CHAPTER 1

Basic Principles and Core Practices of Prescriptive Play Therapy

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History

Prescriptive psychotherapy is not new, and in recent years it has evolved into a leading form of psychotherapy (Goldstein & Stein, 1976; Dimond, Havens, & Jones, 1978). The fundamental goal of prescriptive psychotherapy is to tailor the intervention to the presenting problem and personal preferences/characteristics of the client. In formulating a treatment plan, prescriptive psychotherapists seek to answer Gordon Paul's (1967) important question: "*What* treatment, by *whom*, is most effective for *this* individual, with *that* specific problem, with *which* set of circumstances, and *how* does it come about?" Thus, the goal is for the treatment plan to be truly *client-centered* rather than focused on the personal preferences of the therapist.

The *prescriptive play therapy* model was first described by Heidi Gerard Kaduson, Donna Cangelosi, and Charles E. Schaefer (1997) in their book *The Playing Cure: Individualized Play Therapy for Specific Childhood Disorders*. They detailed the application of the therapeutic powers of play (Schaefer, 1993) to the common psychological disorders of youth. The popularity of prescriptive play therapy has mushroomed over the past two decades and is likely to continue to expand in the years ahead. The goal of the present, state-of-the-art volume is to describe the numerous advances

in the theory, research, and clinical practice of prescriptive play therapy as it is applied to the broad spectrum of childhood disorders. The chapters are written by prominent play therapists with broad experience in the field of play therapy.

Conceptual Foundation

Basic Principles

Prescriptive play therapy is founded on a set of basic principles that serve as fundamental cornerstones of the approach and guide its practice. The five foundational principles of prescriptive play therapy follow.

Principle 1. Differential Therapeutics

Play therapy has been evolving over most of its 100-year history based on the "one true light" assumption. This is basically a nonprescriptive position which holds, in the absence of supportive evidence, that one's preferred treatment approach is equally and widely applicable to most or all types of client problems. Based on this belief, treatment is conducted essentially independent of diagnostic information. The difficulty with this "one-size-fits-all" assumption is that no one theoretical school (e.g., Rogerian, Adlerian, Jungian) has proven strong enough to produce optimal change across the many different and complex psychological disorders that have been identified (Smith, Glass, & Miller, 1980).

The prescriptive approach to play therapy (Kaduson et al., 1997) is based on the core premise of *differential therapeutics* (Frances, Clarkin, & Perry, 1984), which holds that some interventions are more effective than others for certain disorders and that a client who does poorly with one type of play therapy may do well with another (Beutler, 1979; Beutler & Clarkin, 1990). It rejects the Dodo bird verdict that all major forms of psychotherapy are equally effective for specific disorders (Beutler, 1991; Luborsky, Singer, & Luborsky, 1975; Norcross, 1995). Rather than forcing clients to adapt to one therapeutic approach (in a procrustean manner), prescriptive therapists adapt their remedies to meet the different treatment needs of individual clients.

Notwithstanding the "common" or "nonspecific" elements that characterize effective therapies of all types, increasing evidence has shown that specific interventions work better for specific disorders and problems (Chambless & Ollendick, 2001). Support for the efficacy of *disorder-specific treatment* is seen in the findings of meta-analytic outcome meta-studies, which indicate that the mean effect sizes of specific factors consis-

tently surpass those of common factors (Lambert & Bergin, 1994; Stevens, Hyman, & Allen, 2000).

Principle 2. Eclecticism

Instead of strictly adhering to one particular school of thought, eclectic psychotherapists employ elements from a range of theories and/or techniques, with the aim of establishing an intervention tailored to a particular client's characteristics and situation. Prescriptive, eclectic therapy is a flexible and multifaceted approach that allows the therapist to select the method that has proven most effective in resolving a client's problems. A single theory does not prepare therapists to treat the ever-expanding range and complexity of psychological problems that clients present with today.

Prescriptive, eclectic therapists believe that the more remedies you have in your repertoire, coupled with the knowledge about how to apply them differentially, the more effective you'll be in meeting a particular client's needs (Goldstein & Stein, 1976). Using more than one change agent in therapy helps clinicians avoid the trap that Abraham Maslow has described: "If the only tool you have is a hammer, every problem starts to look like a nail."

According to Norcross (1987), "synthetic eclecticism" involves combining various theories into one coordinated treatment intervention. This differs from "kitchen-sink eclecticism," in which practitioners apply techniques from various schools of thought in a manner that ignores the theory that underlies them. Norcross warns that this atheoretical approach is haphazard and ineffective at best, and may, in fact, be harmful to some clients.

Surveys of clinicians have indicated that most clinicians identify themselves as eclectic, making the eclectic, "meta-theory" approach the modal theoretical orientation across disciplines (Norcross, 2005; Prochaska & Norcross, 1983). Similarly, a poll of play therapists (Phillips & Landreth, 1995) found that an eclectic, multitheoretical orientation was, by far, the most common approach reported by the respondents. Although eclectic psychotherapy is still not widely taught in graduate schools, it is likely to remain the treatment of choice by most practitioners in this country (Norcross, 2005).

