Chapter 6
Incorporating Play into Cognitive Behavioral Therapy for Youth

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6.1 Incorporating Play into Cognitive Behavioral Therapy for Youth

Psychotherapy is widely considered to be both a science and an art. There are thousands of clinical trials and hundreds of efficacious psychotherapy protocols for addressing a variety of youth social, emotional, and behavioral problems (Chorpita et al., 2011). These evidence-based treatments significantly improve youth well-being and functioning and outperform usual care delivered in public sector mental health settings (Weisz et al., 2013). At the same time, common or non-specific factors, such as therapeutic alliance, therapist expertise, therapist style (e.g., warmth, respect, empathy), and trust between a client and their therapist, substantially contribute to client outcomes (Huibers & Cuijpers, 2015). These findings suggest that children, adolescents, and families enrolled in mental health services may benefit from psychotherapy that is informed by the extensive evidence base and that explicitly attends to ways for promoting a positive client experience.

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A promising approach for balancing the science and art of psychotherapy is to use psychotherapy practices that are supported by research evidence but to adapt the script for delivering those practices, as needed, based on the characteristics of the client and context (Chorpita & Daleiden, 2014; Kendall & Frank, 2018; Lau, 2006). The use of play is a natural strategy for adapting the youth psychotherapy process in a way that promotes a positive client experience. It is often easier and more comfortable for youth to express themselves through play than through oral or written dialogue (e.g., Ray et al., 2013). Play can also facilitate rapport building, psychological defusion (e.g., viewing specific thoughts and behaviors as problematic rather than viewing oneself as problematic), and knowledge and skill acquisition (Beidas et al., 2010; Briggs et al., 2011; Lieneman et al., 2017). Additionally, play can be enjoyable for both clients and their therapists.

In this chapter, we describe how to incorporate play into Cognitive Behavioral Therapy (CBT), an evidence-based treatment for many youth social, emotional, and behavioral problems. First, we provide an overview of CBT. Next, we propose a general process for incorporating play into CBT. We then offer ideas for delivering common CBT practices through the use of play. We conclude this chapter with a discussion of considerations for incorporating play into CBT with diverse clients and contexts.

6.2 Overview of Cognitive Behavioral Therapy (CBT)

CBT is one of the most widely researched and practiced psychosocial interventions for promoting youth well-being and functioning. More than 200 randomized clinical trials demonstrate the efficacy of CBT for treating youth anxiety, depression, disruptive behavior, eating problems, substance use, and traumatic stress (Chorpita et al., 2011; PracticeWise, 2020). CBT is a treatment family of time-limited (i.e., usually between 6 and 20 sessions), present-oriented, skills-based interventions that focus on the relationships between thoughts, feelings, and behaviors (Beck, 2011; Bunge et al., 2017). In CBT, clients initially learn to identify their thoughts (i.e., the words or images that pop into their mind), feelings (i.e., their emotions and/or physiological sensations), and behaviors (i.e., what they say or do). For example, in a situation where Alex sees a friend at the grocery store and waves, but Alex's friend does not wave back, Alex may have the thought, "My friend does not like me," experience the emotion of sadness and the physiological sensations of feeling cold and shaky, and then enact the behavior of ignoring a message sent by their friend later that day. Once clients are able to identify their thoughts, feelings, and behaviors, they are taught cognitive and behavioral skills for effectively responding to distressing situations, under the premise that changing an unhelpful thought or behavior will lead to more adaptive thoughts, feelings, and behaviors. Returning to the previous example, if Alex practices the cognitive skill of restructuring unhelpful thoughts to be more accurate, then they may generate the thought, "My friend did not see me," feel indifferent about the situation, and engage in an enjoyable

