between the stages were more clearly understood, EPR also became an assessment tool (Jennings, 1998, 1999).

These three stages of EPR and their appropriate transitions are essential for healthy development and maturation. They influence the development of both the right and left hemispheres of the brain as well as encouraging resilience and self confidence. For example:

A child who has not been able to go through an appropriate embodied stage at 0-13 months, may have a distorted body image and potential eating disorders or become anxious in space.

A child who struggles with hand-eye coordination and literacy, and maybe has little confidence in their own artistic abilities, 14-36 weeks, may never have been through the projective stage.

Sue Jennings PhD is a play therapist and dramatherapist, with a particular focus on the play and drama process. She has retired from formal lecturing, having established major training programmes in UK, Czech Republic, Israel and Romania. She is concentrating on supervision, storytelling and writing, and the support of ToR projects. She also has an intensive programme in NDP, EPR and ToR skills and application.
A child who is unable to ‘pretend’, from 3-4 years to 6-7 years, or to take on the role of the other, described by Mead (1934) may well play out destructive or isolated roles in everyday life.

These children have not only missed out the role stage of EPR, but also the time of dramatic playing during the early weeks and months. They are unable to dramatise their roles but continue life in a series of day-to-day destructive encounters, where they often play out roles of aggressors or victims. I have worked with children who will happily play at physical games or movement exercises (Sherborne, 2001) or will create collage or self portraits or intricate clay models, but they have been quite unable to play a role i.e. to become someone other than themselves. To play a role means that we are able to play ‘as if’ we are the other person (or creature): this is what I term ‘the dramatic response’ (Jennings, 2005). It is only through being able to play dramatically, to take on roles in thought or action, that we are able to consider the feelings and experiences of somebody else. This is how we develop empathy and the child who cannot engage in dramatic playing will have great difficulty with understanding how someone else is feeling.

Limitations of EPR

The application of EPR developed when work took me to the Royal London Hospital. I was invited to establish a fertility clinic where individuals and couples could join a creative arts therapy group, and sometimes they became pregnant. I observed that whereas women who are pregnant could often be very playful once the sickness was over, women who had difficulties conceiving often made an assault course on their bellies, and in some cases beat themselves up if there was no pregnancy. Observations in the ante-natal and fertility clinics showed me that I needed more fine tuning of the rather broad categories of EPR and I became mindful of the dominance of physical experience during pregnancy and the first year of life.

Embodiment can be sensory and messy; it can involve gross and fine body movement; it is part of all sensory playing, and can demonstrate love and affection as well as cruelty and violence. Our bodies are the primary means of learning (Jennings, 1975).

Projection also has many forms from sand play to jigsaw puzzles; some children stay longer in this stage than others. The beginnings of Role can be observed in the early mother-baby interactions (Burton, 1986), long before it becomes an important developmental stage, once the child is walking and talking. The observation of the dramatic response even in newborn babies (Szalavitz & Perry, 2010c), convinced me to define a new paradigm, one that preceded EPR, but that was intimately linked to it.

The Emergence of Neuro-Dramatic-Play

From the fertility clinic of the Royal London Hospital to the Mother and Baby Units in Romania, I began to initiate a programme of play for pregnant and nursing mothers (Jennings, 2003/2005). This included massage and storytelling, and the sharing of hopes and dreams. However there were new theories and research to consider that had a bearing on the development of NDP, and the critical time (3 months in utero – 6 months of life outside), for it to make an impact on the growth of a child (Odent, 1999/2001; Jennings, 2010c).

The ‘Good enough’ Brain

Much of what we have learned about the brain in recent years has come about because of the exposure of the appalling cruelties in the Eastern European orphanages (Chisholm, 1998; Chugani et al, 2001; Gerhardt 2004). Observation of the orphans has shown that parts of their brains did not develop, in particular the social function of the brain that develops after we are born. Research demonstrates (Sunderland, 2006), that the growth of our early brain is dependent on the quality of our social interaction with our mothers (or primary carer), and that includes trust and empathy.

‘Much of the infant brain is developed after birth, so it is very open to being sculpted by both negative and positive parent interactions. At birth your child’s higher brain, in particular, is very unfinished...’ (Sunderland, 2006, p 20)
The higher brain is also referred to as the rational brain and is located within the neo-cortex. Because it is still ‘soft-wired’, i.e. not all the synaptic connections have been formed, it will be influenced by external influences in parenting and care. Loving interactions, affirmation and playfulness will have a strong influence on the growth of the higher brain and its functions. It is responsible for the imagination and problem-solving, empathy and the capacity to reflect. However the rational brain needs to work in collaboration with other parts of the brain and not separated from the ‘emotional brain’ (mammalian) or the ‘instinctive brain’ (or survival or reptilian brain).

The reptilian brain is the most ancient part of our brains and is necessary for survival. It reminds us to take food, to keep warm or sheltered but especially it warns us of danger and whether to ‘fight, freeze or take flight’. Certain innate responses such as fear, usually through freezing are processed through the amygdala. However this part of the brain can also accommodate new fear responses and store them for future use. The synapses in the brain are modified through experience but also have some biologically determined stored information (Cozolino, 2002, 2006). Therefore for many children whose previous experiences have been unsafe and abusive, the proximity of anyone can pose a permanent threat to their security.

