PLAY THERAPY

Clinician Manual & Session Guide

MindLift Alliance Counseling, Assessment & Education Services

Clinical Use Notice

This original guide is an educational clinician reference. Play therapy is a specialized clinical practice requiring developmentally informed training, supervision/consultation, and practice within professional competence. It is not a substitute for formal play-therapy education, independent clinical judgment, or applicable legal/ethical requirements.

Meet children where they are - through the language of play.

1. What Play Therapy Is

Play therapy uses the therapeutic powers of play within a defined theoretical and relational framework to help children communicate, regulate, process experience, practice new responses, and support healthy development. Because many children cannot yet explain complex internal experiences in adult language, play can provide a developmentally appropriate pathway for expression and change.

Two Broad Clinical Styles

- Child-centered / nondirective: the clinician follows the child's lead, reflects feelings and meaning, tracks behavior, communicates acceptance, supports responsibility, and sets therapeutic limits only when needed.
- Directive / prescriptive: the clinician intentionally introduces activities, stories, games, art, role-play, coping practice, or problem-solving tasks linked to treatment goals.
- Integrative play therapy: the clinician selects developmentally appropriate interventions from more than one model while maintaining a coherent case formulation.

Clinical Principle

Play is not simply a reward or distraction. In play therapy, the relationship, materials, therapist responses, limits, and therapeutic process are intentionally connected to clinical goals.

2. Assessment Before Beginning

- Clarify referral concern, developmental history, family structure, school functioning, peer relationships, medical/psychiatric history, trauma/adversity, strengths, culture, language, and current stressors.
- Interview caregivers about behavior patterns, antecedents, consequences, parenting responses, family routines, and treatment goals.
- Meet with the child in a developmentally appropriate way and explain therapy, privacy, and its limits.
- Assess safety: suicidal/self-harm concerns when developmentally indicated, aggression, abuse/neglect concerns, exposure to violence, elopement, unsafe sexual behavior, and other immediate risks.
- Screen for conditions that may require additional assessment or adaptation, including ADHD, autism, anxiety, trauma, depression, learning difficulties, developmental delays, and disruptive behavior disorders.
- Clarify custody, consent, access to records, and caregiver participation when parents are separated or litigation is involved.

Do Not Over-Interpret Play

A single toy choice, drawing, story, or play theme is not diagnostic evidence by itself. Form hypotheses from repeated patterns plus history, observation, collateral information, standardized measures when appropriate, and the broader clinical context.

3. Treatment Planning

Translate the Referral Problem Into Play-Therapy Goals

Presenting Concern	Observable Treatment Goal	Possible Play-Therapy Focus
Frequent meltdowns	Increase recovery from frustration and use of coping/communication skills	Emotion identification, limit setting, regulation practice, mastery play
Anxiety / avoidance	Increase approach behavior and tolerance of uncertainty	Symbolic expression, graded play-based exposure, coping rehearsal
Grief / loss	Increase ability to express and integrate grief reactions	Memory play, art/story work, symbolic connection, caregiver support
Aggression	Reduce unsafe behavior and increase safe expression/problem solving	Therapeutic limits, emotion language, role-play, alternative actions
Family transition	Improve emotional expression and sense of predictability/safety	Family figures, narratives, routines, parent-child sessions

4. Preparing the Play Environment

- Choose materials that allow expression, mastery, nurturance, aggression in safe symbolic form, family/relationship themes, creativity, and real-life rehearsal.
- Use durable, developmentally appropriate materials that can be safely cleaned and monitored.
- Keep the environment predictable. Consistent placement and session routines can increase psychological safety.
- Avoid an overwhelming number of highly stimulating toys that make purposeful observation difficult.
- Consider cultural representation in dolls, figures, family structures, skin tones, occupations, abilities, and everyday objects.
- For telehealth, collaborate with caregivers on a simple play kit and privacy/safety plan.

