Overview of Play Therapy: Play Therapy with Autism Spectrum Disorder (ASD) and Adlerian Play Therapy

A Summary Paper

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Abstract

Children communicate and learn about the world around them through play. Children with autism lack the natural ability for symbolic or pretend play, but they can learn to engage in symbolic play activities. Children with autism improve in brain functioning, language development, and social interaction through play therapy. Adlerian play therapy is a theoretically based framework of play therapy that utilizes many techniques and concepts to understand children's lifestyle through their play themes and the way they interact with others. This paper explores play therapy, various methods for teaching symbolic play to children with autism, and a synopsis of Adlerian play therapy and concepts.
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Children communicate with the world through play, which helps them to develop social skills. Many areas of growth including intellectual, social, and emotional development relate to how children play (Holmes & Willoughby, 2005). Children develop motor and social skills in safe and supportive conditions during play activities (Naber, et al., 2008). Catherine Garvey is a professor of psychology at the University of Maine who wrote a book titled *Play* in 1977. As defined by Garvey, play is pleasurable and enjoyable, has no goals imposed from the outside, is spontaneous and voluntary, involves engagement from the player, is flexible and changing, and does not have a precise orientation (Mastrangelo, 2009).

Cognitive development starts with manipulative play, then functional play, followed by symbolic play (Naber, et al., 2008). For babies and toddlers, play is work. It is the way children learn about their surroundings and about others that they meet (Youell, 2008). Discretion and inhibition in play is an important diagnostic factor in a child's emotional, psychological, and cognitive development particularly for children with autism (Youell, 2008).

Researchers agree that play is a valuable method of learning for children (Moore & Hall, 2004). The Association for Childhood Education International (ACEI) believes that play is an active and constructive behavior. The ACEI states that play is a crucial and essential part of all children's health, growth, development, and learning across all ages and cultures.

Observing children at play is very useful for childhood professionals who can gain important insights about a child's development by observing their play (Vig, 2007). When working with children with developmental disabilities, play observation is very valuable, since children with developmental problems display unique play patterns (Vig, 2007), such as exploration, goal orientation, enthusiasm, initiative, attention, ways of handling toys, toy selection, and in the amount of play in which they engage.
**Play Therapy**

Play therapy began in the 1940s by Virginia Axline, who is the founder of child-centered play therapy (LeBlanc & Ritchie, 1999). Since children under the age of 11 have not mastered abstract symbols and concepts that are essential for verbal communication and they lack experience in mature use of language, they use play to express feelings, explore relationships and discover themselves (Kottman & Warlick, 1989).

Roger Phillips, who has done empirical research on the process and outcome of play therapy, states that play therapy is a suitable form of therapy for children with emotional and behavioral issues. He also affirmed that play therapy is one of the most commonly agreed upon techniques with these children (Phillips & Landreth, 1998)

A meta-analysis from a sample of 42 studies comprised of 166 individual outcome measures and derived from numerous sources, defined play therapy as the relationship between a child and a trained therapist who uses play activities as the main method of treatment (LeBlanc & Ritchie, 1999). The most significant finding of the meta-analysis was that play therapy is an effective form of treatment for children 12 years and younger who have emotional and behavioral issues.

**Success in Play Therapy**

LeBlanc and Ritchie (1999) identified two characteristics that predict the success of play therapy outcomes: parents’ involvement in play therapy and the number of play therapy sessions. The authors concluded that treatment lasting from 30 to 35 sessions proved to have the most benefit; after that, the benefits of play therapy seemed to decline.

Research shows that approximately 80% of children, boys and girls under age 12, ended treatment successfully (Phillips & Landreth, 1998). Two factors emerged that
contributed to the success of therapy: the relationship between the therapist and the child (88%) and the involvement of the parents or family in treatment (78%) (Phillips & Landreth, 1998).

Consistent with what we know about therapeutic effectiveness in general, certain problems are more amenable to intervention with play therapy. These issues are physical and sexual abuse, depression and withdrawal, acting out or impulse control, and school adjustment or academic difficulties (Phillips & Landreth, 1998).