How many damaged children do we know who live their lives around food and fear? They seem to live only through survival and often sabotage attempts to bring about change through a new family or intensive therapy. The basic stage of ‘Hope: Trust versus Mistrust’ which usually develops from birth to 18 months (Erikson, 1968) has not taken place, and a host of other fearful experiences have entered the amygdala, creating a self-perpetuating situation of Reactive Attachment Condition (Hughes, 2006).

The lower or emotional brain is also called mammalian because it is shared with other mammals. All mammals appear to care for their young and also share with humans the capacity to be playful and social. Sensory play through touch and massage, soothing sounds and loving gestures and words, all strengthen the emotional areas of the brain including the thalamus and the hypothalamus. Babies quickly learn to respond to the nurturing from their mothers with nurturing in return: cuddling, stroking, nestling. The small infant who has not been nurtured is often confused about human responses, is uncertain of their own bodies and has difficulty in feeling secure in space (Jennings, 2010c).

Stressful experience, such as separation from the person who feeds us and the food itself, increases the release of the ‘fear-chemical’, cortisol in the brain, and makes an infant wary and distressed. Large institutions in Eastern Europe, with untrained staff, meant that thousands of abandoned, disabled or orphaned infants received the most rudimentary ‘care’. Babies were abandoned in cots and fed with propped feeding bottles, with no physical nurture of any kind. Many small children were tied to their beds for long periods of time so that their limbs grew back-to-front or disproportionately.

In some places children were fed alternate days which led to ‘scoffing, sicking-up, slow-eating’ (Jennings, 2010c). Children snatched and scoffed as much food as they were able, then sicked it up again in order to eat it more slowly. This way they would not feel such hunger pains while waiting one or two days for the next food to arrive. We can see that these children were forced into their survival, instinctual brains with little opportunity to develop their positive emotional lives or their capacity to play or socialise.

Many of the neglected Romanian children escaped from the institutions when they became older and spend their lives on the streets, railway stations or under bridges, even now. Many children as young as seven years, learned how to fend for themselves, rather than continuing to tolerate the cruelty and frequent physical and sexual abuse of the orphanages. There was no feeling of safety or security, and children chose to break free rather than stay as institutionalised victims. This understanding of the brain function contributes to the ‘neuro’ in Neuro-Dramatic-Play.
Play and Playfulness

Play occurs in all cultures and all traditions; it is the way that children communicate to each other as well as to receptive adults. As Landreth (2001) ironically suggests, ‘In order to make children’s play more acceptable, some adults have invented a meaning for play by defining it as work’ (p.3). Whereas he says that play is, in fact, non-goal directed. He goes on to discuss how play is something where the child feels they are in control. They can choose what they want to play and how to play it:

‘The story, happening, or activity can be what the child wants it to be. In the safety of play, the child can confront monsters, fantasy characters, and frightening experiences with real people and be in charge of the outcome’, ibid (p.8).

However it can still be difficult for play to be taken seriously by adults, despite the fact that the Convention on the Rights of the Child was adopted on 20 November 1989 by the United Nations General Assembly. Article 31 states: ‘Every child has the right to rest and leisure, to engage in play and to participate in recreational, cultural and artistic activities’.

It is only recently, for example, that anthropologists have started taking interest in the play of children, as a subject in its own right, and a lot of time is being spent in definition and observation. Goldman (1998) states that anthropological monographs about child play, including make-believe play, are extremely thin on the ground:

‘Play analysts have suggested that such neglect is an outcome of the way academia itself, a quintessentialiy adult pursuit, perpetuates and embraces a socio-historical legacy which devalues infant interaction. Thus the most conspicuous facet of children’s behaviour – their indulgence in ‘play’ - has often been typified as irrational, non-productive and decidedly something other than work’.

(Goldman, 1998 p.xv)

There are children who are discouraged from playing in families where there is emphasis on academic and factual learning, rather than learning through the imagination. I have described in detail contrasting approaches and definitions of play and play therapy (Jennings, 1999) but I want to re-emphasise the centrality of play in the life of a child, (Bruner, 1986; Huizinga, 1949). Huizinga puts it most succinctly:

‘Play is not ‘ordinary’ or ‘real’ life. It is rather a stepping out of ‘real’ life into a temporary sphere of activity with a disposition all of its own. Every child knows perfectly well that he is ‘only pretending’ or that it was ‘only for fun’ ibid (p.8).

There is no shortage of literature describing the essentially therapeutic nature of play (Smilansky, 1968; Winnicott, 1974; Oaklander, 1978; Moyles, 1989; Jennings, 1993; Cattanach, 1997) to name but a few, but there are several models, depending on the therapeutic underpinning. Is it the play that is important (Cattanach, 1992; Jennings, 1999) or is it the interpretation (Freud, 1922; Klein, 1932)?

However, playfulness does not only belong to the world of the child; in my own observations during pregnancy and the first few months of life, it is important that the mother is able to be playful with her unborn and newborn child. She will be establishing a unique communication through her playfulness that does not require regression as suggested by some theorists (Raphael-Leff, 2001), but is the function of her own imagination and capacity to be child-like.

Shared playful worlds are essential for a dynamic attachment to commence during pregnancy and to continue after birth.

Healthy Attachments

Whereas historically nature and nurture were seen as opposing factors in understanding human thought, feeling and behaviour, recent research by neuroscientists shows that nature and nurture are in fact doing the same thing (LeDoux, 1998). They are both building the human brain and its capacity
to function. The brain of the baby is not fully built before he or she is born, the newborn infant will develop most of the higher brain after birth. Nature gives the brain its potential but it is the quality of the nurture (or the neglect) that will determine the eventual growth of the brain and its function. Much of what we have learnt in recent years about attachment has stemmed from the ‘living research’ on neglected children from Eastern Europe.

