Chapter 14

PRESCRIPTIVE PLAY THERAPY

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Prescriptive psychotherapy is a term used to describe approaches that attempt to tailor the application of psychological interventions to individual clients. Prescriptive psychotherapists base their guidelines on a foundation of empirical research and attempt to answer the age-old question: What treatment(s)/intervention(s)/strategy(s), by which therapist, will work best for this particular client? (Paul, 1967). The prescriptive eclectic approach to play therapy attempts to incorporate the theories and techniques of many psychotherapists into a broad framework that facilitates the development of client-specific treatment strategies. The goal of the play therapist is to construct an individualized treatment plan that matches the client's needs and situation and thus is likely to maximize therapeutic gain.

The concept of prescriptive psychotherapy is not new (Dimond, Havens, & Jones, 1978; Goldstein & Stein, 1976). However, the popularity of this approach has increased markedly in the past decade (Beutler & Harwood, 1995) and is likely to continue to expand in the years ahead.

BASIC CONSTRUCTS, GOALS, AND TECHNIQUES

Every school of psychotherapy rests on a foundation of basic propositions or beliefs that serve as fundamental starting points or cornerstones of the approach. Ten basic tenets of prescriptive play therapy are described in the following sections.

Tenet 1 Differential Therapeutics

Play therapy has been developing over most of its 100-year history based on its "one true light" assumption, which holds, in the absence of supportive

evidence, that a therapist's preferred approach is equally and widely applicable to most or all types of client difficulties. The problem with this "one size fits all" approach is that no single theoretical school (e.g., Jungian, Rogerian, Adlerian) has proven strong enough to produce change across the many different and complex psychological disorders that have been identified (Smith, Glass, & Miller, 1980).

Psychotherapists, more than any other profession, have been prone to apply only those interventions that are valued by their particular therapeutic model rather than those that best address a particular client's needs or concerns. This is akin to physicians' treating every disorder with acupuncture because it is the remedy they have been trained to use. The prescriptive approach, on the other hand, asserts that the more remedies you have to offer in psychotherapy, coupled with knowledge about how and when to use them, the more effective you'll be across the diverse problems that clients present with (Goldstein & Stein, 1976).

Thus, the prescriptive approach to play therapy espouses as its core premise the *differential therapeutics* concept (Frances, Clarkin, & Perry, 1984), which holds that some play 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). It rejects the Dodo bird verdict that all major forms of psychotherapy are equally effective over all disorders (Beutler, 1991; Luborsky, Singer, & Luborsky, 1975; Norcross, 1995).

Notwithstanding the "common" or "nonspecific" qualities that characterize effective therapies of all types, increasing evidence has pointed in the direction of specific interventions working better for specific disorders or syndromes (Chambliss & Ollendick, 2001). Support for the strength of specific treatment effects is seen in the findings of psychotherapy outcome meta-analytic studies, which indicate that mean effect sizes of specific factors consistently surpass those of common factors (Lambert & Bergin, 1994; Stevens, Hyman, & Allen, 2000). Because differential rates of improvement are being found among different treatment procedures, the prescriptive approach seeks to "match" the most effective play intervention to a specific disorder (Norcross, 1991). On the face of it, practically every therapist endorses the premise that treatment should be tailored or matched to the needs of the individual case. It makes intuitive sense. However, prescriptive matching at the optimum level goes beyond this simple acknowledgment. It differs from the typical basis in at least three ways:

1. The typical basis of matching is a theory of psychotherapy rather than—at the highest level—direct evidence of efficacy.
2. The typical basis of matching is within a single theory, rather than eclectically across theories.

3. The typical basis of matching is on client diagnosis, rather than on multiple diagnostic and nondiagnostic variables, including client and therapist variables.

Tenet 2 Eclecticism

The second basic tenet of the prescriptive approach is eclecticism. *Eclectic* simply means that you select from different theories and techniques a therapeutic strategy that appears best for a particular client. Prescriptive play therapists embrace multiple theories, including those previously described in this volume, and thereby expand their theoretical frame and therapeutic repertoire. They reject a strict allegiance to a particular school of treatment. According to Norcross (1987), "synthetic eclecticism" involves applying various theories to one interactive and coordinated modality of treatment. This differs from "kitchen-sink eclecticism," which, Norcross states, is an atheoretical treatment approach. In the latter, practitioners apply techniques from various schools of thought in a manner that ignores the theory that underlies them. Such an approach, Norcross warns, is haphazard and ineffective at best and may, in fact, be harmful to some clients.

