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Perspective

Play Therapy: An Analytical Mode of Therapy in Children

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Abstract

Childhood play assumes a myriad of forms, each offering a unique canvas for growth. Physical play builds motor skills and body awareness, while imaginative play nurtures expression, creativity, and conflict resolution. Social interactions within a play therapy environment foster co-operation, empathy, and social understanding. Cognitive development is stimulated through problem solving; emotional development is nurtured through expression of emotions. All these modalities are used in the context of various theories of development and have given rise to a number of techniques of play therapy, each following either a single approach or in some cases an eclectic approach. This chapter unveils the world of play therapy, its origins, core principles, and the transformative potential it holds for children.

Keywords

Play therapy, play, children, childhood, therapy

Introduction

In the tapestry of human life, childhood is a vibrant thread adorned with the colors of imagination, curiosity, and boundless energy. It is a fleeting yet precious season of life, characterized by innocence, wonder, and the capacity for unbridled joy. It is a period when the world is viewed through a lens untainted by the complexities of adulthood. At the heart of this remarkable journey lies play—the most natural, instinctive form of learning and self-expression. Play is the medium through which children explore their environment, build relationships, and make sense of their emotions. However, childhood can also be marked by challenges, fears, and uncertainties. For children facing emotional turmoil or navigating complex issues, the ability to express themselves can be limited, as words often fail to capture the depth of their emotions. It is within this unique space of childhood where the power of play and play therapy shines as an invaluable mode of therapeutic intervention.

Play, Children, and Childhood

Play is as natural to children as breathing and is considered to be the singular central and critical activity of childhood, their universal behavior and innate mode of self-expression.[1] It transcends differences between language, culture, and ethnicity. It is intrinsically motivated, requiring active involvement, directed toward oneself and having multiple positive effects. Play is not only essential for growth and development but is also a powerful healing force for overcoming a multitude of emotional and psychological problems.[2] While play is often seen as something frivolous that children do to pass the time, it is an incredibly important part of a child's healthy development.

As a neonate grows into an infant and then a toddler and so on, similarly play also develops through various developmental stages corresponding to the developmental stage of the child. Six stages of play that children progress through have been identified in the literature by researcher Mildred Parten. There are developmental variations in play as each child develops at their own pace and children of the same age may not engage in exactly the same type of play. The six stages of play are as follows:

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1. Unoccupied play—seen in neonates from birth to three months of age, wherein they are relatively still and explore materials around them without any sort of organization. This type of play builds the foundation for the other five stages of play, as it allows children to practice manipulating materials and mastering self-control.
2. Solitary play—usually seen in infants from birth to two years of age; infants entertain themselves without any other social involvement; do not acknowledge or notice other children; engage in the free exploration of the environment, mastering new personal skills (e.g., motor and/or cognitive skills); and prepare themselves to play with others. It might be a matter of concern for parents to see their children playing all by themselves, but it is developmentally normal for infants up to two years of age to engage in solitary play.
3. Onlooker/spectator play—seen in two-year-old infants; they engagingly watch other children playing but do not join them; learning about social rules of play and relationships by watching others play also helps infants to explore different ways of playing or using materials and learning about the world in general.
4. Parallel play—seen in toddlers two years and older; it involves playing next to each other without interacting with each other. During parallel play, children do not engage in social exchange. It works as a warm-up phase where children are engaged side by side on the same activity, practicing skills and learning new methods to engage together.
5. Associative play—seen in three- to four-year-old children; children become more interested in the other players rather than their own play, activity, or objects. It allows children to practice what they have learnt during the onlooker and parallel phases of play and also allows them to use their newfound social skills to involve with other children or adults during play or other activities.
6. Co-operative play—seen in four-year-old and older children; it is characterized by co-operative play between players; group play establishes rules for play. Co-operation is an advanced skill and involves conflict, which can be difficult for young children to navigate by way of sharing, taking turns, and negotiating control during play. This is normal, and young children can be supported by staying close to them and helping them learn healthy ways of expressing emotions and teaching them problem-solving skills.[1,2]