Common Categories of Materials

- People/family figures and dollhouse materials
- Animals, vehicles, blocks, construction materials
- Art supplies, clay, paper, puppets, masks
- Nurturing/medical/home-care items
- Safe aggression/release materials such as foam items or sturdy figures
- Games for turn-taking, frustration tolerance, problem solving, and social skills
- Sensory/grounding materials when clinically appropriate

5. Child-Centered Play Therapy: Core Responses

- Tracking: describe what the child is doing without interrogation. Example: “You’re lining every animal up very carefully.”
- Reflecting feeling: name the emotional experience tentatively. Example: “That was really frustrating when it fell down.”
- Reflecting meaning/content: capture what seems important in the play without making a definitive interpretation.
- Returning responsibility: support the child’s problem-solving capacity. Example: “You’re deciding what will work best.”
- Facilitating choice and responsibility: identify real choices and natural consequences.
- Esteem-building: reflect effort, persistence, decision-making, and self-direction rather than giving constant praise.
- Relationship responses: communicate presence and acceptance. Example: “You want me to understand exactly how this works.”

Use Fewer Questions

In nondirective play, repeated questions can shift the child into adult-led performance. Prefer tracking, reflection, and genuine relational responses unless information is clinically necessary.

6. Therapeutic Limit Setting

Limits preserve safety, protect the relationship and materials, and help children experience boundaries without shame. Set only necessary limits and use calm, predictable language.

ACT Limit-Setting Sequence

1. Acknowledge the feeling, wish, or intention: “You’re really angry and you want to throw that.”
2. Communicate the limit: “The blocks are not for throwing at people.”
3. Target an acceptable alternative: “You can throw the foam ball at the wall, or you can tell me how mad you are.”

If the Limit Is Repeated

State the consequence clearly and carry it out consistently when necessary. Avoid threats, lectures, power struggles, humiliation, or consequences that are unrelated to safety and treatment.

7. Directive Play Interventions

Directive interventions should be selected from the formulation rather than used as generic activities.

- Emotion identification: feelings charades, emotion drawing, body maps, color/shape metaphors.
- Coping and regulation: breathing games, grounding scavenger hunts, sensory tools, coping-card creation.
- Cognitive/behavioral work: thought detective games, coping stories, role-play, graded exposure, reinforcement planning.
- Social skills: turn-taking games, perspective-taking, flexible thinking, conflict rehearsal.
- Trauma-informed work: stabilization, safety, narrative/symbolic processing only within the clinician’s competence and appropriate trauma model.
- Grief: memory boxes, continuing-bond activities, symbolic goodbye/hello rituals, story work.
- Family work: family play tasks, cooperative games, parent-child coaching, communication practice.

8. Observing Play Themes Without Pathologizing

Themes are best understood longitudinally. Document what occurred and what changed over time before making meaning.

Possible Theme Domains

- Safety / danger / rescue
- Power / control / helplessness
- Nurturance / rejection / abandonment
- Competence / mastery / failure
- Aggression / protection / revenge
- Family roles / separation / reunion
- Rules / punishment / fairness
- Identity / belonging / difference
- Loss / death / repair / renewal

Document Observation Separately From Interpretation

Example

Observation: “Child repeatedly placed the baby figure outside the house and had adult figures lock the door.”
Clinical hypothesis: “Theme may relate to exclusion/separation; continue observing and explore in context of known family transitions.”

9. Parent & Caregiver Involvement

- Set expectations early: play therapy is not child-only work when caregiver behavior, routines, attachment, or family stress affect the presenting concern.
- Obtain regular caregiver updates without turning every child session into a report to the parent.
- Protect the child’s therapeutic privacy while sharing safety concerns, treatment themes at an appropriate level, progress, and caregiver recommendations.
- Coach caregivers to notice and reinforce regulation, effort, communication, and flexible behavior.
- Teach developmentally appropriate limit setting and co-regulation.
- Address family accommodation, inconsistent consequences, excessive reassurance, high conflict, or parent-child interaction patterns when relevant.
- Consider filial/parent-child play approaches when trained and clinically appropriate.

Confidentiality With Children

Explain to both child and caregiver what information is private, what will be shared for treatment progress, and what must be disclosed for safety or legal reasons. Follow applicable law, licensing rules, custody orders, and practice policy.

10. Trauma, Abuse Disclosures & Forensic Caution

- Do not lead the child or repeatedly question for details when abuse is suspected or disclosed.
- Respond calmly, supportively, and without promising secrecy.
- Document the child's spontaneous words as accurately as possible and distinguish direct statements from clinician interpretation.
- Follow mandatory-reporting requirements and organizational procedures promptly when a report is required.
- Avoid using play themes as proof that abuse occurred.
- When forensic interviewing or custody evaluation is needed, maintain clear role boundaries and refer to appropriately trained professionals.