There is a joint irony that we understand much more about attachment behaviour both from the work of Harlow (1968) and his cruel experiments on rhesus monkeys, and from the results of years of cruelty, neglect and abuse of babies and children under politically repressive regimes.

*From the first moments of our lives, we exist within a complex matrix of social relationships. This elaborate social relatedness is organised and controlled by neural networks of bonding and attachment, play, predicting other’s intentions and being able to see the world through others’ eyes*. (Cozolino, 2002, p.172)

Most infants pass through the stages of sensory, rhythmic and dramatic play within the family that provides the necessary attachment (Bowlby, 1953/1966, 1979/89) and secure parenting. These playful processes commence during pregnancy when mothers have playful interactions through movement, rhythms and enactment and continue in their most intense form until the infant is 6 months old. The dynamic quality of interaction between a mother and a young baby can be predictive of the emotional attachment relationship between them many months later (Trevathan, 2005; Jaffe et al., 2001).

Gerhardt (2004) uses the phrase ‘emotional immunity’ to describe the positive attachment and affective development of babies and infants:

*Good emotional “immunity” comes out of the experience of feeling safely held, touched, seen and helped to recover from stress, whilst the stress response is undermined by separation, uncertainty, lack of contact and lack of regulation’* (Gerhardt, 2004, p.84)

The development of our brains and the maturation of our emotions are therefore dependent on our early playful attachment. This loving interaction is a two-way communication, at first through touch, sound and gaze. The social interaction influences the development of the social brain, and without this interaction the brain will not fully develop.

The growth of the brain, playfulness and healthy attachment seem to be inextricably linked. However before moving forward to an understanding of Neuro-Dramatic-Play, it is important to consider that word ‘drama’ about which there is always ambivalence (Jennings, 1977).

**Theatre, Drama and Mirrored Reactions**

I have written extensively about Western societies’ wavering views on actors and acting, (Jennings, 1977, 1986c, 1990, 1999): how we love actors’ scandalous stories, identify with them in soaps yet dismiss their work as marginal, middle class and a financial drain. Antagonism towards the theatrical professions is not new (Plato, 360 BCE), and Christianity has over history, periodically banned theatrical performances since the Roman times (Jennings, 1994).

It is perhaps difficult to relate the dramatic playing of children to the artistic forms of theatre, which are integral to an aesthetic understanding of dramatherapy and therapeutic theatre. Nevertheless, for the ancient Greeks, going to the theatre would keep society stable since anti-social sentiments would be enacted in the theatre rather than in everyday life. This is exactly one of the functions of dramatic playing both in a preventative sense as well as in therapy. The drama and the play allow extremes of feeling and pent up emotions to be expressed safely in a creative form, and then understood in their context.

There is also another interesting development from neuroscience (Whitehead, 2001; Cozolino, 2002) with the discovery of mirror neurons. Mirror neurons in the brain fire when humans and other animals perform specific actions, and when they see
another perform the same action. Babies within hours of birth begin to 'mirror' their mother's expressions (Jennings, 2010c). Mirror neurons and their networks within the social brain, link brains and bodies (Whitehead, 2008) which may stimulate sharing and turn taking. Mirror neurons may also help to explain theories of role modelling, and group collective and cooperative activities such as rituals, drama and dance (Whitehead, 2008).

Perhaps the earliest reference to mirroring is when Hamlet instructs the actors 'to hold as 'twere, the mirror up to nature' when they are performing their plays (Shakespeare, Hamlet 1600 circa).

Dramatic playing takes on its own important function in Neuro-Dramatic-Play with the realisation that babies are already able to imitate and initiate soon after birth. This has led me to speculate (Jennings, 1998) whether civilisation is actually based on theatre rather than language; a proposition that is also suggested by Whitehead (2003).

The Emergence of Neuro-Dramatic-Play

I was increasingly observing the play of pregnant women, and mothers and infants. I realised that most attention in the literature addressed the issues of the physical well being of the birth, evidenced by the plethora of publications on pregnancy and birth (Kitzinger, 2003), and the psychological well being of mothers (Dalton & Holton, 1996; Kleiman & Raskin, 1994). There was very little that considered the mother-baby interactions in the context of play and attachment, although writings on prenatal (Verney, 1981) and perinatal psychology (Association for Pre-natal and Perinatal Psychology and Health) have published and promoted extensively on the importance of pre-birth experiences and the relationship between mothers and their unborn babies. Authors such as LeBoyer (1976) and Odent (1999/2001) have urged unceasingly for more humane approaches to childbirth itself.

The dramatic play or pretend play was very clear to me: mothers would talk to their unborn child and sometimes answer themselves as if they were the child. They would also tell stories about themselves and their secrets, hopes and fears. This dramatic play during pregnancy is similar to the newborn play in the early weeks of life, when mothers and babies have conversations, imitate each other, and play simple games.

I had yet to tease out what I was actually seeing in the sensory and embodied playfulness. I noticed that mothers would often rock themselves and their unborn child, and I have noticed that other women will sometimes rock themselves without being aware that they are doing this. The womb creates the first circle of containment; the encircled arms create a circle of safety, a circle that will soon become the circle of attachment once the baby is born. Almost like a 'theatre in the round' that contains a ritualised containment of two people, one very much dependent on the other. Perhaps this is another way of understanding playful attachment in the early weeks: as a piece of 'physical theatre' that maintains the safe borders and guards against danger and intrusion until there is a cue to be a little more adventurous (figure 1).