Play is critical to child development too. During play, inputs from various sensory and physical stimuli along with emotional repertoire and social engagement help in forming brain circuits and prevents neuron loss.[3] Since play involves engagement of brain areas responsible for thinking and reasoning (cortical structures) and emotional regulation and memory (subcortical structures), it leads to long-term emotional learning and enhancing emotional regulation.[2] Play is considered to be the most developmentally apt and convincing medium to learn to develop adult–child relationship, social skills, emotional control, cause–effect thinking, and problem solving and to derive a sense of control and power.[4] It enhances feelings of confidence and accomplishment. It gives children the medium to communicate non-verbally, symbolically, and in an action-oriented manner.[5] Lev Vygotsky, a Russian developmental psychologist, also emphasized on the importance of imaginative play as a leading factor in development, whereby children learn and experience a wide array of challenging skills and culturally valued competencies, the most significant of these being the strengthened capacity for self-regulation.[6] Montessori referred to play as the work of children and toys as its tools helping them to learn about the world, themselves, and others by ways and means such as picking up new ideas, figuring out how things work, using imagination, solving problems, and learning co-operation among fellow beings.[7]

What Is Play Therapy?

Play is not only an essential requisite to enhance normal child development but has many therapeutic and healing powers as well. It is a well-known fact that for any therapy to work, the formation of a therapeutic relationship that serves as a medium of exchange is a must. By using the medium of play, a working relationship with children can be established. It is helpful with not only younger children lacking verbal expression but also older children who show resistance or are unable to articulate their feelings and problems. Therefore, keeping in view the importance of play in the child's growth and development, various play-based exploratory and therapeutic approaches are being devised for management of emotional, psychological, and behavioral problems of children. Various definitions of play therapy have been provided in literature. VanFleet defines it as "a broad field that uses children's natural inclination to play as a means of creating an emotionally safe therapeutic environment that encourages communication, relationship-building, expression, and problem resolution for the child."[8] It is also understood as a "means of creating intense relationship experiences between therapists and children utilizing play as the medium of communication with the aim of bringing a change in an individual's primary relationships and to bring children at par with the developmentally appropriate emotional and social functioning."[2] Landreth defines play therapy as "a dynamic relationship between a child and a trained therapist aiming at facilitating the development of a safe environment and a safe relationship for the child so that the child is able to fully express and explore self.[9]" The Association for Play Therapy (APT) defines it as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent

or resolve psychosocial difficulties and achieve optimal growth and development."

Play used as a therapeutic tool has been practiced as early as 1930s, when Melanie Klein and Anna Freud began using play techniques in child therapies. There are four broad functions of play in therapy:

- First, since play is a natural form of expression in children, it is used to express feelings and thoughts and reflects the child's internal world—be it fantasy or troubling, conflict-laden feelings.[10] Just the expression of feelings during play is supposed to be "cathartic," which is thought to be therapeutic in itself.[11]
- Second, play is used as a communication tool with the therapist, and it becomes important on the part of the therapist to understand these communications for a therapeutic relationship to establish.[10] Since the child feels understood in this play-based interaction, it initiates changes in the child's interpersonal representations and functioning.
- Third, the psychodynamic theory assumes that resolution of emotional trauma is central to initiate change, and play acts as a vehicle for occurrence of insight and working through. For example, repetition of a traumatic situation during play over and over again makes it manageable, and children attain mastery over the traumatic situations over time.[12,13] There is a general agreement in psychodynamic literature on child therapy that mastery and working through are important tenets of change in play therapy.
- The fourth function of play deals with the fact that play provides opportunities to practice with different ideas, verbal/non-verbal expressions, and behaviors. More so, these opportunities are made available to the child in the presence of a permissive, non-judgmental therapist in a safe and make-believe environment.

Historical Roots and Major Approaches to Play Therapy

The history of play therapy is as old as the history of child therapy. Despite the understanding that play is the natural form of expression and communication for children, there are different approaches to play therapy based on the school of thought being followed.

Play was first used as a form of therapy in the early 1930s based on the psychoanalytic understanding of the problems. Psychoanalytic techniques were adapted to children and substituted play for free association, and therapists became proactive in getting involved with children in an effort to develop a therapeutic relationship with them.[14–16] Melanie Klein endorsed active and direct interpretation of a child's play, thereby getting an idea about the unconscious processes expressed through play. Anna Freud in addition advocated greater participation of a child in the play, making it a positive experience and, thus, the child wanting to come back to therapy.[17] Therapists using psychodynamic principles in play therapy usually have fewer sessions per week (once a week), have more focused and immediate goals, and are more flexible in including a variety of techniques, with play being the core of the therapeutic process.[18] Object relation/thematic play therapy is based on attachment-based object relation theory. Children who have suffered abuse/violence/disrupted attachment in interpersonal relationships benefit most from this approach. The focus in this is on developing a secure base and trusting relationship between the child and the therapist and empowering the child to modify the negative internal working models into healthier ones.[19]