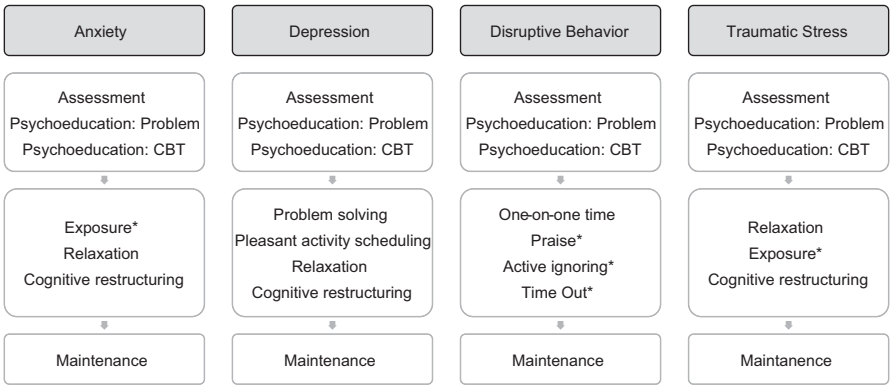
conversation when their friend messages them later. Alex may also practice relaxation skills to soothe any physiological feelings of distress after their friend does not return their greeting, which may allow Alex to respond effectively to the situation rather than react emotionally. As another option, Alex may practice engaging in prosocial behavior, such as sending a friendly response to their friend's message, which may promote feelings of camaraderie and warmth, as well as test and potentially disprove their negative automatic thought.

6.3 Process for Incorporating Play into CBT

Play is commonly featured in youth CBT and other evidence-based treatment protocols. For instance, the *Coping Cat* program, an evidence-based treatment for child anxiety, recommends the use of fun activities, particularly in the first session, to build rapport, cultivate trust, and promote client engagement in their mental health treatment (Beidas et al., 2010). As another example, the developers of trauma-focused CBT (TF-CBT) suggest scheduling periodic free play or nondirective play during sessions to reward clients' willingness to engage in difficult work and to help clients regulate their emotions (Briggs et al., 2011). In Parent–Child Interaction Therapy (PCIT), caregivers play with their child and receive real-time coaching from their therapist on how to increase their child's positive behaviors (e.g., compliance, prosocial behaviors) and decrease their child's negative behaviors (e.g., temper tantrums, aggressive behaviors) (Lieneman et al., 2017). Additionally, many social skills programs call for children and adolescents to play games in small groups to learn and refine skills related to reading social cues, perspective taking, and social problem solving (Laugeson & Park, 2014).

Although many youth psychotherapy protocols encourage the use of play, there are not always clear guidelines on how to do this, or therapists may wish to incorporate play in ways other than what is specified in the protocol. To provide some guidance, we propose the following process for incorporating play into CBT:

1. *Develop an evidence-informed treatment plan.* There is an extensive evidence base on efficacious psychotherapies for children, adolescents, and families (Chorpita et al., 2011), so it seems efficient and logical to leverage it. There are dozens of youth CBT protocols that can be used to inform which psychotherapy practices therapists choose to implement with their clients. We have also included sample treatment plans featuring psychotherapy practices supported by research evidence in Fig. 6.1.
2. *Identify your session objective.* What do you want to accomplish in your next session? What do you want your client to learn? What skill do you want them to strengthen? Identifying a clear session objective will help you use play in a way that bolsters rather than detracts from your client's psychotherapy experience.
3. *Prepare a play activity for meeting your session objective.* We offer some ideas of play activities for delivering common CBT practices in the next section. If you



Note: *Practice is not described in this chapter but is commonly featured in evidence-based treatments for the corresponding problem area.

Fig. 6.1 Sample treatment plans. Note: *Practice is not described in this chapter but is commonly featured in evidence-based treatments for the corresponding problem area

Table 6.1 Examples of developmentally-appropriate activities

Activity	2–7 years old	7–13 years old	13–17 years old
Art	Finger painting, molding Play-Doh, drawing and coloring with crayons or washable markers	Drawing and coloring with colored pencils or glitter pens	Drawing and coloring with colored pencils or paint
Games	Playing Candy Land, Go Fish, Uno	Playing Connect Four, Jenga, Exploding Kittens	Playing Scrabble, Taboo, card games
Sports	Running, hopping or skipping, throwing and catching	Playing soccer, dancing, jumping rope	Playing baseball/ softball, basketball, bowling
Toys	Playing with giant building blocks, dolls or trucks, simple jigsaw puzzles	Playing with Legos, Rubik's cube	Playing with Legos, 3-D puzzles

are creating your own play activity, consider whether your session objective will be best accomplished through structured or unstructured play (e.g., Bratton et al., 2009). Structured play works well for assessing presenting problems and skill competency, promoting self-expression, and teaching psychosocial concepts and skills. Unstructured play works well for building rapport, trust, and psychological safety. Choosing a developmentally appropriate activity that your client will likely find enjoyable is advised (e.g., an activity that they do with their friends) (see Table 6.1 for a list of developmentally appropriate arts and crafts activities, toys, games, and sports).