The rocking patterns also led me to consider the importance of rhythmic play: the regular rhythms, like heart-beats, create security. It has been discovered that babies will sometimes adjust their heart beats to that of their mothers when they are being held close, (Kitzinger, 1987; Stoppard, 2008), and that unborn babies synchronise their heartbeats with their mothers (BBC News, 31 July 2010c). Massage, singing and cradling all have
strong rhythmic elements that create a predictable patterning for early attachment, and form part of sensory play, of ‘making sense’ both before and after infants are born.

Making sense of the world around us happens through our senses and commences early during pregnancy. We can sense temperature, sound, rhythm, touch and emotional changes while we are still in the womb and our mothers have a profound effect on our well-being through their own sensory experience (Jennings, 2003a).

Women who avoid sensory experiences and perhaps find touch or stickiness distasteful, have difficulty in providing any sensory stimulus for their small children. Early sensory play experiences involve touch and holding, textures and smells, visual movement and colours, sucking and taste, voice and music. It can be messy as well as magical! Plastic bibs are no substitute to ‘skin to skin’ contact.

We can encourage pregnant women to create massage times while they sing songs to their unborn child. The telling of soothing stories and the playing of calming music can all influence the state of trust and tranquillity for mother and her unborn child.

Often storytelling helps us to understand the world and the people around us. Throughout history we have needed to ‘make sense’ of the world around us: we discover the rules of the universe and the need for the social group. So we tell stories (Storylore in Jennings, 2004) and imitate through ritual, drama and dance, our view of the world and our shared place within it. However this starts much earlier when we start to make sense of our world a few months after conception. Play and creativity in our relationship with our unborn child commences at the beginning.

Not only are we rehearsing life while in the womb, we are making connections between the world outside the womb and ourselves. Babies do recognise birthing songs and music once they are born; they will shy away from harsh voices they heard before they were born, and they begin to have a sense of who they are in relation to their mothers in the way they are picked up and held as soon as possible after birth.

‘And did you sing as I came into the world? As you opened the door for me to come into the light? Sing at my birth and for all babies as they start their journey on this earth’ (Jennings, 2003/2005, p.134 & p.139)

This ancient chant from the Nordic goddess of birthing, Uks Akka, reminds us of the ritual and creativity that needs to be present at childbirth. The increase in the use of birth pools and mothers wanting to give birth at home illustrates our desire for a less sanitised and technological birth experience. The birthing pool creates a continuation of the ‘safe waters’, helps to alleviate some of the pain, and provides an immediate context for warm bonding through smell, touch and sound.

It should be noted that research suggests that certain painkillers given during birth can dull the attachment process:

‘Infants who are exposed to epidurals can have behaviour difficulties in the first few days after birth. They can be more irritable and hard to console and may be less responsive. Additionally the bonding between parents and the baby can be disturbed, which has life-long consequences for the parent-child relationship’ (McCormick, 1997).
It is important that women feel supported and listened to during pregnancy and childbirth. Parents who feel they have some control over the birth of their child, will also feel they have some control over the life of the baby after it is born: making choices and setting boundaries for example. Parents who do not belong to a supportive network or mothers who are on their own often struggle ‘to get it right’ and end up feeling failures. All of these feelings are communicated to the infant. A mother who feels depressed or inadequate will discover that their child experiences similar feelings.

‘Birth, like death, is a universal experience. It may be the most powerful creative experience in many women’s lives. It can either be a disruption in the flow of human existence, a fragment having nothing to do with the passionate longing that created the baby, or it can be lived with beauty and dignity, and labor itself can be a celebration of joy.’ (Kitzinger in Odent, 1984, p xxiii)

This early playing, which is physical and consonant between mother and child is necessary before ‘the echo play’: you smile – I smile. The consonance in the circle establishes the security of oneness before it is possible to establish difference. This circle of safety is important to establish before there are any extended absences of the primary attachment figure. If there is prolonged absence before an infant can grasp ‘going away and coming back again’ then the result may be sustained anxiety and potential depression.

The early sensory and embodied play between mother and newborn child as well as being anticipated during the pregnancy has all the qualities of a danced duet (see Theatre of Body, Jennings, 2010c). Physically, mother and baby are living life through each other’s physical proximity and non-verbal communication. The paradox of their closeness will enable the infant to eventually tolerate distance, and once the child is physically secure he or she can also tolerate absence.

These were the three elements now that characterised this early playful attachment from which I formulated the basis for Neuro-Dramatic-Play: sensory, rhythmic and dramatic play. These are not just playful activities, they have a basis in established thinking and research across several disciplines.

**Definition of NDP:**

Neuro-Dramatic-Play is the sensory, rhythmic and dramatic playfulness that takes place between mother and unborn and mother and newborn from conception to six months. It has a profound effect on the growth of the brain, the chemical balance of the body and the healthy attachment between infant and parents. It influences the future emotional and social maturation of the child.

We can now consider an NDP continuum that develops from the playful pregnancy (which is like a life rehearsal and includes massage, conversations and stories), to playful consonance (playing at the same time with movements and sound) to playful echo (mother and baby echo each other’s sounds and movements) and mimicry (baby begins to initiate sound and movement): all of these stages of playfulness are usually completed within the first three months of life, (Figure 2).