Play has also been used in client-centered and person-centered approaches for treatment of children. Axline employed non-directive approaches utilizing play as the major form of communication for and with children.[20] She laid emphasis on understanding and empathizing with a child during play rather than on interpretation of underlying unconscious/subconscious processes. Moustakas[21] also laid importance on play as a medium of expression of feelings and also for building a relationship between a child and therapist. He emphasized on "genuineness" in the relationship as an important thread of therapy.[22] Adlerian play therapy utilizes play in the context of principles of individual psychology and involves strategies such as story-telling and therapeutic metaphors, movement/dance experience, sand tray activities, art techniques, and structured and unstructured play experiences.

Play has also been utilized within the framework of cognitive behavioral therapy.[23] Play has been used as a vehicle for changing thoughts as well as utilizing principles of modeling and reinforcement and mutual story-telling.[24–26] The narrative approach of David Epston and Michael White have been adapted in play therapy as a "narrative play therapy" wherein children express and explore their experiences with the therapist by co-constructing stories enabling the children to separate from the problem and regain control.[27] David Levy came up with "release play therapy" based on the psychoanalytical understanding that re-experiencing and re-enacting a traumatic situation time and again leads to the release of pent-up feelings that eventually get extinguished. Children with traumatic experiences are involved in free play, and when they are comfortable with the surroundings, they are made to re-enact the traumatic event using specifically selected play materials to play out their trauma. This helps them in working through that particular event and gain mastery over the feelings associated with that event.[28,29] Filial/family play therapy developed by Bernard and Louise Guerney[29] in the 1960s involves elements of play therapy and family therapy, wherein one or both parents are taught and made to practice basic non-directive play techniques with the aim of improving parent–child relationships.[29]

Processes Expressed in Play Therapy

A number of affective, cognitive, and interpersonal processes are expressed in play and can be directly or indirectly observed by way of the verbal, non-verbal, and behavioral expressions emerging during play.[30–32] In the cognitive domain, organizational skills required for telling a story; narrating events in a sequence in variable detail and complexity (appropriate to age); divergent thinking necessary for generating different ideas, stories, and symbolism (transforming simple objects into representation of other objects; e.g., a rectangular block is used as a mobile phone); and engaging in make-believe/fantasy play are some of the processes involved. Affective processes include expression of emotion and emotional themes, feelings of joy and comfort while engaged in play, emotional regulation and modulation of affect, and the ability to integrate affect into a cognitive context. Interpersonal processes include empathy, communication, problem solving, and conflict resolution skills and developing trusting relationships.[30–32]

Benefits of Play Therapy

Any psychotherapy works by bringing about some changes in the individual's thoughts, actions, and/or emotions. The mechanisms by way of which this change is brought about is not specific to any one type of psychotherapy or psychotherapeutic approach. Usually, it entails a mix of all the different kinds of change that happen during the process of therapy. In child therapy, these changes are based on the major functions of play. The role of play in bringing about changes was discussed by Russ.[33]

Play facilitates the following during the process of therapy:

1. *Ventilation/catharsis, expression, and labeling of feelings* happen through play. By becoming aware of the feelings and emotions and labeling them, a child develops an understanding of the why and what of the emotions, and thus, emotions become less overwhelming.[11,20,21] This is mediated by the therapist talking to the child and labeling feelings of, for example, puppet/doll/animal toy/human figurine, etc. The expression during play is encouraged by majorly two important therapeutic techniques—permission and labeling. This helps the child understand, label, and thus freely express thoughts and feelings in a context.
2. *Corrective emotional experience* occurs when the therapist accepts the child's feelings and thoughts as it is expressed in a non-judgmental, non-punitive manner and talking through to understand the reasons for the particular emotion. Once acceptance and understanding of the felling have happened in therapy, the next step is to separate feelings and thoughts from behavior; for example, it is okay to feel angry but not to be destructive or hit somebody.
3. *Re-experiencing trauma and working through and gaining insight* are essential vehicles of change in play psychotherapy. Working through is achieved by re-enacting the conflictual situation in order to gain insights into genesis of disturbing thoughts and feelings and the connection between thoughts, feelings, and actions.[34] While reasoning out the genesis of problem behaviors can be attempted with older children, it may not be possible with younger children.
4. More directed play therapy can be used to teach children about *problem-solving techniques and coping strategies* by helping them think about alternative views of a situation and generating problems and testing them.
5. Developing a *secure attachment, good object relations, and internal representations* is of utmost benefit in children who have suffered trauma and abuse. Therapeutic relationship between the therapist and child is perhaps the most important and determining factor in facilitating development of good interpersonal representations.[35]
6. *Transference and counter-transference* are common when working with children as the relationship formed between the child and therapist is very intimate. Transference allows the therapist to recognize the child's likely behavior toward important people in their lives as the child may be responding to the therapist's style/behavior, which may remind them of a significant person in the past. Similarly, it is important to recognize counter-transference in the therapist as it strongly impacts the quality of relationship with the child and utilize it in therapy by using alternative modalities such as art and drawing.
7. *Non-specific variables* such as hope, awareness of parental concern, expectation of change, and the belief that someone is there who can be trusted and who support are other important mechanisms of change. Thus, play in play therapy is an important mediator for facilitating communication, fostering emotional wellness, improving social relations, and increasing personal strength.