4. *Play!* Everyone involved is likely to have a more positive experience if you engage in the play activity with your client rather than simply observe them. If a solitary play activity is chosen, try to model the activity before asking your client to engage in the activity, provide enthusiastic descriptions or commentary of

their play, and look for opportunities to praise their use of skills during the play activity.

5. *Evaluate whether the activity was successful and adapt as needed.* Following the play activity, we encourage you to reflect on whether the session objective was achieved. Did the activity strengthen the client's understanding or use of the skill you were targeting? Did the client seem engaged in the session? Did the client seem to enjoy the play activity? If the answer to any of these questions is "no," then consider repeating steps 2–5 of this process with an adapted play activity.

6.4 Common CBT Practices and Play

There are several psychotherapy practices that are commonly featured in youth CBT protocols. In this section, we provide brief descriptions of some of these practices, as well as ideas for using play in practice delivery.

6.4.1 Assessment and Rapport Building

Assessment is typically the first procedure of any psychosocial intervention. This procedure involves gathering information about the youth's strengths, social, emotional, and academic functioning, and presenting problem. In addition to gathering information that will inform the case conceptualization (i.e., how the youth's thoughts, feelings, and behaviors contribute to their distress), a primary aim of assessment is to promote client engagement (Becker et al., 2018).

Accordingly, both unstructured and structured play can facilitate assessment. As a client and therapist get to know each other, they may engage in unstructured play (e.g., drawing or playing with building blocks) while the therapist casually asks the client questions about their family, friends, hobbies, favorite subject in school, and so forth. Unstructured play can also provide valuable information about the client's social functioning (e.g., Does your client interact with you as they play? Does your client offer to share?). Once some rapport is established, structured play can be very informative. For example, a therapist can ask a client to draw a picture of their family and then describe their relationship with each family member. This activity may provide insights into the client's social supports, as well as any potentially negative and unhelpful beliefs the client may hold (e.g., "My brother hates me"). Structured play can also provide helpful information about the client's compliance with requests from adults and ability to transition from one task to another. As an example, a therapist may ask to be handed a toy that the child client is playing with and may note the child's willingness to hand over the toy. This observation can help the therapist conceptualize the client's strengths and challenges and inform the treatment plan (e.g., if the client refuses to hand over the toy, then it may be beneficial to

incorporate psychotherapy practices for addressing noncompliance into the treatment plan).

6.4.2 Psychoeducation about the Problem

The goal of providing psychoeducation about the problem is to promote a shared understanding of the client's social, emotional, or behavioral concerns. Psychoeducation about the problem usually involves normalizing the problem, dispelling any misconceptions, and providing information about what causes and maintains the problem (Becker et al., 2018). Increasing the client's understanding of the problem can help validate their experiences, enhance their engagement in psychotherapy, and even reduce symptomatology (Martinez et al., 2017). That said, it is easy for psychoeducation to become didactic.

Play enhances the process of psychoeducation by making it more interactive and enjoyable. One fun activity is to have a client envision and draw themselves as a superhero and their problem as a villain. The villain's abilities should be based on the nature of the problem (e.g., puts self-critical thoughts in others' minds; makes others feel down), with their power being fueled by stressful situations (e.g., the client being bullied at school or getting a bad grade on a test). The superhero's powers should initially be based on the client's strengths but grow as the client learns more cognitive and behavioral skills. This activity aims to create psychological distance between the client and their problem and instill hope that they will be able to better manage their problem with the help of psychotherapy.