Polls of practitioners have indicated that most psychotherapists report that their orientation is eclectic and that, in the future, there will be even more cross-fertilization among theories (Brabeck & Welfel, 1985; Prochaska & Norcross, 1983). A survey 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 the treatment of choice by most practitioners in this country (Norcross, 1986). As Goldfried (2001) observed: "Most of us as therapists eventually learn that we cannot function effectively without moving outside of the theoretical model within 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 growing eclectic movement reflects a decisive departure from a "purist," one-size-fits-all orthodoxy, together with a much greater openness by most psychotherapists to adapt to changing circumstances and to tailor their strategies to the individual needs of the client.

Tenet 3 Evidence-Based

The prescriptive approach emphasizes the application of science to the practice of psychotherapy. In the broadest sense, a scientific approach involves gathering empirical evidence as a systematic way that either supports or disconfirms a priori hypothesis. The primary criterion employed by prescriptive play therapists to match an intervention to a disorder is *scientific evidence*. This is a "bottom-up" approach in that interventions with empirically supported efficacy are applied and subjected to further scientific validation.

If empirically supported treatments have not been developed for a particular disorder, prescriptive matching is based on the clinical experiences of self and others as to what has worked best in actual practice for the dysfunction. If both research and practice are uninformative, the therapist turns to the most compelling theory linking change mechanisms to the disorder. Thus, the selection of an intervention for a particular disorder is based on a rational process. It is not conducted in a haphazard or subjective (personal preference) manner. A core belief is that evidence-based practice should triumph over personal opinion.

To function as evidence-based practitioners, play therapists must know how to correctly interpret and critically appraise scientific studies, how to use results published in the literature to select diagnostic tests and therapies, how to search the empirical literature to answer clinical questions, and how to keep up to date with the latest developments in their field.

Tenet 4 Understanding Therapeutic Change Mechanisms

In recent years, there has been a change in direction away from the development of elaborate, formal theories of psychotherapy to a focus on defining the basic principles of therapeutic change, principles that are not tied to any specific theory or model (Beutler, 2000). Change mechanisms are not theories—they are descriptions of observed relationships. They are more general than techniques, and they are more specific than theories. They are the "if . . . then" relationships that tell us when to do, what to do, and whom to do it to.

Perhaps the most basic question faced by play therapists today relates to the mechanisms of change in play therapy; that is, what are the therapeutic factors that actually produce the desired change in a child's behavior (Schaefer, 1993)? Once the active ingredients in a play intervention have been identified, the inert factors can be eliminated and a more time-efficient and cost-effective intervention can be developed (Goldfried, 1980).

Therefore, in addition to outcome research, the prescriptive play therapist looks to process or *component analysis* research (Hunsley & Rumstein-McKean, 1999) to identify the therapeutic change mechanisms underlying the effective outcome. Furthermore, they continually search for mediator and moderator variables that can help them understand the relationships between a specific play treatment and outcome (Shadish & Sweeney, 1991).

The major therapeutic powers of play proposed to date are listed in Table 14.1. The most well-known powers of play (Kaduson, Cangelosi, & Schaefer, 1997) are its communication powers (e.g., young children express themselves better through

Table 14.1 Therapeutic Powers of Play

I. Communication
Self-expression/self-understanding:
1. Conscious
2. Unconscious
3. Direct teaching
4. Indirect teaching

II. Emotional Regulation
5. Cognitive-behavioral
6. Abreaction
7. Catharsis
8. Sublimation

III. Relationship Enhancement
9. Alliance
10. Attachment
11. Friendship-peers
12. Friendship-adults

IV. 13. Moral Judgment

V. Stress Management
14. Stress inoculation
15. Stress management

VI. Ego Boosting
16. Power
17. Competence
18. Self-control
19. Creative problem solving
20. Fantasy compensation
21. Reality testing