Therapy Is Not a Forensic Interview

The therapist's role is treatment and safety unless separately qualified and retained for a forensic function. Mixing roles can create ethical, legal, and clinical problems.

11. Suggested Session Structure

1. Brief caregiver transition/check-in when indicated (often 3-5 minutes, not a full parent session).
2. Predictable entry into the play space and reminder of any essential limits.
3. Therapeutic play period: child-centered, directive, or integrated based on the treatment plan.
4. Clinician tracks themes, regulation, relationship behavior, skills, and changes without over-directing.
5. Give a consistent transition warning before ending.
6. Closure ritual: summarize effort/process, restore materials as appropriate, and support transition back to caregiver.
7. Document observations, interventions, response, risk, and plan.

12. Suggested 10-Session Roadmap

Session	Primary Focus
1	Caregiver intake + developmental/family assessment; define observable goals.
2	Child orientation, rapport, safety, play observation; establish therapeutic limits.
3	Continue assessment through play; identify themes, triggers, strengths and regulation patterns.
4	Target emotion recognition and safe expression; caregiver coaching as needed.
5	Build coping/regulation and frustration-tolerance skills through play.
6	Address core treatment theme using child-centered or

	directive intervention.
7	Practice new responses through role-play, symbolic play, games, or graded exposure.
8	Parent-child/family intervention when clinically indicated; support generalization at home.
9	Consolidate mastery, flexibility and coping; review progress with caregiver.
10	Termination/transition: review gains, prepare for setbacks, create maintenance plan and closure ritual.

13. Clinician Documentation Template

Progress Note Prompt

Presenting target / caregiver update: _____
Child affect/regulation on arrival: _____
Play/activity used: _____
Observable play themes/behaviors: _____
Clinician interventions (tracking, reflection, limit setting, directive activity, parent coaching, etc.): _____
Child response / skill use / relational changes: _____
Safety concerns / disclosures / actions: _____
Caregiver communication: _____
Progress toward treatment goal: _____
Plan for next session: _____

14. Quick Reference: Helpful vs. Unhelpful

Helpful	Use Caution / Avoid
Reflect feelings and behavior	Interrogate the child about every toy choice
Use consistent, necessary limits	Create unnecessary rules that restrict expression
Observe repeated patterns over time	Diagnose from one drawing or play scene
Collaborate with caregivers	Tell parents every detail of the child's play
Use developmentally appropriate language	Expect adult-style verbal insight
Document observable behavior	Write speculative interpretations as facts
Refer/consult outside competence	Use play therapy techniques without adequate training

15. Client/Caregiver Handout: What Parents Can Expect

- Children often communicate through play before they can explain everything in words.
- The therapist may not ask your child to “talk about the problem” every session.
- Progress may first appear as better regulation, more flexible play, improved communication, or changes in behavior.
- Your participation may include caregiver meetings, parenting support, home practice, or parent-child sessions.
- The therapist will protect your child’s privacy while communicating what you need to support treatment and safety.
- Consistency matters. Skills practiced in therapy become stronger when caregivers use similar language and limits at home.

For Caregivers
You do not have to analyze your child’s play at home. Focus on connection, predictable routines, calm limits, and noticing healthy efforts. Healing is a process, not a switch.

16. When to Refer / Consult

- Acute safety risk, severe aggression, significant self-harm/suicidality, or need for a higher level of care.
- Suspected abuse requiring mandated reporting and/or specialized forensic response.
- Severe developmental, neuropsychological, psychiatric, or medical questions requiring additional evaluation.
- Custody/forensic matters beyond the treating clinician’s role.
- Complex trauma or dissociation beyond clinician competence.
- The clinician lacks specialized play-therapy education, supervision, or experience for the child’s presentation.

Evidence & Professional Resources

- Association for Play Therapy (APT). Definition, training, credentialing, research and best-practice resources. https://www.a4pt.org/
- Association for Play Therapy. Why Play Therapy? Developmentally appropriate use of play and caregiver involvement. https://www.a4pt.org/page/WhyPlayTherapy
- Use current state licensing-board rules, mandatory-reporting law, custody/consent requirements, and organizational policies for legal/ethical decisions.

MindLift Alliance • Warm. Clear. Professional. Growth-Oriented.