**Therapeutic Processes of Play Therapy**

Eleven processes explain the change that occurs in children during play therapy (O'Connor, 2002), among which are four cognitive processes. One is schema transformation, which involves changing the child's beliefs or expectations. The second is symbolic exchange, during which the problem becomes clearer to the child. Insight or sorting out meaning of experiences is the third cognitive process, and fourth, skill development facilitates the child learning of adaptive skills.

Affective processes include action or release of feelings, which helps change to take place through play therapy. During emotional experiences, children identify why they feel a certain way. Affective education helps children label and express their emotions. Through emotional regulation, children become skilled at new ways of coping and they become more capable of regulating their emotions (O'Connor, 2002).

Interpersonal processes include validation and support, which assist children with emotional and social growth and development. Supportive scaffolding takes place when the therapist helps the child face their problems. The corrective relationship is where the therapist responds to the child differently than others have in his or her past (O'Connor, 2002). These interpersonal processes enable the child to look at the problem from a different perspective.
Types of Toys Used in Play Therapy

Five categories of toys used in child-centered play therapy include the following: family/nurturing toys, scary toys, aggressive toys, expressive toys, and pretend/fantasy toys (Landreth, 1991). Family/nurturing toys help children explore family relationships. Scary toys investigate fears and past trauma. Aggressive toys examine control and trust issues. Expressive toys enable children to be creative and explore their feelings. Pretend/fantasy toys allow children to learn about relationships and practice new behaviors (Kottman, 1995).

The variety of toys allows children to convey feelings and desires about which they are not aware. Observing children in play with different types of toys makes it possible for the therapist to communicate with children in many different ways.

Theories of Play Therapy and Role of Therapist

Child-centered play therapy. Child-centered play therapy is a type of play therapy introduced by Virginia Axline and modeled on Carl Rogers’ person-centered approach (Menassa, 2009). Absolute faith in the natural tendency of children to have an effect on their own healing within the therapeutic relationship is central to child-centered play therapy, which is genuine, warm, and empathetic. The instrument used for growth and change is the therapist.

Regents Professor at the University of North Texas Dr. Garry L. Landreth has several writings on play therapy and works in promoting the development of play therapy. He is also the founder of the Center for Play Therapy, the largest play therapy training program in the world. According to Landreth, the goals of child-centered play therapy are to assist the child in developing a more positive self-concept, greater responsibility, increased self-direction, self-acceptance and self-reliance, better self-control, and better coping mechanisms (Menassa, 2009).
Structured/directive play therapy. Gove Hambidge developed structured play therapy in 1955. In Hambidge's view, the therapist is to keep the child focused and engaged in play while acting as a facilitator. Structured play therapists choose situations that illustrate the child’s problem. The child-centered play therapist is an "empathetic adult who enters into an authentic, accepting relationship with the child, provides only minimal structure, and trusts in the self-actualizing tendency of the child to reach child-determined goals" (Menassa, 2009, p. 22).

According to Hambidge, the goal of structured play therapy is to minimize the child’s symptoms by the "acting-out principle" in a structured setting. The structured play therapist is "a shifter of scenes who carefully creates play experiences through which the child can release bypassed affect, thereby diminishing maladaptive symptoms and behavior” (Menassa, 2009, p. 23).

Play Therapy with Children Diagnosed With Autism Spectrum Disorder (ASD)

What is Autism?

According to federal guidelines of The Individuals with Disabilities Education Act (IDEA), autism is a developmental disability considerably affecting verbal and nonverbal communication and social interaction, and generally apparent before age three. Other traits often associated with autism are engagement in repetitive activities and stereotypical movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences (Shriver, Allen, & Mathews, 1999).

Autism is not a behavioral, emotional or conduct disorder, or a mental illness. It is a lifelong neurodevelopmental disorder. Currently, no medical testing is available to diagnose autism. Genes may be responsible in autism, as there is a higher rate of autism in affected families (Shriver, Allen, & Mathews, 1999). One of the criteria for autism in the DSM-IV-TR is
"a delay of abnormal functioning in symbolic or imaginative play" (American Psychiatric Association, 2000, p. 75).