Neuro-Dramatic-Play brings together theories drawn from neuroscience, play, attachment and theatre, and provides a new opportunity to look at the development of the mother-baby relationship.
throughout pregnancy and the first six months after the baby is born. However, I want to emphasise that I do not suggest that this relationship is less important after six months, but at that point it begins to change and contains additional variations in the play and the relationships (Courtney & Schattner, 1981; Jennings, 1999).

**Neuro-Dramatic-Play as Therapy**

Children and teenagers are referred for play therapy or therapeutic play for a variety of reasons, many of which involve disrupted or neglected attachments.

Many of them have not experienced making sense of their worlds through the sensory experiences with their mothers. They have been deprived, for a variety of reasons, of the physical and emotional surge, which is the focus of the early weeks and months and creates the joyousness and excitement of primary play through the senses, especially through smell and touch, rhythmic and dramatic playing. They may have been unwanted during pregnancy, neglected from birth or subject to misuse and abuse. They may be labelled as having conduct disorders, behaviour disorders, developmental delay or ADHD, and they may already be on medication.

Teachers, parents and foster carers may describe such children as out of control, impossible to handle, violent, mean, bad, dangerous, hyperactive, no conscience, no empathy, acting-out, attention seeking. It would be very interesting to speculate whether the children in question actually spark attachment issues in the adults around them.

We may not be able to have a full attachment history of the child (see Jennings, 2010c/2011: Play and Story Attachment Assessment), although we may be able to infer potential themes in early diagnostic play sessions. For example what does a child or teenager play at or play with? Do they play football (sensory and rhythmic play), or make rhythms with the percussion instrument (rhythmic play) or grab the puppets and make a nonsense conversation (dramatic play)? If so, then they are already engaged in NDP in their own way. These are activities that we can then build on and help the child to develop in a variety of ways. So much of what a child in therapy is trying to express is larger than life; the enormous pent up emotions that have usually built up over a period of time.

‘Children come to therapy with monstrous feelings – monstrous grief, monstrous rage, monstrous longing – to name a few. These feelings are unacceptable, unfaceable, and unmanageable to themselves, as well as the world around them. The invitation to draw themselves as a monster is an immediate acknowledgement of their feelings as a fact, and an acceptance of their existence and legitimacy.’ (McCarthy, 2007, p.20).

Many children express their immediate needs in the play therapy space: using a feeding bottle, seeking appropriate massage (Jennings, 2004), playing messily with finger-paints or the sand tray (Beckerleg, 2009); they may rock or play rhythmically on drums, or make use of hats and dressing up clothes. They are showing their need of NDP activity to address some deficit in earlier development. Therapists are able to participate within the play, leading when the child indicates or sharing with the child in order to develop a playful relationship. Sensory play can be encouraged with bubbles and shaving foam; rhythmic play with a variety of instruments, the discovery of pulse and heartbeats, and repetitive ball games, singing games and dance. Dramatic play can start at the most basic level of hide and seek (Burton, 1986): a version of the ‘peekaboo’ of babies for older children; dressing up, hats, masks (Landy, 1993). Storytelling can happen in all stages and in its own right: the telling of stories by the therapist as well as the creating of stories by the child or teenager (through puppets, newspaper cuttings, sand tray and so on).

If the child or teenager has the opportunity to play intensively and repeatedly with variations of these three forms (sensory, rhythmic, dramatic), it is possible that they can move on to further play development, for example through EPR (Jennings, 1998).
These are more general ways in which NDP can be applied in therapy, but there are three specific areas on which I will now focus. The first I have already referred to in relation to NDP and the re-creation of appropriate attachment, to which I add, and positive relationships. I am not advocating a dependent transferential relationship being established in the model of conventional child psychotherapy. I work wherever possible in groups where all children or teenagers have an adult who works with them in a shared playful endeavour (Jennings et al, 2007a; Jennings, 2011b). The activities of the group develop the activities of NDP, with as much focus as possible on satisfying sensory and physical rhythmic play, and the fostering of the dramatic response, the ‘as if’, described earlier. Cyrulnik talks about children and teenagers needing to recall at least one person who was kind to them (2005).

Secondly, I wish to address the importance of the development of empathy which seems to be lacking in so many young people in contemporary western life. I am increasingly concerned by the lack of empathy shown many children and adults on TV shows and commercials.

The early work of Mead (1934) described how people understand the feelings of another person by being able to ‘stand in their shoes’, to be able to take the role of the other person. Much therapeutic drama work achieves just that through role play and role reversal, and the recreation of family scenes.

We are living in times where empathy seems to be absent on one or two generations of children: lack of empathy means that not only do we not understand how others feel, we are capable of inflicting enormous pain on them with no remorse or conscience (Jennings, 2007b).

A useful understanding of empathy is given by Baron-Cohen and Chakrabarti (2008):

Empathy is a defining feature of human relationships. Empathy stops you doing things that would hurt another person’s feelings. Empathy also stops you inflicting pain on a person or animal.

Empathy allows you to tune into someone else’s world, setting aside your own world – your perception, knowledge, assumptions or feelings.’ (ibid p.317).

In NDP the early dramatic play between mother and infant is where we can see the roots of empathy. The mother is playing ‘as if’ she is the baby, and the baby is behaving ‘as if’ he or she is the mother. This primary attachment based play is likely to be predictive of the capacity to empathise in later life.

