# GAME PLAY

## THERAPEUTIC USE OF GAMES WITH CHILDREN AND ADOLESCENTS

THIRD EDITION

EDITED BY

JESSICA STONE | CHARLES E. SCHAEFER


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Part One

# INTRODUCTION

CHAPTER ONE

# Game Play Therapy: Theory and Practice

CHARLES E. SCHAEFER and JESSICA STONE

## HISTORICAL PERSPECTIVE

Children and people across the world have been playing games throughout recorded history. Indeed, archeologists have discovered 5000-year-old board games from Egyptian times. Games not only provide players with a source of amusement and entertainment, but they make important contributions to our general well-being and mental health. The Greek philosophers Aristotle and Plato knew the importance of games in fostering learning and development. Plato recommended that "in teaching children, train them by a kind of game and you will see more clearly the natural bent of each." Recently child therapists have begun to realize that games are an untapped therapeutic resource. The playful aspects of games strengthen players' motivation to engage in therapy and maximizes the therapeutic effect through better client involvement.

## GAME PLAY IN PSYCHOTHERAPY

Loomis's (1957) article describing the use of the game of checkers was the first published article on the therapeutic use of conventional games. Loomis used checkers as a means of handling children's resistances to therapy and introducing interpretations. The first made-for-therapy board game was *The Talking, Feeling, Doing Game*

by the child psychiatrist Richard Gardner, published in 1973. It is still one of the most popular tools used in child psychotherapy. Because games are designed to be enjoyable and interesting, they are powerful motivational tools for children to engage in the work of therapy.

In particular, latency-aged (aged ~5–onset of puberty) children are drawn to board games. Stone (2016, p. 313) asserts that "some of the important aspects of playing games include communicating verbally and nonverbally, reciprocal respect, learning how to share, patience, taking turns, and having fun while connecting with others." When children reach elementary school age, they become more reality oriented, so structured games become more attractive to them than sensory play or fantasy play with dolls.

The use of therapeutic games by child and adolescent therapists has increased dramatically in the past few decades, and the number of available games has mushroomed. There are now over 1000 games available for treating the psychological and social problems of youth. Game play therapy is a frequent treatment choice for youth by therapists of diverse orientations, including psychoanalytic (Bellinson, 2002), Gestalt (Carroll & Oaklander, 1997), Adlerian (Kottman & Meany-Walen, 2016), and cognitive-behavioral (Knell, 1997).

## GAME PLAY THERAPY: BASIC CONCEPTS

### Definition of a *Game*

A *game* can be defined as an interactional activity of a competitive or cooperative nature involving one or more players who play by a set of rules that explain the content of the game. According to Schaefer and Reid (1986), games have six basic characteristics:

1. Playing a game is an enjoyable activity.
2. Games have an as-if quality that separates them from real life and allows for fantasy experiences.
3. Rules exist or are created that define and restrict the behavior of the players and add organization and structure to the game.
4. A contest is implied or explicit in games, in that players complete either with each other or with themselves in order to achieve a goal.
5. Games, by virtue of their structured makeup, pose a challenge to players. At the lowest level, the challenge is to play with other people in a

self-controlled, cooperative fashion. More complex games require more in terms of emotional control, intellect, and social skills.

6. Game playing usually involves interaction between two or more players.

### Types of Games

Games can be classified into three main types in terms of what determines the outcome (Sutton-Smith & Roberts, 1971): (i) games of physical skill, in which the outcome is determined by the players' motor activities; (ii) games of strategy, in which rational choices among possible courses of action determine the outcome; and (iii) games of chance, in which the outcome is uncontrolled by the players (e.g., guesses or some sort of artifact such as a die or a wheel).

### Therapeutic Powers of Game Play

Among the multiple therapeutic benefits of game play are the following:

1. *Therapeutic alliance*. Experiencing mutually positive affect through playing a game together helps establish rapport and a working alliance between therapist and child.
2. *Self-control*. The focus of many games is to help the child learn self-control coping skills, such as anger management, and relaxation (Swanson, 1986).
3. *Moral development*. Games are activities in which the fundamental elements of moral development–rule conformity and acceptance of group socialization norms—are integrated components of the play process (Piaget, 1965; Serok & Blum, 1983).
4. *Self-expression*. The intense affective involvement that commonly accompanies game playing, together with their separation from reality constraints, tends to result in the expression of feelings, thoughts, and attitudes that ordinarily would not be disclosed (Capell, 1968). Moreover, integrating games with the expressive arts (e.g., Winnicott's Squiggle Game [Ziegler, 1976]), facilitates a child's self-expression by combining elements of drawing, storytelling, and game play.
5. *Executive functioning skills*. Strategy games like mancala help children learn to slow down, pay close attention, stop and think, plan ahead, and anticipate consequences of their actions (Diamond & Lee, 2011).