VII. Preparation for Life
22. Role play
23. Behavioral rehearsal
24. Growth and development

VIII. 25. Self-Actualization

play activities than with words), its teaching power (e.g., children learn and remember better when instruction is made fun and enjoyable), its ego-boosting power (e.g., children derive a unique sense of power, control, and competency through play), and its self-actualization power (e.g., children, adolescents, and adults have the freedom and safety to be completely themselves in play). The

prescriptive play therapist continually seeks to acquire a deeper understanding of all the therapeutic powers of play and tries to determine for which disorders each of the change mechanisms is best applied. It is recognized that there is much to be gained in using component analysis designs to determine the effective elements of a play treatment that has been established as empirically supported in randomized clinical trials.

Based on an understanding of the therapeutic powers of play, prescriptive play therapists seek a prescriptive matching of therapeutic power or change mechanism to identified casual mechanism, for example, attachment-oriented play therapy for a child exhibiting emotional disturbance due to a failure to attach (Benedict & Mongoven, 1997).

Tenet 5 Treatment Specificity

If, in treating a case, you don't know what you want to accomplish, that is, specific treatment goals or how to accomplish your goals, that is, specific strategies, you are not likely to accomplish anything. Thus, prescriptive play therapists look to prescribe a specific intervention to alleviate a client's problem. This involves formulating, at the outset of therapy, clearly defined treatment goals and detailed, "nuts and bolts" strategies for achieving these goals. The prescriptive therapist prefers to have a blueprint to follow in a session rather than "winging" it or improvising throughout the entire session.

Because specific treatment is sought, this often results in manualizing treatment by prescribing a set of session-by-session guidelines that instruct or inform the user how to do a certain intervention. Treatment manuals based on outcome and component analysis research are a valuable resource for practitioners. If you want to develop, evaluate, or use scientifically supported treatment, there really is no viable alternative to codifying treatment issues and strategies in some form of manual (Kazdin & Kendall, 1998).

A manual is not meant as a rigid straitjacket but as a set of guidelines to be adapted as needed to individual cases. Analogous to a flight plan or IEP, a treatment manual offers explicit instructions on how to conduct treatment. In recent years, a number of play-based manuals have been published, including treatment manuals for sexually abused children, bereaved children, angry children, and children with social skills deficits. Such detailed manuals facilitate replication of effective treatment by independent investigators, making clear exactly what the therapist did to produce change.

In summary, prescriptive therapists believe in manuals and in the axiom that the best method for ensuring optimization of practice is to train therapists to use treatment models (specific procedures) that have been shown by empirical studies to work for clients with a particular diagnosis.

Tenet 6 Comprehensive Assessment

The prescriptive approach begins with a comprehensive assessment of the symptoms and determinants (internal and external) of a client's problem. Multiple sources and methods of assessment (interview, rating scales, projective techniques) are used to gather data. Based on this information, an individualized case formulation is conducted before initiation of therapy. A case formulation is a descriptive and explanatory summary of the client's most important issues/problems (as well as strengths) and the probable causal or contributory variables. The case formulation also includes the treatment goals and plans, predicted obstacles, and a means for evaluating progress.

An individually tailored intervention is the goal of this assessment and case formulation. As the treatment proceeds, the therapist collects more assessment data to evaluate the effects of treatment and to revise the intervention as needed.

Tenet 7 Multicomponent

Because the prescriptive approach is not confined by single-school theories, prescriptive therapists often combine diverse theories and techniques to strengthen an intervention. Thus, individual, group, and family play strategies may be integrated to treat a particular case, as well as psychodynamic, client-centered, behavioral, and ecosystemic strategies. A multicomponent, multimodal intervention reflects the fact that most psychological disorders are complex and multidimensional; that is, they have a biopsychosocial origin. Because most disorders are multidetermined, they need a multifaceted remedy.

Tenet 8 Pragmatic

Prescriptive therapists espouse this practical attitude: If it works, use it. Pragmatism is based on the philosophical orientation of William James, John Dewey, and Charles Pierce. The central idea is that the truth of a theory or the value of practice is demonstrated by its *usefulness* (Fishman, 1998). The best therapeutic approach is the one that gets the job done with an individual case in the most cost-effective manner. Pragmatists do not let theoretical elegance or biases bind them to what works and what doesn't work for a disorder in the real world.