These behaviours can be practised through NDP therapy (Jennings, 2011c), and the applied use of stories (Gersie & King, 1990; Jennings 2010d) where there is a strong focus on empathy, can form a basis for changed behaviour. It is important that the play therapist or play therapeutic worker is able to role-model appropriate empathic responses, both to the child or teenager as well as through the stories.

We can only develop empathy if we are able to feel ‘as if’ we are the other person. Thus the early mimicry between mother and baby is enabling the possibility of acknowledging, and feeling for ‘the other’. (Jennings, 2007b Power Point slide 7)

Finally I want to draw attention to the importance of resilience in the lives of the children. Resilience is the capacity to deal with the ups and downs of life, the major traumas as well as the smaller setbacks. Various writers have conducted research on resilience, such as: Rutter (1997) carried out longitudinal studies on children exposed to trauma; Maston (2001) identified specific components in resilient personalities; Lahad (2000) has designed various interventions that are applied in his community stress prevention programme.

Part of the attachment process is a ‘coping process’: infants witness how their mothers and later their fathers deal with everyday setbacks. Parents can role-model how to manage life’s vicissitudes, and they give comfort and protection to children who have experienced a traumatic event. Children who have not had this type of support often end up as ‘non-copers’: life is always getting at them or punishing them. Everything is experienced
as a huge obstacle, everything is hopeless. However, according to Erikson (1965/1995), hope belongs to the first developmental stage: ‘Hope: trust versus mistrust’. He says that this stage lasts from birth to 18 months, so of course it fits into the early play experience of NDP. Children who are left and sink into depression as babies will of course not trust themselves or others and will feel hopeless. Children who do not have their cries answered, similarly cannot build any hope that their fears will be acknowledged. As McCarthy (2007) describes:

‘Monsters are after all our first creative act as humans. From early on we dream about them and imagine them. They dwell under our beds and behind our bedroom doors. They peek in through our windows. They are often right at the edge of our developing consciousness, part instinctual urge and part deity. We wake our parents in the middle of the night because of them, and our parents try ineffectually to dispel them by saying things like ‘There’s no such thing as monsters’ or ‘It was just a dream’.

(ibid p. 19).

The EPR/NDP Project (2007a)

This project in South West England, was an intensive summer school of seven days, for children who were excluded from school or were at risk of being excluded. The first day involved assessments (Boxall Competency, Strengths and Difficulties Questionnaire, BASICPh) and information-giving about the programme to children and their families. During the subsequent six days, we expected to move through the developmental paradigm of Embodiment-Projection-Role with this group of children aged 8 – 11 years. There were 9 children in the project, 2 girls and 7 boys, although one boy dropped out through parental misinformation. The 11 staff (dramatherapists, psychology student, play therapists, learning mentors, 2 men and 9 women), meant that every child had a significant adult to work with, but the work was within the large group. There were four senior staff with experience of children with attachment difficulties, who were able to role-model appropriate interventions both for the other staff as well as for the children. Senior staff had daily supervision and the remainder every other day. The only one-to-one time for the children was an afternoon session of ‘quality talk’ where the child could indicate how they were feeling, and what they liked and disliked. The day closed with rhythm and echoes on the large drum.

The staff and children had lunch together and after the first day the children asked if they could help prepare and serve the lunch which seemed to be the highlight of the day. They appreciated sitting down with adults and having grown-up conversations and were in no hurry to rush off and play. We also began to provide breakfast as the children arrived because many of them started the day feeling very hungry.

The day was structured, beginning with names, greetings, communications and rhythms being beaten out on a very large circular drum. This was followed by Embodied Play: creative movements involving developmental stages (Sherborne, 1991), collaborative and oppositional exercises, balancing and containing, risky movement and repetitive exercises. The embodiment work included sensory play: massage and the use of different mixes of essential oils.

The Projective Play included paint and crayons: drawing a handprint, painting a self portrait with everyone’s likes and dislikes, clay modelling and collage pictures. Some children struggled with the materials but overall there was involvement and focus. Some children expressed initial anxiety that others would destroy their work or ridicule them.

What surprised everyone was that none of the children were able to make the transition into Role or drama work. We tried masks, story enactment, puppet play, dramatic playing, but none of the children engaged with the process. Indeed if we tried to persist, the children reverted to the behaviour that had brought them there in the first place. They would literally run round in circles, try to escape through windows, hide inside boxes, express extreme anger or switch off and be ‘not there’. None of this behaviour was exhibited during
the embodied work: sensory play and rhythmic play, or the projective work with paints and clay.

The senior staff made more observations of the involvement and depth of the children and linked it to what was known about their profiles. The embodied and projective work continued until the end of the programme and the children asked if their parents could come and see the work: they wanted to massage their parents’ hands.

What was affirmed between staff was that:

All children played ‘everyday roles’ that were either destructive or isolated. They would revert to these roles if they were not engaged in activities that involved sensory and physical play, sensory projective play (finger paints for example), drumming and rhythms, and storytelling.

None of the children were able to make any transition into ‘as if’ dramatic play or role play.

Based on EPR observation, children would normally be expected to begin role-playing by the age of four years, and even allowing for developmental delay, they would be expected to enter some kind of ‘as if’ by the age of 8 years.

Staff were in agreement that the children were all functioning at an emotional age of 2 – 3 years, and in some cases less, because of their preference for sensory play.

It was not that they would not play roles – developmentally, they could not play roles.