**Play Behavior in Autism**

Children with ASD display specific traits in their play behavior, such as lack of eye contact, the need for sameness in both the content and style of play, and peculiar speech. They also have periods of elevated anxiety, withdrawal, and unusual references unrelated to anything that is going on in the play activity (Bromfield, 1989). These children have deficiencies in role-playing, the degree of persistence in their play, and time spent with make-believe conversations (Thorp, Stahmer, & Schreibman, 1995).

In the first phase of play, manipulation of toys, children with autism show atypical features, such as limiting their play to a small selection of objects or an isolated part of a toy (Naber, et al., 2008). They can become preoccupied for long periods with one object. In addition, it is common for children with ASD to pick toys based on the sensory stimulation they provide, such as smell, touch, sound, taste, or sight (Holmes & Willoughby, 2005). Children with ASD also prefer to play with non-toy items like paper, pots and pans, and other household items (Holmes & Willoughby, 2005). Perseveration is the quality seen in play behavior in children with ASD, where the play is very repetitive and lacks imagination.

Children with autism have lower levels of using objects appropriately, less variety in functional play, and show more repetition (Naber, et al., 2008).

Naber states that children with autism have difficulty with symbolic or pretend play and their play is less spontaneous. The majority of children with autism also have mental retardation, but children with autism show even greater deficits in pretend play than children with mental retardation (Vig, 2007).
The key characteristics of object play in children with autism spectrum disorder are repetitively shaking toys, sniffing toys, listening to sounds, focusing on unimportant details, lining up or spinning toys, no interactions with dolls, attachment to non-toy objects like paper and rubber bands, etc. (Vig, 2007). They lack imagination, which is why they demonstrate repetitive behavior during play (Honey, Leekam, Turner, & McConachie, 2007). They also are deficient in imaginative behaviors, ranging from simple pretend play to creative fictional stories.

According to major pioneers in child development, such as Piaget and Bates, play and language develop simultaneously, with the first signs of play occurring around the time when children speak (Honey, Leekam, Turner, & McConachie, 2007). Without symbolic communication or the ability to use mental representation, it is unlikely that a child would be able to take on symbolic play activities, as is the case with children with ASD.

**Symbolic and Social Play in ASD Children**

Empirical evidence shows that children with ASD exhibit delay and difficulty in social play (Jordan, 2003). Pretend play is one of the areas of development most affected by autism. "Children with autism show reduced frequency, complexity, novelty and spontaneity in pretend play" (Rutherford, et al., 2007, p. 1025). Deficiency in pretend play occurs in three areas: diminished frequency of spontaneous pretend play, decreased play in complex symbolic sequences, and less spontaneity.

Three forms of symbolic play exist in child development; object play, which is using an object as something else, functional play or giving objects properties that do not exist, and symbolic play that makes reference to something that is not there as if it were there (Libby, et al., 1998). Children with autism have rigid behavior toward toys, with lack of pretend play. One interesting finding in the study is that children with autism produced more sensorimotor
activities, which may support the view that sensorimotor play may dominate and avert children with ASD from engaging in symbolic play.

Normally, children’s play progresses through developmental stages, which include sensorimotor play, manipulative play, physical play, social play, and pretend play (Bass & Mulick, 2007). Children with ASD show abnormalities in the first stage of play, which can produce developmental delays in the other phases.

Social play in children with autism involves less interest in playing with other children and more self-stimulatory behavior, along with inappropriate and inflexible use of toys (Bass & Mulick, 2007). Social play is essential for cognitive, social, and cultural development and helps children learn about relationships and consequences. The absence of social play in children in their younger years becomes a problem later in their lives if intervention is not undertaken.

Training in symbolic play can help improve skills in other domains, such as social, language, speech, and communication skills (Stanley & Konstantareas, 2007). There is a delay in natural play patterns in children with ASD, which leads to social isolation and disturbing effects on their development (Jordan, 2003). Failure to experience symbolic play can lead to problems with self-awareness, motivation, memory, self-control, and socialization. Results of an investigative study propose that sociodramatic play training with ASD children of suitable developmental levels increases sociodramatic play, improves language skills, and improves social behavior (Thorp, Stahmer, & Schreibman, 1995).