Tenet 9 Realistic

The prescriptive play therapist seeks a realistic appraisal of the potential as well as the limitations of what psychotherapy can accomplish. By making greater use of short-term or time-limited play approaches (Kaduson & Schaefer, 2000; Schaefer, Jacobson, & Ghahramanlou, 2000), prescriptive therapists are abandoning the rather perfectionistic goals that once dominated the child therapy scene. They now realize that psychotherapy rarely heals completely or permanently, and they are thus often willing to settle for amelioration instead of cure. Because so many clients terminate prematurely, they may try to effect change in only a few sessions. They have become more tolerant of the fact that many clients are in need of recurrent help as they attempt to cope with differing developmental tasks. In short, the goal is to be a "good-enough" play therapist, not a perfect one, as we attempt to resolve complex disorders with limited knowledge and within a limited time span.

Because play therapy is not a panacea for all client problems, prescriptive therapists employed it as an adjunct therapy with some problems and not at all for certain disorders where an alternative intervention has been proven clearly superior.

Tenet 10 Practice Guidelines

The basic premise behind practice guidelines is the belief that science has matured enough to provide at least some guidance about practice quality. Treatment guidelines that direct therapists to the interventions that have proven most effective for certain disorders have the potential to improve the practice of prescriptive play therapists. Practice guidelines highlight specific treatments for specific disorders based on available empirical studies. They are meant to aid in clinical decision making, not dictate or take precedence over it.

Based on a review of the literature, a list of play interventions that have proven effective with various childhood disorders is provided in Table 14.2. Typically, clinical guidelines are promulgated by a task force convened by a professional organization. The task force recommends the best treatments based on the available scientific evidence. This is an important way to link clinical practice with clinical science (Hayes & Gregg, 2001).

The American Psychological Association, Division of Clinical Psychology, has created a special task force whose express purpose is to promote the dissemination of empirically validated psychological treatments. The task force initially identified and published 22 "well-established" treatments for 21 different syndromes. It is hoped that the Association for Play Therapy will soon establish such an interdisciplinary task force to develop and promulgate a consensus list of evidence-based treatments.

ROLE OF THE THERAPIST

The therapist who wishes to practice prescriptive play therapy must be familiar with the major theories of play and play therapy. The therapist should develop a

Table 14.2 Practice Guidelines

Childhood Disorder/Condition	Play Interventions with Empirical Support
Fears and phobias	Systematic desensitization (Knell, 2000; Mendez & Garcia, 1996); emotive imagery (King, Molloy, & Ollendick, 1998).
Posttraumatic stress disorder	Release therapy (Galante & Foa, 1986).
Aggression	Play group therapy (Bay-Hinitz, Peterson, & Qualitch, 1994; Dubow, Huesmann, & Eron, 1987; Orlick, 1981).
Adjustment reaction	Release therapy (Brown, Curry, & Tittnich, 1971; Burstein & Meichenbaum, 1979; Rae, Werchel, & Sanner, 1989).
Oppositional/defiant	Parent-child interaction therapy (Eyberg & Boggs, 1998).
ADHD	Cognitive-behavioral play therapy (Kaduson, 2000).
Sexually abused	Abuse-specific play therapy (Fenkelhor & Berliner, 1995; Corder, 2000).
Elective mutism	Cognitive-behavioral play therapy (Knell, 1993).
Anxiety	Cognitive-behavioral play therapy (Barrett, 1999).
OCD	Cognitive-behavioral play therapy (March & Mulle, 1995).
Obesity	Play group therapy (White & Gauvin, 1999).
Peer relationship difficulties	Play group therapy (Schaefer, Jacobson, & Ghahramanlou, 2000).
Reactive attachment disorder	Theraplay (Booth & Koller, 1998).
Anger	Cognitive-behavioral (Lochman, Fitzgerald, & Whidby, 1999).
Autism	Behavioral play therapy (Rogers, 1991); play group therapy (Wolfberg & Schuler, 1993).
Chronic illness	Filial (Van Fleet, 2000).
Children of divorce	Play group therapy (Pedro-Carroll & Cowen, 1985); filial (Bratton, 1998).
Bereaved	Play group therapy (Netel-Gilman, Siegner, & Gilman, 2000; Zambelli & DeRosa, 1992).
Children of alcoholics	Play group therapy (Rohde, 1999).
Foster/adoptive	Filial (Van Fleet, 1994).

clear understanding of play and the way it has been integrated into play therapy, the way play behavior changes with development, the many play materials and techniques now available, and the diverse ways in which these materials and techniques can be modified to deal with specific client populations.