6. *Mood elevation*. Among the numerous positive emotions triggered by game play are excitement, enjoyment, interest, flow elation (flow), and fun.
7. *Self-esteem*. Accomplishing the goals of a game gives players a sense of achievement and competence.
8. *Stress release*. For children under stress, such as those about to undergo a medical procedure, games provide a form of escape from reality for a while.
9. *Attachment formation*. Playing nurturing games enhances attachment feelings between caregivers and children.
10. *Social skills*. Games are ideal situations for teaching a range of social skills, including taking turns, sharing, cooperation, conflict resolution, and good sportsmanship (Oden & Asher, 1977).

## ADVANCES IN THE PRACTICE OF GAME PLAY THERAPY

There have been a number of major advances in the field since the publication of the second edition of *Game Play: Therapeutic Use of Childhood Games* (Schaefer & Reid, 2001). Among the most significant are these five:

1. There has been a great increase in the number and quality of readily available therapeutic games for children and adolescents.
2. There are now "disorder-specific" games designed to treat all the common presenting problems of youth, including internalizing disorders (e.g., anxiety, depression); externalizing disorders (e.g., aggression, attention-deficit/hyperactivity disorder); and developmental disorders (e.g., autism spectrum disorders). This matching of specific game treatments for specific disorders improves their efficacy as well as the practice of short-term psychotherapy.
3. The clinical use of electronic games with children and adolescents has expanded rapidly with proven effectiveness.
4. In addition to specifically designed psychotherapy games, a growing number of commercially available games are being modified for therapeutic purposes.
5. In the past, game play therapy was used an as ancillary intervention to other forms of therapy. Currently, game play therapy is used more and more as the sole or primary intervention for a variety childhood disorders.

## SUMMARY AND CONCLUSION

Game play therapy is an exciting and rapidly expanding clinical frontier. This structured form of play therapy appeals to child and adolescent therapists because of its time-limited nature, popularity with youth, and efficacy for such specific disorders, such as aggression, anxieties, fears, and attention-deficit/hyperactivity disorder. Games can be adapted for clinical, group, and school setting.

Designed for both beginning and experienced clinicians, this practical guide book provides expert guidance on how to select and apply games to maximize their therapeutic potential. Indeed, the wide scope of therapy games enables one to implement all major therapeutic powers of play.

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CHAPTER TWO

# Parent Involvement in Children's Game Play: Accelerating the Therapeutic Impact

MARY ANNE PEABODY

## INTRODUCTION

Children deserve empirically supported interventions to prevent or treat mental health concerns. Developmentally, children must rely on adults, typically their parents, to locate and provide them with the services they need. While it is parents who are chiefly responsible for initiating treatment and facilitating attendance of their child (Nock & Kazdin, 2005), simply ensuring a child attends treatment is not the same as being an engaged parental participant in the therapeutic process. Parent participation engagement (PPE) includes sharing opinions and providing one's point of view, asking questions, discussing feelings, as well as participation in therapeutic activities, such as games and role-plays (Haine-Schlagel & Walsh, 2015; Karver, Handelsman, Fields, & Bickman, 2005; Staudt, 2007). PPE also includes parental follow-through with therapist-generated homework, such as practicing the social skill of turn-taking during board game playing to advance treatment goals (Hoagwood, 2005; Karver et al., 2005).

Prior research indicates when PPE is high, treatment effectiveness improves (Dowell & Ogles, 2010; Friedberg & McClure, 2015; Karver, Handelsman, Fields,

& Bickman, 2006). In addition, parent-focused intervention strategies are a key feature of many evidence-based treatments for children across many disorders, including disruptive behaviors (Eyberg, Nelson, & Boggs, 2008), attention-deficit/hyperactivity disorder (Evans, Owens, & Bunford, 2014), depression (David-Ferdon & Kaslow, 2008), and anxiety (Silverman, Pina, & Viswesvaran, 2008). With this evidentiary support across disparate treatment approaches and disorders, it is important to examine how play therapists can utilize specific interventions to engage parents as active participants in the treatment of their child. Given that (i) PPE has been demonstrated to improve treatment effectiveness and (ii) many evidence-based treatments have PPE strategies as key features of their treatment process (Dowell & Ogles, 2010; Friedberg & McClure, 2015; Karver et al., 2006), it is incumbent upon play therapists to gain further knowledge regarding PPE strategies to inform their clinical practice.