Staff therefore decided that the children needed much more focus on early years activity, which is possible through NDP. Observations were then based on the early NDP in relation to the children’s behaviour and their responses to the creative media.

This initial exploration of an NDP model of play therapy provided useful insights in the emotional ages of the children, and a greater understanding of early deprivation of playful attachments that can bring about great neediness. The children demonstrated repeatedly their feelings of security by having their own adult partner who quite literally ‘held’ them some of the time, as well as setting limits and boundaries. The adults were also able establish the beginnings of trust as the children took risks in climbing and exploration. The highlight of the week was most certainly the rhythm work which we developed through a large drum around which everyone could sit. At the end of the project the children were calmer, alert, and focussed in their chosen activities. They requested the opportunity to show the parents some of the activities. Everyone wanted to massage their parent’s hands using essential oils. (This project is described in detail in Jennings, 2011b)

NDP is able to build up resilience strengths through addressing the fears of children and teenagers in their play and stories. By developing the child’s imagination as a coping strength rather than as a provocateur of fear, resilience will begin to grow. NDP and EPR are the foundations of Theatre of Resilience (ToR) which is being developed with traumatised children in Israel and Romania. Theatre of Resilience enables children or teenagers to make the transition from their personal traumas and difficulties to participating in their own culture and traditions, through artistic and performative skills (Jennings, 2011a).

**Closing Thoughts**

Having described the emergence of NDP, its theories from contrasting disciplines and its practice across a range of hurt and hopeless children, I wish to return to the simple principles that govern NDP:

Firstly, NDP is based on actual lived experience, from the observations of mothers and babies, and pregnant women. People actually relate in these ways, even though society is not always supportive of mothers.

Secondly, NDP can work in a preventative way through ante-natal clinics, doctors’ surgeries, hospitals and medical schools to try and reverse some of the perverse thinking that is passed on to hapless mothers. For example the toxic way in which mothers are taught to punish toddlers who cannot yet grasp adult ideas.

Thirdly, we can develop even greater change if we teach NDP to teachers: they can better understand why some children behave as they do, and they can also build it into the curriculum, time for understanding life and social skills.

Fourthly, we can equip SENCOs, teachers and therapeutic play workers in order to develop an
NDP attitude towards pupils they see as ‘difficult’. There is no reason why they should not apply some of the basic principles, for example in the nurture room, of course with appropriate supervision.

Fifthly, we can make sure that therapists working with children and teenagers, no matter what orientation, are trained in NDP basic principles, in order to understand their child population in broader brushstrokes.

Neuro-Dramatic-Play is still work in progress, and will be expanded and refined by practitioners in the future. The final poem on attachment is just one illustration of how applied NDP can release creative potential.

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Poems of the Body 2
What a Rocker!

I rocked and rocked, ‘look Mummy, rock me please!’
I rocked and rocked, higher and higher, ‘LOOK Mummy
I am reaching the sky, push me more, more!’
But the Mother in my head took no notice and I fell to the earth!
I couldn't rock wearing the plaster ’til a nice lady rocked
Me in a wheel chair, and left me in the garden of the
Children's ward; and the nasty man explored the plaster
Pretending to be a doctor; rock, rock, rock, in my head,
Stay calm, don't look, just rock in your head. The kind
Lady saw the tears in my eyes and thought it was the pain.
Yes it is the pain, I said in my head, but not the one that
You are talking about. You are kind but you can never
Understand the rocking in my head. Many rockers came in
Me, riding high and low, until now. I have lost the rocker in
My head as I sit on my bed, rocking with the pillow, and wait.
Wait for the next nurse, the next doctor, the next pill,
I call to the Mummy in my head but there is no reply.

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REFERENCES


As the title suggests, this newly published text is firmly located in the Child Centred Play Therapy tradition originating with Virginia Axline, herself a student of Carl Rogers and developed further by key people including Louise Guerney and Garry Landreth, each interpreting Axline’s work slightly differently. In terms of understanding the history and development of Guerney’s approach to Child Centred Play Therapy (CCPT) it will help to read the authors’ introduction, “Who We Are” (p.13). We learn that in 1992 one of the authors William Nordling, together with Louise Guerney co-founded the National Institute of Relationship Enhancement (NIRE) in Maryland, USA, with the aim of applying and remaining true to Axline’s work. Nancy Cochrane has also been closely involved in teaching at NIRE and the third author Jeff Cochrane (Nancy’s husband) has extensive experience in teaching and researching in this area also. So individually and as a writing team, the three authors have an impressive range of experience as child centred play therapists, teachers, educators and supervisors and they have sustained a passionate and dedicated commitment to this way of working with children. Meanwhile Louise Guerney, who has written the foreword, acknowledges the challenges in remaining true to Axline’s Eight Guiding Principles for Play Therapy (p.xi) and expresses her confidence in the training and supervision experience of the authors which has enabled them to clearly describe and explain the skills required to do so (p.xii).

In the Preface, the authors clearly identify their target audience. Yes, it is for beginning play therapists but more specifically for those with existing experience in the mental health field (p.xiv). Then of course there are the key themes we would expect to see amongst the Chapter headings in a text on Child Centred Play Therapy, including: Ideal Therapist Qualities, Eight Basic Principles of CCPT, Preparing your Setting for CCPT, Core Therapist Skills, Legal and Ethical Issues etc. Understandably therefore, an initial glance indicates that this book contains many similar themes to an earlier classic text which has been very influential in the field of Child Centred Play Therapy, Garry Landreth’s, Play Therapy: The Art of the Relationship (2002). Indeed the authors afford warm and generous respect to Landreth’s immense work in the development and promotion of CCPT through the University of North Texas’ Center for Play Therapy (p. xvii) - a wise acknowledgement that it is possible for child centred play therapists to remain true to Axline’s Principles and yet have some variation in emphasis in their practical application.