The therapist's role in the prescriptive approach varies depending on the particular play approach that is applied to a case. For example, the therapist is directive and structured when implementing a behavioral approach but nondirective when following a child-centered orientation. The degree to which support, insight, or confrontation is offered depends on the approach chosen. At times, the therapist trains a child's parents to be partners in treatment, while such parent training may be contraindicated in other cases. The prescriptive play therapy approach is best suited to therapists who are flexible and skillful in adapting a particular treatment protocol to their own personal style.

CHALLENGES

It has been suggested that a weakness of the prescriptive approach is its lack of investment in theory generation. Indeed, the main interest of prescriptive therapists is not in the development of single theories but, rather, in the identification of change mechanisms underlying successful psychotherapy of all types and in the development of a prescriptive matching of change mechanisms to underlying determinants of a disorder. In essence, it is a metatheory that transcends single theories of therapeutic change.

Because prescriptive therapists need to be competent in more than one therapeutic orientation, a second challenge for them is the expanded training needs implicit in this approach. As part of their graduate education, prescriptive therapists receive instruction and supervision in one or two major schools of psychotherapy. They then expand their areas of competence by supervision and enrolling in continuing education workshops and institutes. Believing that learning is a lifelong process, they gradually acquire knowledge and skills in the major schools of play therapy, including humanistic, psychodynamic, and cognitive-behavioral, as well as in the three main modalities—individual, group, and family play therapy. For some of the more complex treatments, the traditional weekend continuing education format does not afford sufficient instruction. Hence, new methods of postdegree training of play therapy practitioners are needed, including distance education formats.

A third challenge of the prescriptive approach is that flexibility can deteriorate into a mindless fluidity of approach. According to Hans Eysenck (1981), "Eclecticism can become little more than a mish-mash of theory, a hugger-mugger of procedures, and a hodge-podge of therapies" (p. 2). However, when

you have a rational basis for prescriptive matching, particularly scientific evidence, this challenge can be overcome.

PROMISE

As to the future of prescriptive play therapy, efforts to match specific treatments with specific disorders based on empirical evidence of effectiveness are certain to increase. There will be a growing realization that diagnosis alone is limited as a basis for determining play interventions. Accordingly, research studies designed to aid in client-therapist and client-treatment matching will expand.

Because the complex client-by-therapist-by-treatment interaction lies at the heart of prescriptionism, greater research efforts will be directed toward understanding the change mechanisms in successful play therapy, as well as client and therapist variables that influence treatment.

A third prediction is that the movement toward greater technical specification of the process of play therapy will continue through the development of treatment manuals.

Prescriptive play therapy will continue to be impacted by developments in the area of managed care, with its emphasis on short-term treatments, limited goals, and cost containment. Open-ended, long-term play therapy will increasingly become an intervention that is difficult to afford.

Assessment of client variables at intake will be systematized and expanded as a means of planning a tailored, individualized intervention.

Finally, collaboration among various professional, regulatory, and accreditation bodies will increase to further promulgate treatment guidelines and promote evidence-based standards of practice.

CONCLUSION

This chapter presented an overview of the 10 basic principles of the prescriptive approach to play therapy, together with current challenges and predictions about the future. The cardinal premise of the prescriptive approach is that the more tools you have in your therapeutic toolbox, the more effective you can be in treating a wide range of disorders. Furthermore, scientific evidence rather than personal preference should be the gold standard used in selecting an intervention for a specific disorder.

Most play therapists today more or less employ a prescriptive approach in their practice. This means that there are relatively few "purists," who strictly adhere to a single theoretical orientation. If the phenomenal growth and development

that play therapy experienced in the twentieth century is to continue throughout the twenty-first century, it is my firm belief that it will be because the prescriptive approach becomes more fully and widely implemented by practitioners across the world.

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