As Goldfried (2001, p. 229) observed, "Most of us as therapists eventually learn that we cannot function effectively without moving outside of the theoretical model [to] which we had originally been trained, recognizing that the strength of another orientation may at times synergistically complement the limitations of our own approach."

The widespread eclectic movement (Kazdin, Siegel, & Bass, 1990) reflects a decisive departure from the aforementioned "purist," one-size-

fits-all orthodoxy, together with a much greater openness by psychotherapists to adapt to differing contexts of the client's life, and thus tailor their strategies to the circumstances and needs of individual clients.

Principle 3. Integrative Psychotherapy

Since prescriptive play therapists are not confined by single-school theories, they often combine different theories and/or techniques to strengthen and/or broaden the scope of their intervention. Integrative play psychotherapy refers to the blending together of healing elements from different schools of play therapy into one combined approach in the treatment of a client. Thus, individual, group and family play strategies may be integrated to treat a particular case or psychodynamic and humanistic play theories. An integrated, multicomponent intervention reflects the fact that most psychological disorders are complex and multidimensional, caused by an interaction of biological, psychological, and social factors. Because most disorders are multidetermined, an integrated, multifaceted course of treatment is needed. The fact that there is high comorbidity among many psychological disorders, such as conduct disorder and attention-deficit/hyperactivity disorder, also points to the need for an integrative treatment approach.

Although prescriptive therapists seek to be both integrative and eclectic, many prefer to call themselves integrative rather than eclectic (Norcross & Prochaska, 1988). The type of integrative psychotherapy practiced by most prescriptive play therapists is termed *assimilative–integrative*. This means that therapists begin their training with a firm grounding in one primary orientation, typically child-centered, and then, over the course of their career, gradually incorporate or assimilate a number of practices from other schools (Messer, 1992).

Although prescriptive play therapists are often integrative, they are not always so. At times, the implementation of a single theory (e.g., child-centered play therapy) will be found to be the most effective prescription for a child's particular disorder.

Principle 4. Prescriptive Matching

Since the rate of improvement varies among different treatment procedures, prescriptive play therapists seek to match the most effective play intervention to each specific disorder or presenting problem (Norcross, 1991). It makes intuitive sense that treatment should be tailored to the needs of each individual child. However, prescriptive matching at the optimum level goes beyond this simple acknowledgment. It differs from the typical basis in the following way.

The typical basis of matching is a theory of psychotherapy rather than a direct matching of a specific change agent to the particular cause of the disorder. Optimally, in formulating a treatment plan, the clinician selects a therapeutic change agent that is designed to reduce or eliminate the cause of the problem. Thus, by treating not only the symptoms but also the underlying cause, the problem will be less likely to reoccur in the future. For example, an attachment-oriented play intervention such as Theraplay (Munns, 1992) would be a logical match for a child exhibiting disruptive behaviors where the underlying cause of the problem is the child's lack of a secure attachment. In a similar vein, abreactive/reenactment play therapy—a trauma-focused intervention—would be indicated for a fearful child whose symptoms are the result of an unresolved trauma experience.

One goal of a comprehensive assessment prior to treatment selection is to pinpoint the underlying cause of the disorder so that the therapist can then select a change agent (a therapeutic power of play) that is most likely to remedy this causal factor.

The 20 therapeutic powers of play identified by Charles Schaefer and his colleagues (Schaefer, 1993; Schaefer & Drewes, 2013) are listed in Table 1.1. The heart and soul of play therapy is contained in these therapeutic powers of play. They are the specific, essential ingredients in play that produce therapeutic change. Thus, prescriptive matching for a play therapist focuses on selecting the specific change agent(s) in play that will best resolve the client's presenting problem. For example, the "directing teaching" power of play would be indicated for a child who has difficulty making friends because of his or her lack of social skills or anger control skills. The "stress inoculation" power of play would be a good match for

TABLE 1.1. Therapeutic Powers of Play

Facilitates communication
- Self-expression
- Access to the unconscious
- Direct teaching
- Indirect teaching

Fosters emotional wellness
- Catharsis
- Abreaction
- Positive emotions
- Counterconditioning fears
- Stress inoculation
- Stress management

Increases personal strengths
- Creative problem solving
- Resiliency
- Moral development
- Accelerated psychological development
- Self-regulation
- Self-esteem

Enhances social relationships
- Therapeutic relationship
- Attachment
- Social competence
- Empathy

a child with medical related-fears or anxieties. Likewise, the "moral development" power of play would be a logical match for a child with conduct disorder. Prescriptive play therapists continually strive to acquire a deeper understanding of the multiple therapeutic powers of play and the disorders for which each of the change agents is most effective.

Principle 5. Individualized Treatment

The overarching aim of prescriptive play therapy is to tailor the intervention to meet the needs of a specific client. The goal is not just to treat the presenting problem but the person who is suffering from it.

The main idea behind individualized therapy is that each client is unique, and what works for many with the same disorder may not work for this particular individual. Research has found that therapy is more effective when it is adapted to the client's personal characteristics, in particular, culture, resistance, preferences, spirituality, therapy expectations, attachment style, environmental circumstances, and motivation to change (Norcross & Wampold, 2011). An important goal of the initial assessment is not only to determine a diagnosis, but also to highlight such important personal variables. It is important to remember that we are treating a *person* with a disorder, not just a disorder.