**Play Interventions for Children with ASD**

Techniques based on behavioral psychology and applied behavior analysis can enhance and develop play skills in children with ASD (Stahmer, Ingersoll, & Carter, 2003).

**Discrete trial training.** The most "well-researched and well-known behavioral technique for the direct instruction of play behaviors is the discrete trial training approach"
OVERVIEW PLAY THERAPY

(Stahmer, 2003, p. 402), which came about in the 1960s. It involves breaking complex skills into subparts through a sequence of teaching trials. Children learn steps individually, and then connect the steps through "chaining" (Mastrangelo, 2009). This form of training uses reinforcements and modeling, with the therapist deciding what materials to use during the play therapy session. The environment is very structured and teaching is strictly controlled. Studies using discrete trial training show that play skills continue to in follow-up sessions.

**Pivotal response training.** Pivotal response training enhances motivation by integrating factors that are previously learned, child choice of play activities, turn taking and reinforcements. Parents, teachers, therapists, and other people in the child's life can use pivotal response in children with ASD in the home environment, school, and in the community (Mastrangelo, 2009). PRT has enough structure to help children with multifaceted play skills, but is still flexible enough to permit children to be imaginative. Research has shown that children with ASD can learn symbolic play skills and connect with "language-age" matched peers through pivotal response training (Stahmer, 2003).

**Reciprocal imitation training.** Reciprocal imitation training is a variation of pivotal response training to educate ASD children in unstructured imitation skills during play (Mastrangelo, 2009). The therapist imitates the actions and verbal communication of the child and labels the child’s actions. This type of training is well suited for very young children with ASD, and research shows that it increases pretend play actions. Research also shows that children with ASD increase social behaviors, such as joint attention skills, following reciprocal imitation training (Stahmer, 2003).

**Video modeling.** Video modeling through taping others doing an activity uses expected and duplicate presentations of targeted activities (Stahmer, 2003). Video modeling includes components such as edited images of new or appropriate behaviors, repeated
examples of actions or behaviors, practice sessions and role-playing of new skills, and evaluation of new skills (Hine, 2006).

Research shows that children with ASD demonstrated improvement in verbal responding, helping behaviors, and acquiring new skills with video modeling (Stahmer, 2003). Video modeling is effective for children with ASD because they are visual learners. Positive effects remained in play ability after video modeling interventions in children with ASD (Hine, 2006).

**Child-centered play therapy.** Maureen Kenny's article discusses the case of a pre-adolescent girl with autism and emotional and behavioral problems who participated in both directive and child-centered play therapy. The child reacted more positively to the child-centered play therapy than the directive play therapy (Kenny, 2000).

Child-centered play therapy helps children feel capable and facilitates an increased sense of self-esteem, in which many children with ASD are deficient (Kenny, 2000). The girl’s affect improved during child-centered play therapy, and her play selection increased. When the therapist was directive, the child with ASD became difficult, angry, more annoyed and less cooperative. This case demonstrates the significance of the therapist relationship with the children, and it illustrates that some high-functioning children with ASD can benefit from child-centered play therapy.

**DIR floor-time model.** The developmental, individual-difference, relationship-based (DIR) model was developed by Wieder and Greenspan (Mastrangelo, 2009). The interactive relationship is the most important element in the DIR model (Erba, 2000). This model looks at children with ASD in the context of their biological makeup and family relationships, with respect to their functional and mental development.
The DIR model or “floor-time” play therapy takes place between an adult and a child; where the adult follows the child's lead, and together they create shared attention, engagement, straightforward and difficult gestures, and words with exaggerated affect (Mastrangelo, 2009). Greenspan and Wieder state that early intervention and daily episodes of symbolic play can help children move ahead developmentally (Greenspan & Wieder, 1998).

In the DIR model, children need to master six emotional skills (Greenspan & Wieder, 1998). These skills are: (a) ability to self-calm and process environmental information; (b) engage in relationships; (c) participate in joint communication; (d) create complex gestures and connect a series of actions into a problem-solving sequence; (e) create ideas; and (f) build connections between ideas.