As another example, psychoeducation about anxiety can be provided using the red light, green light game. Specifically, anxiety can be likened to an alarm system: just like a fire alarm warns us about a potential fire, feelings of anxiety warn us about potential danger. However, sometimes our anxiety alarm goes off when there is no danger—similar to how a fire alarm sometimes goes off when there is no fire (i.e., sound a false alarm). To help clients understand this concept, a therapist may brainstorm a series of situations that are cause for a real alarm, false alarm, or no alarm. For example, for a client who experiences social anxiety, a situation that may be cause for a real alarm is being bullied on the playground, a situation that may prompt a false alarm is hearing peers laughing at another student's silliness while the client asks a question in class, and a situation that may not necessitate an alarm is speaking with a sibling. As another example, for a client who experiences separation anxiety, a situation that may be cause for a real alarm is becoming separated from their caregiver at the zoo, a situation that may prompt a false alarm is being in a different room than their caregiver at home, and a situation that may not necessitate an alarm is playing with their caregiver. Within the context of the red light, green light game, the client can be instructed to run from the starting line when the therapist mentions a situation that is cause for a real alarm, walk when the therapist mentions a situation that may raise a false alarm, and stop when the therapist mentions a situation that is not cause for any alarm.

6.4.3 Psychoeducation about CBT

Psychoeducation about CBT is usually provided early in psychotherapy before starting to teach cognitive and behavioral skills. Psychoeducation about CBT aims to enhance the client's knowledge about CBT, specifically how CBT can help address the client's social, emotional, and behavioral concerns. This involves teaching the client that their thoughts, feelings, and behaviors are inter-related and that intervening on any one of these components can help the client respond to distressing situations more effectively.

An initial but crucial step of this work is to teach the client how to identify their thoughts, feelings, and behaviors. To build this skill, a therapist could brainstorm a list of thoughts (e.g., "I'm a loser," "I'm dumb," "No one likes me"), feelings (e.g., sad, scared, angry), and behaviors (e.g., watching TV, sleeping, yelling at a caregiver). The therapist could then set up a ball toss game, where the therapist reads a thought, feeling, or behavior from the list and instructs the client to toss the ball into the appropriately labeled bucket (e.g., if the therapist says, "mad," then the client should toss the ball into the bucket labeled "feelings").

To help a client understand the relationships between thoughts, feelings, and behaviors, a therapist may ask a client to draw a four-square comic—where the first square depicts a situation, the second square depicts a thought, the third square depicts a feeling, and the last square depicts a behavior. See Fig. 6.2 for an example.

Case Example. Lilah[1] is a 9-year-old, Mexican American girl. Lilah was referred for individual psychotherapy by her parents for frequent complaints of boredom, bouts of crying, low energy, and negative commentary about herself, such as "It's my fault when my parents argue" or "Other kids don't want to be friends with me because I'm boring." After starting the rapport building process, assessing the presenting problem, and identifying the family's treatment goals, Lilah's therapist determined that Lilah could benefit from CBT for depression and collaboratively developed a treatment plan with the family. Lilah's therapist introduced the connection between thoughts, feelings, and behaviors and decided to use play to reinforce this concept. Lilah's therapist set session objectives of (a) enhancing Lilah's ability to distinguish between thoughts, feelings, and behaviors; (b) building Lilah's insight into how thoughts, feelings, and behaviors are inter-related; and (c) improving Lilah's mood through engaging in a fun activity. To achieve these session objectives, Lilah's therapist planned a game of "CBT baseball," where each base represented thoughts, feelings, and behaviors. Lilah and her therapist played CBT baseball at a local park, but this game could be played in a traditional psychotherapy room with each corner representing a base. Lilah's therapist "pitched" by stating an example situation that would exacerbate negative mood. To advance bases, Lilah was tasked with providing an example of a thought, feeing, and behavior. Lilah was prompted to nominate a more adaptive thought or behavior to run to home base. As innings progressed, Lilah's therapist used example situations that were increasingly

[1] This case example is a composite of several clients, and the name has been changed.

Fig. 6.2 Comic depicting the relationships between thoughts, feelings, and behaviors. (CC BY 4.0 Alayna Park)

similar to the challenges reported by Lilah and her parents during their assessment. In early innings, Lilah struggled to differentiate between thoughts and feelings (e.g., labeling sadness as a thought). Following some gentle correction from her therapist, Lilah began to distinguish between thoughts and feelings. She also presented as increasingly engaged and incrementally happier as the game progressed—indicating that CBT baseball was successful in achieving the therapist's session objectives.