Basic Principles/Practical Considerations for Play Therapy

The task of the therapist becomes highly challenging as it requires gaining trust and confidence of the child so that the child allows some space for the therapist in his/her world. To become a part of the child's world is important, as that is the gateway to the child's thoughts, feelings, and internal world so that some meaningful play-based therapeutic interventions can be put in place to help the child gain/regain emotional

well-being, psychological health, and optimal functioning in domains of life. In doing so and being able to achieve the above-mentioned state, the therapist has to act like a child and as a professional.

- Taking a thorough and detailed history, keen observation, impeccable description and documentation of the problematic behaviors, being aware of responses of family members, friends, teachers, and significant others to those behaviors, and the interpersonal relationship between the child and others is very important. Depending on the available information and clinical evaluation, a treatment modality is to be chosen that is appropriate for the age and suitable for the problems at hand.
- Establishing rapport with the child by way of acceptance and responding with empathy becomes the first step in the child being able to trust the therapist. Therapeutic relationship has to come from the play and should never be forced upon the child.
- A non-judgmental approach has to be followed, and the child should be accepted as they are.[36] A non-directed play here helps the child to choose the optimal therapeutic path for changes to occur. An atmosphere of complete, non-judgmental acceptance has to be created wherein the child finally has the trust and confidence that no matter whether they bring out their "bad side," they will not be rejected. This kind of atmosphere also enables and empowers the child with confidence in choosing options and making decisions.
- As already mentioned, recognizing and reflecting on the feelings expressed during play helps the child in gaining insights into their behaviors when working through those problems can be initiated.
- Respecting the child as an individual no less than anyone is important, and part of this respect comes when the therapist does not offer solutions and whenever an opportunity comes, the child takes up the responsibility to solve their own problems.
- The child should be leading the play and the therapist should exercise utmost care in trying not to lead and direct the play. When children are allowed a free hand to choose play objects and activities, it symbolically reflects their internal world and the problems thereof.
- Play therapy cannot be a hurried therapy as change and growth is a gradual process and enough time and space should be allowed to the child during the therapeutic process. Depending upon the child's problems and needs, the therapy sessions may range from 15–20 sessions to over 1–2 years, and the duration of the session is usually 30–60 minutes per day. The sessions may be taken twice weekly or more frequently as the need and goals may be. Sometimes, the parents may be required in the play sessions, which should be decided on a case-to-case basis.
- Minutely observing the progress of therapy and any hindering factors should be identified, documented, and worked through.
- The session should end by adequately informing the child of the time and the child should be asked to put the toys back in place before leaving the play room.
- Confidentiality of the information obtained in the sessions should be maintained.

Play therapy can usually be applied to younger children more often than older children. For children aged 3–12 years, play therapy is an effective treatment modality. Play therapy in its true sense may not be too practical with older children but applying cognitive behavioral approaches in the context of play may be beneficial even in older children. There is no fixed number of sessions that is adequate for play therapy since each child has his/her unique problems and may require a variable number of therapy sessions; however, in a majority of the cases, 12–20 sessions may be sufficient. Children with low self-esteem; aggression; shyness; worries; sadness; feelings of loneliness, trauma, and abuse; academic difficulties; interpersonal problems; expressing a wish to die; grief and loss; family problems; marital discord; sibling rivalry; defiance; stress management issues; coping skill deficit; behavior problems associated with any condition; etc. are good candidates for play therapy. There is no absolute contraindication for play therapy, but play therapy is to be postponed for acutely agitated children, those with psychotic symptoms, and actively suicidal children till they come in a frame of mind when they can be engaged in play therapy.