Specific to the field of play therapy, meta-analysis studies examined the role of parents in treatment with promising results (Bratton et al., 2005; LeBlanc & Ritchie, 2001). These studies combined and compared parents-as-therapist therapies to other therapies that did not involve the parent. Involving parents in treatment and training them in therapeutic play therapy skills clearly outperformed all other modes of play therapy (Bratton, Ray, Rhine, & Jones, 2005; LeBlanc & Ritchie, 2001; Lin & Bratton, 2015).

Several play therapy approaches position parents or primary caregivers as central agents of change in the therapy process. These approaches include filial therapy (Guerney, 1964), child-parent relationship therapy (Landreth & Bratton, 2006), and Theraplay (Booth & Jernberg, 2010). Additionally, other orientations such as Adlerian (Meany-Whalen, Bratton, & Kottman, 2014), Ecosystemic (O'Connor, 2015), psychoanalytic (Bromfield, 2003), and cognitive-behavioral play therapy (Knell, 2009) all encourage parent engagement to varying degrees throughout the treatment process. This list is certainly not an exhaustive one, as most child clinicians understand the significant influence parents play on children's development and well-being and focus on parental roles regardless of orientation or treatment approach (Kazdin & Weisz, 1998).

One play therapy treatment approach that requires therapists to be knowledgeable of evidence-based treatments is prescriptive play therapy (Schaefer, 2018). Using the knowledge that certain treatments are more effective than others for specific disorders (Siev & Chambless, 2007), prescriptive play therapists focus on

multimodal methods of assessing client needs and developing an evidence-based treatment plan that tailors the play intervention to meet individual clients' presenting symptoms, needs, culture, and personal preferences (Schaefer, 2018) while taking into consideration the therapist's own judgment, educational training, and experience (Kazdin, Siegel, & Bass, 1990; Schaefer, 2018; Schaefer & Drewes, 2015). In this chapter, we conceptualize a prescriptive play therapy approach that guides therapist clinical reasoning to engage parental participation through the use of game play therapy. Using this approach, the play therapist develops a treatment plan based on the individual client's specific problem and situation while simultaneously increasing PPE.

## PARENTAL PARTICIPATION AND ENGAGEMENT IN GAME PLAY THERAPY

Game play therapy is a psychotherapeutic method that utilizes a variety of game forms, such as board games or card games, to help apply the therapeutic powers of play (Schaefer & Peabody, 2016). In game play therapy, a mental health professional purposefully utilizes games for diagnostic and therapeutic purposes. These games may include role-playing, communication, socialization, problem-solving, and electronic games (Schaefer & Reid, 2001; Stone, 2015; Swank, 2008).

For many parents, games were the first way they naturally interacted with their newborn, often imitating the sounds and behavior of the baby in a reciprocal manner. Now, as their child is older, this reciprocity skill might well be reintroduced if the therapist decides that the parent can serve as a "co-provider" of treatment. Conversely, many families seek the help of therapists when they are experiencing a heightened level of stress, trauma, or difficulty; in such cases, the parent may not be emotionally available for playful game-based connections. When children lack a responsive, joyful relationship with their parents, or when they have been traumatized in some way, the parent-child bond may be disrupted or weakened, leading to a host of behavioral or emotional problems. The therapist's clinical decision-making process must include if, when, and how parent involvement should occur. Questions the therapist might consider include these: Should PPE occur in parent consultation sessions only without the presence of the child? If so, why? Should the parent participate in game play therapy during all sessions, some sessions, as homework, or in some combination? Should the frequency of PPE in game play therapy increase over the course of treatment?