The primary goal of the DIR model is to assist children with ASD to work around processing difficulties, make contact with primary caretakers, and to master the six relationship-based milestones listed above (Erba, 2000). The success of the floor-time approach in a chart-review publication by Greenspan and Wieder, where 200 children assessed after two or more years of therapy, shows that 58% were in the good-to-outstanding category, displaying purposeful, organized, and symbolic play.

**Adlerian Play Therapy**

**What is Adlerian Play Therapy**

The major tenets of Adlerian play therapy come from Individual Psychology, which maintains that behavior is purposeful and occurs in a social context; that misbehavior occurs from a sense of discouragement; that children are inherently creative; and through creativity children develop a unique lifestyle (Snow, Buckley, & Williams, 1999).

Adlerian techniques such as encouragement, family constellation, early recollections, goal disclosure, and tentative hypotheses assist children in expressing themselves and
exploring their feelings (Kottman & Warlick, 1989). The therapist uses play therapy to teach children to recognize self-defeating behaviors, gain insight into their purpose of behavior, and how to use different ways of coping with life. "Adlerian play therapists believe that the therapeutic powers of play will facilitate the process of working with children by creating a bond between the therapist and the client, based on shared fun" (Kottman, 2001, p. 2).

The therapist explores the child's way of achieving a sense of belonging and the child's belief about how he or she sees others and the world (Kottman, 2001, p. 2). One of the key roles of the Adlerian play therapist is to explore how children maintain a sense of belonging or a way of being "socially embedded".

The play therapist creates an understanding of how children develop a sense of belonging by watching children play out situations and scenarios; by noting themes children create in play; by examining how children build relationships in the playroom; and by talking to parents and other people in children’s lives (Kottman, 2001).

**Four Goals of Misbehavior and the Crucial Cs**

Another critically important aspect of Adlerian play therapy is that all behavior has a purpose (Kottman, 2001). Children exhibit four basic goals for of misbehavior: (a) attention; (b) power; (c) revenge; and (d) proving inadequacy (Dreikurs, 1990).

Therapists identify children’s goals by observing their behavior during play and paying attention to parents’ or caregivers’ reactions to the behavior (Kottman, 2001). The therapist can discover the child’s goals by questioning and exploring the emotional response of adults, including the therapist's own feelings about the child’s behavior.

Another way to establish the goal of misbehavior is observing children’s responses to modification or regulation of their behavior (Kottman, 2001). The Crucial C's, suggested
by Bettner and Lew, state that in order to survive, children need to master the "Crucial Cs". The Crucial Cs are: (a) connect with others; (b) feel capable; (c) feel as though they count; and (d) have courage.

**Attention.** The first goal of misbehavior is undue attention (Dreikurs, 1990). The belief is that children who want too much attention only count when others notice them, and they feel insecure and inadequate (Bettner & Lew, 1998).

The adult feels irritated and annoyed at the child's behavior (Dreikurs, 1990). The child's response to correction is that the behavior will temporarily stop.

The crucial C is for the child to connect. The positive goal is cooperation and for children to believe that they belong (Bettner & Lew, 1998). Terry Kottman feels that children who connect feel safe and can work together with others, and those who do not feel alone and lack confidence.

Things to help children feel secure and connected are replacing negative attention with positive attention, planning activities together, ignoring the attention-seeking behavior, and teaching children independence (Bettner & Lew, 1998). In the play session, these children have problems with connecting with the therapist, oppose going into the playroom, and they decline the therapist's suggestions regarding activities (Kottman, 1999).

**Power.** The second mistaken goal that occurs after the parents attempt to stop children’s commands for attention is the struggle for power (Dreikurs, 1990). Children struggling for power gain strength in showing adults that they cannot make them stop doing something (Bettner & Lew, 1998). Children believe they are inadequate, dependent, and that others are in control. The adult's impulse is to fight, and they experience anger and feel challenged. Children’s reaction to this type of correction is that their misbehavior intensifies or escalates.
The Crucial C is feeling capable. The positive goal is self-reliance, and the belief of these children is that they can do it (Bettner & Lew, 1998). Children need to feel competent in the things that they accomplish and to believe that they can be independent and responsible for themselves (Kottman, 1999). Children who feel incapable try to control others.