Play Therapy Techniques

Play therapy techniques come majorly from the approach to play therapy that is followed.

1. Psychodynamic play therapy: It basically targets to help children work through trauma or difficulties by helping them gain insights into the genesis and evolution of their problems. However, psychodynamic play therapy is a time consumingtherapy. Thematic play therapy has its origin in the object relation theory. It is said to be useful for children who have suffered abuse, trauma, and neglect in their close interpersonal relationships. Children can express conflicts, desires, and wishes in ways that are affectively tolerable and appropriate to the developmental level of the child. However, the therapist has to be a keen observer attempting to understand, amalgamate, and then communicate the meaning of the play to enable the child to gain insight into their conflicts and working through can be done to achieve resolution of those conflicts.

2. Gestalt play therapy: It was developed by Frederick Perls and Laura Perls and follows the psychoanalytic principles, gestalt psychology, various humanistic theories and neuroscience, philosophy, etc. in its approach.[37,38] The two basic tenets of this technique are: (a) organismic regulation, that is, striving for life and connection and (b) dialogic process, that is, engaging in a mutually involving relationship. From Gestalt's perspective, symptoms of impaired self-regulation and lack of support are the main reasons for entering this therapy. Symptoms lead to interruption in growth and development and thus to behavioral, emotional, and somatic symptoms and interpersonal relationship problems. The therapy sessions aim at supporting the child and organizing the child's experience of therapy sessions so that they can make some sense of their experiences.

   Case vignette: An eight-year-old female child from a rural background of Himachal Pradesh was referred from plastic surgery department for complaints of not adhering to the rehabilitation/physiotherapy instructions three months post re-implantation surgery following traumatic amputation of her right hand. Post-surgery, she started to complain of pain and weakness in the hand and did not cooperate with physiotherapy exercises. Her mother revealed that after about a month of the surgery, she refused to go to school, became irritable, and cried if persuaded. She did not want to talk about the incident that led to the amputation of her right hand and also avoided going to the cowshed where the incident had happened; her hand had come in between the blades of the grass-cutting machine. She avoided meeting her friends and relatives who came to see her. On seeing the same machine elsewhere, she became fearful and sought respite in closeness with her mother. She also complained of "ghabrahat" (abrupt onset episodes of palpitations, shortness of breath, and dizziness). A clinical diagnosis of depression of moderate severity and possibility of post-traumatic stress disorder was considered. Non-pharmacological management in the form of Gestalt play therapy was used. The objectives of the Gestalt play therapy are awareness and integration of fragmented parts in themselves through emotional expression to support themselves. During initial sessions, rapport was established with the child through free play. The toys utilized in the play included family dolls, an animal farm, an ambulance, and a doctor's kit. Play observation revealed anxiety and lack of confidence while using the right hand. She avoided doing tasks with the right hand. Relaxation play was also used to relieve anxiety. The child was taught stretching exercises to progressively relax various body parts, from the feet to the scalp. After initial sessions, dramatized play was used to focus on unconscious fears and feelings. She started playing using the theme of the little girl doll being hurt, crying, and taken to the hospital. By playing with dolls, the child was able to bring reality into the here and now, to relive traumatic experiences, and to gain control over them. Feelings were projected onto the dolls through role plays; for example, she was asked, "How the doll is feeling" and "what can the doll do now for writing and going to school?" She replied that "she has to be brave and do minor tasks with her hands; she will go to school and will do work as the teacher will instruct." Thereafter, new roles and skills were learnt and problems faced by the child in daily life situations such as meeting with friends and doing writing task were accomplished, and through these, the child gained control over the situation. For home, reward-based activity scheduling was done. The child's strengths were explored, and building self-esteem was targeted. Gradually, her self-esteem improved, and she started going to school and started using her right hand more often. She improved significantly with no residual symptoms.
3. Client/child-centered play therapy: In this type of play therapy, play sessions are non-directive and specifically child centered, providing unconditional positive regard, being genuine, understanding, and non-judgmental. In contrast to structured play therapy, the play sessions are rather conducted in a permissive atmosphere so that the child feels safe and accepted in the non-threatening environment without focusing on problem behaviors. More emphasis is laid on expression and exploration of feelings and emotions, thereby increasing self-confidence and self-worth of the child.
4. Release/structured play therapy: In this technique of play therapy, the play sessions are more directed and structured. This is achieved by limiting the confines of the type of play material provided, play situation, and therapist orientation.[39] The major target in this technique is to set the stage for emotional catharsis by directing the play situation, which in all likelihood is anxiety provoking for the child and is bound to lead to intense emotional reactions but avoid interpretation, as in psychodynamic play therapy. Later, interpretation of behavior and emotional reaction enables the child to reflect on their behavior and emotions and then provide the opportunity to learn skills to modify the behavior.[40]
5. Family/filial play therapy: It refers to active involvement of parents in the therapy process and thus bringing about positive changes in the relationship problems between the child and the parents.