A closer look reveals much that makes this book another invaluable and up-to-date resource for learning key skills in CCPT and the structure of the book lends itself to skills based learning: Each chapter has an overview and summary, then an outline of primary skill objectives and ends with activities for further discussion or practicing skills (p.166). There is also a great range of aptly chosen case examples throughout the book. Whilst there is not space to review each chapter in detail, I have picked out some aspects which I found particularly helpful and which address questions and concerns that have come up frequently in training courses I have attended.

Chapter 1, The Child Centred Approach, is an excellent introduction which as well as citing recent research, clarifies some issues in CCPT which have certainly puzzled me at times. These include: Why the authors believe that child centred does not mean the same as non-directive in play therapy terms (p.5): How CCPT can be included in a treatment plan even when there are neurobiological/organic related issues (p.6) and explanations for Mechanisms of Change in CCPT (pp.6-8). One of
the most illuminating of the Frequently Asked Questions (pp.20-21) for many beginning therapists is, “How can I master and perfect the apparently complex skill sets of CCPT before I begin?” The answer is reassuring and one to touch base with frequently whilst training! That is, “You cannot hone all the skill sets immediately…”, and “Although your work may be less efficient in the beginning, most errors will not end the therapeutic progress for the child”.

Chapter 2, Child Centred Play Therapy in Context, provides a comprehensive overview of how CCPT links to other key theories in child development and human change – this is an excellent resource for those who have less knowledge of these areas and/or who need a quick reference when asked about why and how CCPT fits with and differs from other key approaches to working with children. Chapter 10, Recognising Stages in the Therapy Process, is excellent as it provides a comprehensive guide to stages and guidance on problems and challenges which may arise. This together with Chapter 12, Goals, Treatment Planning and Evaluating Progress, provide the beginning therapist with a solid foundation for key aspects of their work with children and parents. Another frequent concern for the beginning therapist is how to record our work and very useful guidance on Case Notes is provided in Chapter 12 and Chapter 16 – Legal and Ethical Issues. Other excellent chapters are Chapter 11, Helping Parents, Teachers and Principals Understand and Support the Child’s Work in Play Therapy & Chapter 17, Your Ongoing Development.

This is book is destined to become a classic text in Child Centred Play Therapy and if I were to identify an additional area which would be helpful for the beginning therapist, it would be a more in depth consideration of the emotional obstacles we face in developing deep empathy, unconditional positive regard and genuineness. Otherwise the final word here goes to Jill Pagotto, Director of Play Therapy Australia, an experienced practitioner, supervisor and trainer in Child Centred Play Therapy.

“I highly recommend this book and it is wonderful to have such an excellent book

Nora O’Loughlin
Scope of the Journal
The British Journal of Play Therapy is a national journal with a focus on the theoretical and research aspects of play therapy practice. Its aim is to bring together the different theoretical and professional disciplines involved in play therapy and this is reflected in the composition of the Editorial Board. Nevertheless submissions are welcomed from all relevant professional backgrounds.

The purpose of the journal is to promote theoretical and research developments in the fields of play therapy practice and to provide information and ideas about the complete spectrum of clinical interventions used in play therapy.

Submission Requirements & Procedures
Submission of theoretical, philosophical, research and literature reviews will be considered, as will articles which focus on beneficial play therapy practices or on current issues or concerns related to play therapy, underpinned by theoretical knowledge. Submissions may therefore assume any of the following forms:
(a) Papers reporting original research findings.
(b) Theoretical papers.
(c) Review papers, which need not be exhaustive, but which should give an interpretation of the state of research or practice in a given field and, where appropriate, identify its clinical implications.
(d) Systematic reviews.
(e) Case studies and comments.
(f) Book reviews of core relevance to play therapy

Papers should be submitted electronically in Word format to journal@bapt.uk.com together with one author’s address, telephone number and email address for correspondence with the Editor. Fuller submission details may be found at: http://www.bapt.uk.com/journalsubmission.htm

Submissions will be sent anonymously to two members of the Editorial Board who will review the paper in terms of the following criteria:
* Importance of the Subject
* Originality of the Approach
* Soundness of the Scholarship
* Degree of Interest to our Readership
* Clarity of the Organisation
* Strength of the Argument
* Writing Style

Style of submissions
A guideline for length of articles is 4,000-7,000 words (excluding references), but shorter articles are also welcomed. Each submitted paper should be accompanied by an abstract, not exceeding 200 words. The abstract should be followed by up to 6 key words. Authors should also include a reference list that includes all the works cited in the text, listed in alphabetical order. A title page with the name of author(s), position and place of work should be submitted separately as this will not be sent to the reviewers.

All figures and tables should be referred to in the text and their appropriate positions indicated in the text. Any artwork should be submitted in electronic form.

References should follow the format described in the Publication Manual of the American Psychological Association (APA). They should list authors’ surnames and initials, date of publication, title of article, name of book or journal, volume number or edition, editors, place of publication and publisher. In the case of an article or book chapter, page numbers should be included.

EXAMPLES OF REFERENCES:
Journal article:

Book:

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Lisa Gordon Clark

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BOOK REVIEW

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