To assist children in feeling capable and self-reliant, adults should be friendly, should not try not to win when in a power struggle with children, and give opportunities and choices so children can exhibit power usefully (Bettner & Lew, 1998). In the play session, children in a power struggle will convey a lot of doubt and unwillingness to try new things (Kottman, 1999).

**Revenge.** The third mistaken goal that occurs from the escalation of the power struggle is revenge or retaliation (Dreikurs, 1990). These children believe that everyone is against them and no one really likes them. They feel insignificant (Bettner & Lew, 1998). The adults’ response is to punish these children, which causes hurt feelings. Children’s reaction to correction of the behavior is to get even.

The Crucial C is for children to count. The positive goal is contribution, and the belief is that they matter, are significant, and feel valuable (Bettner & Lew, 1998). Children who think they count feel special and significant (Kottman, 1999).

Ways parents and therapists can help children feel as if they count include maintaining appreciation in the relationship; offering children chances to help out; and not giving up on them (Bettner & Lew, 1998). In the play session, these children usually make negative comments about themselves and about their life outside of therapy (Kottman, 1999).

**Inadequacy.** Very discouraged children use the fourth goal, as they try to display complete inadequacy and give up completely (Dreikurs, 1990). If children believe they cannot accomplish anything, they will not even try. They feel inferior, useless, and hopeless (Bettner & Lew, 1998). The adults’ impulse is to give up, and the adults usually feel
despair and hopelessness. Children who feel inadequate typically do nothing in the play therapy session (Kottman, 1999). Children’s response to correction is passivity, more hopelessness, and no change.

The Crucial C for inadequacy is courage. The positive goal is resiliency, and these children need to believe they can handle what comes to them and feel hopeful and willing to try (Bettner & Lew, 1998). Courage means children will take risks and try new behaviors and skills (Kottman, 1999).

Ways parents and the therapist can help children with courage is to notice children’s strengths and ignore their weaknesses, set up exposure to tasks that have an assurance of being victorious, and not giving children any criticism (Bettner & Lew, 1998).

**Four Phases of Adlerian Play Therapy**

Adlerian play therapy consists of four phases: (1) relationship building; (2) lifestyle assessment; (3) insight; and (4) reorientation (Kottman, 1995).

**Build an egalitarian relationship.** In the first phase of Adlerian play therapy, the therapist is non-directive (Kottman, 1995). According to Kottman, usually the child has very little change in this phase, as it is first important that therapy be set up as an egalitarian relationship. Techniques used to build a democratic relationship include tracking behavior, having an open relationship, restating content, reflecting feelings, asking questions, encouragement, playing with the child, and setting limits.

Limit setting is imperative to relationship building in Adlerian play therapy (Kottman & Warlick, 1989). Certain rules are set, which prohibit harm to self, others, or materials; yet, some rules are open to discussion. Some rules are negotiable and are important to the relationship, as the child and therapist discuss the terms of the limits.
**Explore client's lifestyle.** During the second phase, the therapist becomes more active and directive while gathering information about the child's lifestyle from the child and the caregivers (Menassa, 2009). The Adlerian play therapist uses three methods to explore the child's lifestyle. They are the family atmosphere, family constellation, and early recollections (Kottman & Warlick, 1989).

By observing the child during play and asking questions to the child’s caregivers, the therapist can gather information about the family atmosphere (Kottman & Warlick, 1989). During play, the therapist observes and pays attention to statements the child makes about discipline, aspirations, and relationships with the child's caregivers. Parents will answer questions regarding the parents' family of origin, the marital relationship, family values, and methods of parenting (Kottman, 2001).

Family constellation is gathering birth order information, asking other people in the child’s life questions about the birth order and finding out how the child perceives their birth order, usually by drawing a family picture and by asking the child to describe his or her siblings (Kottman & Warlick, 1989). Family constellation influences the child’s lifestyle. Adler states that birth order is important in the development of personality. It is not the child's position in birth, but the circumstances that he or she is born into and the way he or she interprets it that is influential to the child’s personality.