   Case vignette: Miss A is an eight-year-old girl living with her mother and maternal grandparents since three

years of age after the death of her father, studying in the fourth grade, and belonging to middle socioeconomic status in a semi-urban locality of Punjab. Her mother suffers from schizophrenia and subnormal intelligence. The child presented with complaints of irritability, crying spells, academic decline, disturbed family relationships, and suicidal attempt, for which she was brought to the Child and Adolescent Unit of the Psychiatry Department, Postgraduate Institute of Medical Education & Research, Chandigarh, and was admitted in the ward for management. Her mother was not able to nurture her or take care of her needs. Her maternal grandparents and maternal aunt were primary caregivers of the child. Her maternal aunt got married a year ago and used to have frequent altercations with the maternal grandparents. The child was neglected during this time and would get upset as she tried to stop the fights but would fail. Due to disturbed family relationships and lack of nurturance from her mother, she often had thoughts that no one loved her or supported her.

During play room observation sessions, the child did not involve her mother in play. She played the role of elder sister or mother in make-believe stories. Play room observation revealed lack of attachment and bond with the mother and a dire need of love and nurturance from her mother and other family members. During the initial phase of treatment, play therapy was used for rapport establishment and ventilation of emotions through making stories using dolls and animal puppets; for example, she played with a girl doll and said that the doll is in distress and thus had thoughts of ending her life. The child was communicative and expressive during the sessions, which helped relieve her emotional distress. In further sessions, the mother and the child were involved in filial play therapy that intends to use play as the primary medium for strengthening child–parent relationships and resolving child and family problems. Story-telling, role play, and make-believe play were conducted in sessions wherein the mother was informed about her responsibilities toward the child such as making her favorite dish with kitchen set and helping each other in making and serving food. The mother was directed toward emotional needs of the child wherein she enacted using the doll house asking the child "how she felt and why was she upset; what were her desires and needs." The child was psychoeducated about her mother's illness, and after receiving information about her symptoms, the child became cooperative toward the mother and enjoyed playing with her. She started talking about her expectations to her mother and asked her to enact in play; for example, she instructed her mother to ask her about school and what she wants to play, etc., which eventually led to an improved bond and communication with the mother. She was defocused from the family environment, and more focus was laid on her functioning at school and social environment.

6. Cognitive behavioral play therapy (CBPT): It essentially incorporates cognitive and behavioral interventions within the setting of play sessions. Cognitive change is imparted indirectly, and maladaptive coping skills are replaced by adaptive coping skills through modeling. The focus remains on resolution of psychopathology more than on general development.

Case vignette: Master A, a 13-year-old male studying in the ninth grade and belonging to middle socioeconomic status, is a resident of Punjab and lived with his parents, younger sister, paternal grandmother, and paternal uncle's family. He was brought for evaluation as he complained of having bad dreams following his father's sudden death in an accident and mother seriously injured in the same accident, which happened a few months back. He was shocked to see the dead body of his father and cried inconsolably. He participated in the funeral rituals but expressed that he was afraid of the fire. At this time, even his mother was hospitalized, and he refused to stay at his home as it reminded him of his father and he had started to have flashbacks of his father's cremation and nightmares when he would visualize himself lighting his father's pyre. He also started to have unresponsive episodes without associated clenching of teeth, tongue biting, and rolling up of eyeballs which lasted for a variable time ranging from 10 to 30 minutes. He continued going to school and felt better with school mates but was sad and cried whenever he was alone. He had started to have difficulty in concentrating in studies, disturbed sleep, and altered appetite.

In-patient play room observation revealed that he was actively involved in playing with different types of toys, like gun, car, ball, etc. and displayed appropriate emotions during play; there was a significant observation of the need for love and nurturance during his play with dolls.

CBPT was initiated, in which a total of 12 therapy sessions over four weeks and two booster sessions were taken over three months post-discharge.