Core Practices

Principle 1. Comprehensive Assessment

The prescriptive approach to treatment planning begins with a comprehensive assessment of the symptoms and determinants (internal and external) of a client's problem. The assessment typically involves (1) multiple informants (i.e., parents, child, teachers) and (2) multiple methods (i.e., clinical interview or standardized instruments, such as behavior checklists) (Achenbach & Edelbrock, 1983), rating scales (Conners, Sitarenios, Parker, & Epistein, 1998), and projective techniques. In addition, direct observations of the child as well as parent–child interactions (Schaefer, 2014) are often used to gather data. Based on this information, an individualized case formulation is conducted before initiation of therapy. The case formulation is a descriptive and explanatory summary of the client's most important issues/problems (as well as strengths), and of the probable causal or contributory factors. A case formulation also includes the treatment goals and strategies, possible obstacles, and a means for evaluating progress.

The object of this assessment and case formulation is an individualized intervention tailored to the specific presenting problem and unique charac-

teristics of the client. Chapter 2 of this book contains detailed guidelines about conducting a comprehensive initial assessment of the child.

As the treatment proceeds, additional assessment data and insights will be collected about the client and utilized to enhance the intervention.

Principle 2. Monitoring of Progress

The ongoing monitoring of change in a client's presenting problem(s) enables play therapists to determine if the client's symptoms are getting better, the same, or worse. This feedback is crucial in deciding whether to maintain or adjust the prescribed treatment plan so as to prevent premature termination and enhance the likelihood of success. Studies have shown that the monitoring of symptom change is most effective when it is done on a *weekly* basis throughout all phases of treatment (Schaefer & Gilbert, 2015).

This routine of monitoring symptoms ensures that the tailoring of treatment will be a continuous process. This allows for midcourse corrections and successful outcomes in treatments that had been producing negligible or negative results (Lambert et al., 2003; Harkin Webb, & Chang, 2016).

Principle 3. Empirically Supported Treatments

In the past, the field of psychotherapy relied too heavily on practices that had little supporting evidence or, at worst, had shown poor outcomes. Therapeutic interventions have been provided based on a belief in tradition (i.e., "that's what we've always done") rather than evidence-based information regarding what truly works. Research reviews reporting the empirical base for effective practice of play therapy are now available to assist therapists in expanding evidence-informed interventions (e.g., Baggerly, Ray, & Bratton, 2010; Reddy, Files-Hall, & Schaefer, 2005, 2016). In summary, prescriptive play therapists are committed to applying interventions that have been scientifically proved to be most effective in alleviating psychological pain in children.

Principle 4. Treatment Selection

The treatment selection procedure most compatible with prescriptive play therapy is the evidence-based practice model developed by the Presidential Task Force of the American Psychological Association (2006). According to this model, the therapist selects a treatment for a client by integrating three main sources of information: (1) empirically supported treatments for the disorder, (2) client needs and preferences, and (3) therapist vari-

ables, such as therapist expertise and clinical judgment. This model, which values *both* science and practice information, has become the dominant model across the field of psychotherapy. For the prescriptive play therapist, it provides the necessary flexibility to tailor the intervention to the specific disorder and unique preferences and situation of the client.

Principle 5. Role of the Therapist

Prescriptive play therapy requires the therapist to be competent in more than one theoretical orientation and technique of play therapy. At the minimum, he or she should develop skills in at least one directive and one nondirective form of play therapy because both will be needed to treat a wide variety of presenting problems and determinants. Moreover, since prescriptive play therapy is, at its core, a person-centered approach, the therapist must become knowledgeable of the personal, social, and cultural characteristics of the client that can boost or impede the efficacy of the treatment.

The role of the therapist in the prescriptive approach will vary depending on the specific play intervention selected for the client. For example, the therapist will be directive and structured when implementing a behavioral or Theraplay treatment plan but nondirective when adhering to a child-centered orientation. Often, the therapist trains a child's parents to be partners in treatment, while such parent involvement may be contraindicated in other cases. Thus, the prescriptive play therapy approach is best suited to therapists who are open, flexible, and pragmatic, as well as skillful in adapting a particular treatment protocol to their own personal style.

Summary and Conclusions

This chapter contains an overview of the basic premises and core practices of the prescriptive approach to play therapy. Prescriptive play therapists draw from a number of play therapy theories and techniques to select an intervention best suited to overcome the client's presenting problem. They then tailor this therapeutic intervention to the characteristics and preferences of the individual client to achieve a truly individualized approach.

The field of psychotherapy therapy today has evolved so that there are few, if any, "purists" who strictly and dogmatically adhere to a single theoretical orientation (Kazdin, Bass, Ayers, & Rogers, 1990). If the impressive growth and development that the field of play therapy experienced in the 20th century is to continue throughout the 21st century, it will likely be because the prescriptive (eclectic, integrative, evidence-informed) approach has become more fully and widely implemented by practitioners across the world.

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