Early recollections are obtained by asking the child to talk about incidents that happened when he or she was younger, playing the recollection out with dolls or puppets, or drawing an early memory (Kottman & Warlick, 1989). Memories are stories shaped by our current perspective of others, the world, and ourselves. Early recollections, a projective technique, help to identify strengths, goals, fears, and other significant information from the client.
Help client gain insight into lifestyle. In the third phase, the therapist acts as an active partner, communicating valuable information to the child and parents (Menassa, 2009). During the insight phase, the Adlerian play therapist utilizes goal disclosure, shares conclusions about the child's lifestyle and helps the child achieve understanding of his or her relationships and purposes of behavior (Kottman & Warlick, 1989). Dolls, puppets or toy telephones can disclose the mistaken goals of a child.

Reorientation and reeducation. During the fourth phase, the therapist acts as a teacher and encourager (Menassa, 2009). This is the stage where most of the change takes place, with this phase enabling the child and parent to learn new skills and attitudes (Kottman, 2001). The therapist teaches the child to replace inappropriate behaviors by encouraging the child to try new behaviors, and by helping the parent work on alternative ways of disciplining and communicating with the child (Kottman & Warlick, 1989). Ways to help a child learn new behaviors during play is to teach problem-solving skills and to ask the child how he or she can attempt to do something differently. The therapist can model other ways of dealing with a problem. The therapist can help the child define the problem by brainstorming and assisting the child with trying out new and different solutions.

Goals of Adlerian Play Therapy

The goals of Adlerian play therapy are to help clients enhance their social interest, reduce feelings of inferiority, and make changes in their life goals. Clients gain insight into mistaken beliefs about self, others, and the world (Mosak, cited in Kottman, 1995). With information about children’s family constellation, the family atmosphere, the family values and attitudes, and children’s perceptions of their birth order, therapists can teach families new communication and discipline skills and work to reorient family values, attitudes, and
beliefs (Kottman, cited in Menassa, 2009). The therapist's main goal is to change the family system.

The Adlerian therapist is a partner, teacher, and encourager. The therapist uses free play, without intervening, to promote social interest, alleviate feelings of inadequacy, and change life goals (Menassa, 2009).

**Adlerian Play Techniques**

Some techniques for Adlerian play therapy are to have the child draw a picture of a special memory, which is helpful in looking into the child's lifestyle (Dahlgren-Daigneault, 1999). “The miracle question” is useful in helping a child think of new options, and involves having him or her pretend that a miracle happened and the problems disappeared. Other techniques include using metaphors for naming problems and using open-ended questions regarding the child's interests, strengths, experiences, and relationships.

**Conclusion**

Play is the way that children communicate with the world. Since children naturally communicate and learn about the world around them through play, it is an effective form of therapy for children. Play therapy has been a form of therapy for children since the 1940s, and research has shown that it is effective when working with children with various problems and disabilities.

Research in play therapy with children who have ASD has proven that play therapy is very productive, since they lack play skills appropriate for developmental stages of learning. Particularly, children with ASD lack qualities in their play that represent pretend or symbolic play. Symbolic play is imperative for language development, social behavior with peers, and is essential to growth and development. Children with ASD also lack abilities in other developmental play levels, such as functional play. They seem to stop play
development with sensorimotor play and fail to progress beyond that. Play therapy is essential for children with ASD so they can master the developmental skills that go along with the developmental stages of play.

Adlerian play therapy is unique in and of itself. It looks at the purpose of the child's behavior and uses encouragement as a growth tool. It looks at many aspects of the child's lifestyle, such as the family atmosphere, birth order, family values, and the child's goals of behavior. Adlerian play therapy offers the child insight into better ways of reaching his or her goals and helps the child become aware of who they are.

Children with autism spectrum disorder can benefit from Adlerian play therapy. The therapist is with the child during play and can engage the child in eye contact, help improve language skills, and help the child develop empathy and relationships with others. Since Adlerian therapy obtains a picture of what the child’s world is, this type of therapy is ideal for children with autism. Children with autism need understanding, empathy, and social interaction with others to thrive and grow.

Great hope exists for the future of children with ASD. Play therapy is one of the ways these children can move forward developmentally and become vital players in the greater society in which they live.
References