During the initial part of the therapeutic process, he was given the space and opportunity to familiarize himself with the playroom and get comfortable. Play offered him the opportunities to ventilate and express his emotions. Relaxation exercise was taught and practiced regularly, which aided in the preparatory work for the therapeutic process to follow. During the middle phase of the therapeutic process, he was directed to make a story using animal puppets. He picked up lion and elephant hand puppets. The initial story made by him was that a lion had attacked the

cow to kill her, but an elephant intervened and saved the cow by killing the lion. A lion's baby finger puppet was introduced by the therapist. The patient said that the lion cub cried a lot and displayed the cub performing all the funeral rituals for his father lion and informed his mother that his father was dead. A bear hand puppet was then introduced, and it questioned the lion cub about its worries now that his father was no more. The lion cub replied that now there was no one to cater to the needs of the family and no one to drop him to school. The bear puppet further enquired if during the current situation at home, there was someone who was helping the family. The lion cub said that the father's elder brother (taya ji/paternal uncle) was helping and supporting the family. On therapists' reaffirmation, he agreed that uncle along with paternal grandmother was there to take care of the family and cater to their basic needs. On discussing about what the future course of action should be for the patient, he informed that he should study hard and take care of his mother. The therapist further added that he should live his childhood, play with friends, study, and discuss his concerns with someone in the family and/or the therapist. He was taught to enhance adaptive thinking and beliefs.

Additionally, story writing using children apperception test (CAT) mother card was used. He was instructed to make the story, mentioning about the past, present feelings of characters in the card, and possible future outcome of the story. The child made the story expressing the feelings of loss and happy reunion with the mother figure. The child was praised for making the ending of the story happy. During the termination phase, diary writing was introduced and writing letter to the father was discussed. He considered it to be a good idea and started writing letters for his deceased father. In one of the letters, he wrote, "Dad, where have you gone. I felt guilty on why I went to school that day and was not able to meet you for the last time. I miss you but now I will go to school regularly and will take care of my brother and mother also."

He felt good and relaxed after writing the letter and said that he would continue to write letters to his father.

At the time of discharge, his dissociative symptoms had significantly reduced and he did not report sadness. Post-discharge and at three-month follow-up, he had recovered from grief-related symptoms of PTSD and had improvement in overall socio-emotional functioning.

Case vignette: Miss A, an 11-year-old girl studying in the eighth grade and belonging to middle socioeconomic status in a Christian family, was a resident of Punjab and was admitted to the Child and Adolescent Ward with complaints of wrist cutting after failing in the sixth grade. She had academic difficulties since she started schooling, and her performance in exams was invariably poor. She had significant difficulty in mathematics and in spellings. After few days of getting her result, she started complaining that she could see a woman wearing a red sari and had scar marks on her face. She started complaining that the above-mentioned woman threatened to kill her and also at times pulled her down from bed or twisted her arm. Later, she had bloody tears two to three times with no apparent medical cause. Apart from the assessment of academic difficulties and intervention required thereof, an eclectic approach was adopted, which included supportive therapy, play-based cognitive intervention, and family therapy for emotional and dissociative symptoms. Rapport was established with the child. The child was allowed to ventilate and verbalize her emotions and feelings regarding the distress in family and school. An activity schedule was made, which included her hobbies like drawing, listening to music, etc. with an aim to enhance her self-esteem. Problem solving and coping abilities were enhanced after the interpretation of thematic apperception stories, and role play on situations from her real life was enacted. Jacobson's Progressive Muscle Relaxation (JPMR) and deep-breathing exercises were delivered during the sessions. Further, emotion management was imparted by using role-play situations during play to teach the child alternative responses/ways of reacting to the situation; for example, whenever the mother asked her to study, she often responded by snapping back at her mother. Discussion about other ways of communicating with others was done, and she was suggested to communicate and clarify politely about what was being asked from her. Gradually, her alternative responses improved and became the predominant mode of responding; for example, now on being asked to study, she politely responded that she would finish the task at hand and then sit for studies. At three-month follow-up, dissociative episodes were absent. Her relationship with her mother and father improved, and she maintained well without any relapse of symptoms.

7. Sand tray therapy: Also known as sand box therapy, it is a type of experiential workshop that allows greater and deeper exploration of emotional issues. It allows children to reach into deeper insights of their problems, leading to resolution of a variety of issues such as anger, grief, abuse, etc. A sand tray is used with many miniatures, and children are encouraged to create a story by arranging toy human/animal/other toy miniatures. Evaluation and interpretation is done on the basis of choice and usage of toys to create the story.