When the therapist's clinical reasoning includes the decision to actively involve parents in game play therapy treatment, the result has the potential to produce a parallel growth experience for both child and parent. Involving the parent in children's game play therapy is like adding a spicy accelerant to an already powerful therapeutic recipe. Therapeutic game play has the potential to speed up interactions, cohesion, and emotional sharing. It may hasten unexpected connections, metaphoric meaning making, and playfulness between parent and child in new ways. Adding game therapy into the therapist-parent-child therapeutic experience may create a remarkable amplification effect, enhancing shared emotional connections, cognitive learning, and healing that deepens treatment impact.

## THERAPEUTIC POWERS OF GAME PLAY SPECIFIC TO PARENT-CHILD INTERACTION

Foundational to play therapy is the belief that play behaviors are a broad spectrum of active forces that produce behavior change (Schaefer & Drewes, 2013). To illustrate how using game therapy can foster therapeutic change and increase PPE, we first examine the role of family dynamics when using game therapy, then review four specific powers of play—positive emotion, self-expression, direct teaching, and moral development—that are activated though game playing. The author recognizes there are other therapeutic powers of play could be further examined and that the four chosen may blend depending on the treatment being done and the client being served. Readers are encouraged to become well versed in all play mechanisms that produce change in a client (Schaefer & Drewes, 2013).

### Observing Family Dynamics

One of the strengths in using game play therapy with children and their parents is the ability to observe family dynamics throughout treatment. Game play with parents and children informs the clinician as to relational and communication patterns, parenting style, problem-solving skills, strengths, and overall functioning (Gil, 1994; Sharp, 2005). The therapist can carefully select, pace, and decide if a specific game should only be played in session or assigned as homework. Intergenerational game play allows the therapist to witness, teach, and support parents in becoming facilitators of change within their own family system.

### Positive Emotion

When families who are experiencing stress begin to play together, laughter often occurs, endorphins are released, and feelings of well-being may emerge. These descriptions encompass the positive emotions associated with one of the therapeutic powers of play. Becoming a playful parent builds connections, improves relationships in families, and teaches the parent strategies to enter the emotional world of their children (Cohen, 2001). Play naturally generates positive emotions and is fun (Kottman, 2013). By extending this therapeutic power of play to parents and by teaching parents about the role of positive emotions when they engage in playful interactions with their children, therapists can maximize this healing power.

### Self-Expression

Children are naturally comfortable with using play activities, materials, and toys as a way to express themselves (Landreth, 2012). Using games to communicate provides the necessary psychological distance for children and parents to discuss thoughts and feelings that may be difficult to express otherwise. In psychotherapeutic game play, the use of direct questions on game cards accelerates the discussion, bringing responses to questions directly out in the open space between child and parent. Conversely, spontaneous self-expression elicited during game playing allows the parent the opportunity to pay close attention to the child's nonverbal and verbal communication, showing interest and curiosity through therapeutic responding. Games are spaces where communication skills such as learning to listen and not interrupt and to accept the perspectives of others can be a part of the self-expression competencies gained. This self-expression power of play promotes psychological development not only in the child but in the parent as well.

### Direct Teaching

Teachers and parents have historically used games as a way to increase learning for both children and adults (Neef, Perrin, Haberlin, & Rodrigues, 2011). Games capture children's attention and increases their motivation to learn (Schaefer & Drewes, 2011), making them valuable tools for direct teaching of psychoeducational content for both children and parents. According to Fraser (2013), game play

is valuable as a direct teaching therapeutic tool reaching across ages, groups, and individuals and at home, in school, and in clinical spaces. Therapists have used psychotherapeutic games as direct teaching techniques to address treatment goals around feeling identification, acquisition of cognitive positive thinking, problem solving, social skills through behavioral rehearsal, and coping skills development (Hromek & Roffrey, 2009; Nash, 2013; Swank, 2008). Game play includes a wide range of cooperative skills that can be directly taught, including turn taking, problem solving, good sportsmanship, empathy, rule following, and reciprocity (Nash, 2013).

## Moral Development

Moral development involves the development of thoughts, feelings, and behaviors regarding rules and conventions about what people should do in their interactions with other people (Santrock, 2019, p. 283). Piaget (1965) believed moral development was fostered when children have to negotiate relationships, rules, and play with others and asserted that children's spontaneous rule-making and rule-enforcing behavior during informal and unsupervised play situations was a critical experience for the development of mature moral judgment. More recently, researchers have examined the extent to which children are aware of right and wrong, are sensitive to violating rules, have a capacity to show empathy, and can indicate discomfort after transgressions, all internal regulators that integrate moral thoughts, feelings, and behaviors (Kochanska & Aksan, 2007; Kochanska & Kim, 2013).

Society is rule bound, and citizens of a society consent to abide by laws and rules. Therefore, games are a microcosm of society, as they inherently include explicit agreed-upon rules. In many families, games are part of family traditions and interactions, cloaked in emotional experiences where family lessons regarding personal boundaries, rules, social, and unacceptable behaviors are learned and practiced (Hinojosa & Kramer, 2008).

Thompson and Newton (2010) found that children who have a healthy relationship with their parents are more willing to embrace their parents' morals and values. Therefore, playing games together may serve multiple purposes for the parent-child dyad, in terms of both building healthy relationships and as

opportunities to transmit morals and values. Parents can use game play to guide and influence valued behaviors, thoughts, and beliefs that align with the moral conduct that they want to impart to their children as members of a civilized society.

## DESCRIPTION OF TWO GAMES

A game that capitalizes on relationship building through experiencing positive emotions is the award-winning family board game called *Silly Street* (Buffalo Games). The playful nature of this game, which is available from www.playsillystreet.com, often has parents and children laughing and enjoying one another in a fun and connecting way. *Silly Street* was developed for players age 4 and above.

To begin, players build a puzzle, which becomes the actual game board. Next, players select game pieces and, one at a time, draw a game card and follow the instructions on the card. The game cards are the key to the positive emotions that the game elicits, with some cards awarding points based on a silly action, some having players compete for points, and some allowing players to grant points to another player. The cards also indicate the appropriate number of spaces moved after a player has completed the task. The developers created *Silly Street* as a character-building game, with a focus on building verbal and nonverbal communication skills. However, perhaps the greatest benefit of *Silly Street* is the joyous moments of positive emotion exchanged that ignite emotional processes and act as a critical change mechanism for strengthening relationships.

A second family game with individual customization capability is *Create a Game* (Crayola). This game can be personalized to teach a variety of concepts across a variety of disorders. A therapist might use an integrated approach, for example, using cognitive-behavioral therapy and family play therapy to focus on cognitive, emotional, and interpersonal processes. The play therapist might customize the game to focus on specific skills, such as positive self-talk, changing automatic negative thoughts, distortions and misconceptions, or feeling identification.

Besides the kits offered by Crayola, many teacher supply stores sell blank game boards, cards, spinners, and dice. *Create a Game* can be used easily with the child and parent during the play therapy session or assigned as homework. Depending on treatment goals, the therapist may need to coach parents to ensure the child

remains in the role of game developer; the parent role is to support the creation. The family can then bring the game to the next therapy session, and all can play together.

## CLINICAL APPLICATIONS OF INTERGENERATIONAL GAME PLAY

When the parent-child relationship is experiencing difficulty, intergenerational game play can create a time and space for family playfulness while building channels of communication. Alternatively, play therapists can use game play to directly teach parents about child development ages/stages through discussing appropriate game selection and length of time to play a game, matching the cognitive, motor, and social complexity of the game to the developmental level of the child. Thinking through each of these steps as part of the clinical decision-making process tailors game selection to therapeutic needs and treatment goals.

*Cognitive complexity* refers to a mix of problem-solving processes inherent in game play that involve both mastering steps through the actual game as well as the number of steps required. Patience, persistence, and self-control are key cognitive and self-regulation skills in many games, and different children develop these skills at various times. *Motor complexity* is related to spatial, visual-motor control, and whether the child can easily move or manipulate the pieces or game cards around the game board without major frustration. *Social complexity* involves how much of an opportunity the game affords for sharing and cooperation, adult attention, and interaction. Depending on what therapeutic goals are involved in the treatment plan, different games vary in these domains of complexity.

This thinking through and tailoring the intervention for the child and parents is especially important if the therapist uses games as therapeutic homework. Therapy homework completion is one important element of parent engagement (Haine-Schlagel & Walsh, 2015; Lindsey et al., 2014) and has been linked to linked to positive treatment outcomes (Baydar, Ried, & Webster-Stratton, 2003). In child therapy, parent homework naturally lends itself to the goal of enhancing skill acquisition and generalization outside of treatment sessions (Becker et al., 2015; Nock & Kazdin, 2005). Thus, it is a core practice in many evidence-based interventions for children (Garland, Hawley, Brookman-Frazee, & Hurlburt, 2008).