Various other forms of play therapy have also been reported in literature; for example, narrative play therapy employs story-telling and narrative techniques to help children create and share their own personal experiences and accounts, helping them to deal with issues of identity, self-esteem, and resilience. In trauma-informed play therapy, the child may re-enact the trauma and thus the therapist may witness the trauma indirectly. It helps children to process trauma and heal from it in a safe and controlled manner.

Effectiveness of Play Therapy

Play therapy is applicable to a variety of problem behaviors and settings, worldwide. And a huge progress has been made in this field; however, research related to play-based interventions have been under the scanner for lack of scientific rigor and high reliance on anecdotal case reports/studies as its research base. A case series from India reported the effectiveness of play therapy in six children with childhood emotional disorders, that is, separation anxiety, generalized anxiety disorder, attention deficit hyperactivity disorder, and depressive conduct disorder in as young as a 5-year-old and as old as an 11-year-old pre-adolescent. The average number of play therapy sessions was 11 (range of 6–20 sessions). Symptomatic improvement was noted in all children with an average improvement of around 80%.[41] However, a few meta-analyses have been conducted on the effectiveness of play-based interventions and have found average to large mean effect size.[42,43] Play therapy is found to be useful in a wide range of difficulties experienced by children. A meta-analysis of 93 controlled studies (published between 1953 and 2000) reported an effect size of 0.80, which is a large effect size and has more positive effects on humanistic than on non-humanistic treatments. A major strength of this meta-analysis was that it included both unpublished and published play therapy outcome studies.[43] A systematic review examining the effectiveness of play therapy in hospitalized children with cancer proved beneficial in reducing hospitalization days using play modalities such as drawing, painting, solving puzzles, and story-telling utilizing cognitive behavioral therapeutic play with 20–60 minutes of play therapy sessions.[44] Another systematic review reported upon the effectiveness of any type of play therapy/filial therapy in improving psychosocial outcomes such as emotional and behavioral issues (anxiety, depression, self-concept) in children with chronic health conditions. This systematic review included six studies, out of which two studies reported improvement in depression scores and another study reported improvement in self-concept, but the remaining three studies did not report any benefit of play therapy. Thus, the authors concluded that due to various limitations such as heterogeneity in study designs and small sample sizes, the current evidence is inconclusive regarding the effectiveness of play therapy in improving psychosocial outcomes in children with chronic health conditions.[45]

Play therapy benefits have been tested not only in children with childhood emotional disorders but also in children with neurodevelopmental disorders such that on-task behaviors in children with attention deficit hyperactivity disorder displayed some benefit with child-centered play therapy and nature-based child-centered play therapy.[46] Group play therapy received by children (five- to eight-year-olds) three times a week for 45– 60 minutes each (20 sessions in total) showed its usefulness in improving understanding and communication in these children.[47]

Conclusion and Future Directions

To conclude, it can be said that play therapy is a dynamic and powerful approach that respects the unique ways in which children express themselves. Play therapy provides a safe, non-judgmental space for emotional exploration, thus facilitating healing, change, and development. It is a transformative experience for both children and the therapist, leading to self-awareness, improved social skills, and greater self-esteem. Through various forms of play, children discover their unique paths to emotional expression and resolution of conflicts. Play therapy harnesses the diversity of childhood experiences to empower them with essential life skills.

It is important to acknowledge that play therapy is not culturally neutral. While undertaking play therapy for a child, the therapist must be aware of the cultural practices, beliefs, and context that have an influence on the child's experience of the inner world as well as the outer world. Only when play therapy is culturally sensitive, it will respect and incorporate cultural norms and values into therapy sessions and thus will ensure therapeutic interventions that are relevant and meaningful within the child's cultural framework.

The under-utilization of play therapy in low and middle income countries is mainly because of limited awareness and accessibility; resource constraints (trained and qualified play therapists, appropriate play materials, and dedicated spaces for conducting play therapy sessions); cultural sensitivity; stigma surrounding mental health; language and cultural diversity; and socioeconomic factors. Addressing these challenges requires a comprehensive and culturally sensitive approach. Efforts should focus on raising awareness, training opportunities for professionals, adapting play therapy to the local context, integration into educational systems, utilization of telehealth and technology to increase accessibility to play therapy services, parental involvement and training, and collaboration with international organizations.

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