6.4.4 Self-monitoring

Self-monitoring is a skill in which the client tracks a target behavior or the intensity of a target emotion over time. For example, a therapist may request that a caregiver document the number of temper tantrums that their child throws each week. As another example, a therapist may ask a client to rate how sad they feel on a scale ranging from 0 (not at all sad) to 10 (extremely sad) at the beginning of each psychotherapy session. Self-monitoring yields valuable information about a client's treatment progress and is associated with positive client outcomes at post-treatment (Borntrager & Lyon, 2015). Since ratings of emotional intensity are subjective, clients should create their own rating scale (e.g., thermometer, dial, or color gradient), with behavioral, physiological, and/or cognitive benchmarks that are meaningful to them. Please see Fig. 6.3 for an example. Therapists may reinforce the practice of

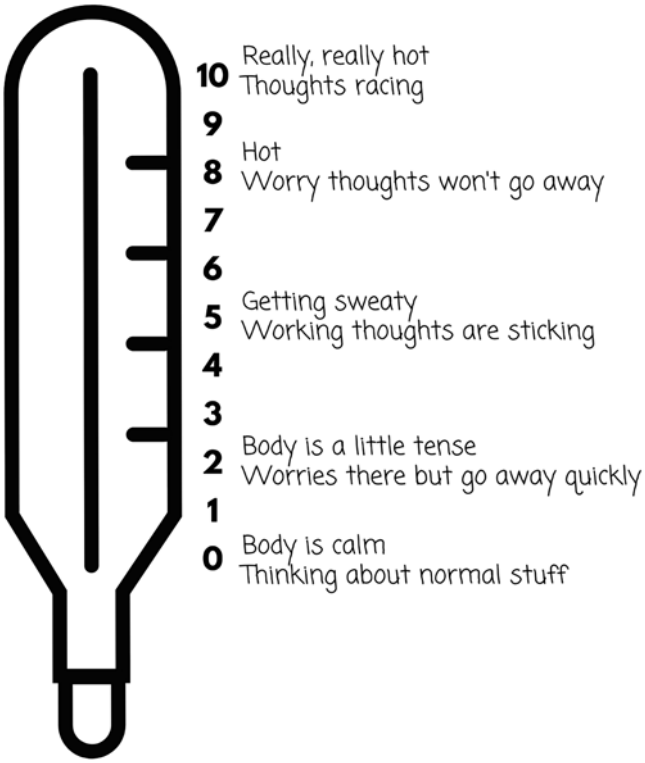


Fig. 6.3 Sample anxiety self-monitoring rating scale. (CC BY 4.0 Rachel Kim)

monitoring behaviors or emotions through play. For example, a therapist can prompt a client to rate their mood, then engage the client in a quick game, and afterwards direct the client to re-rate their mood, with the expectation that the client's mood would improve because of playing the game.

6.4.5 Cognitive Restructuring

Cognitive restructuring aims to help clients challenge negative or unhelpful beliefs and generate more realistic alternative thoughts. This skill usually involves teaching a client how to identify the words or images that pop into their mind, examine evidence for and against those thoughts, and then brainstorm an alternative interpretation that is more accurate, complete, and balanced. In one example, a client challenges their negative and unhelpful beliefs by pretending to be a detective and identifying other possible ways of interpreting ambiguous situations. Returning to the example where Alex waves to their friend who does not wave back, possible interpretations include: "My friend does not like me"; "My friend is mad at me";

"My friend did not see me"; "My friend did not recognize me"; "My friend was distracted"; and so forth—with some thoughts promoting more helpful feelings and behaviors than others. To reinforce a more accurate, complete, and balanced interpretation, a therapist could instruct the client to draw two four-square comics. The first comic should depict an ambiguous situation, unhelpful automatic thought, and consequent, usually maladaptive, feelings, and behaviors (please see Fig. 6.2). The second comic should depict the same ambiguous situation, helpful interpretation, and consequent, often adaptive, feelings, and behaviors (please see Fig. 6.4). These comics can help the client not only internalize the alternative interpretation but also reinforce the relationships between thoughts, feelings, and behaviors.

6.4.6 Pleasant Activity Scheduling

Pleasant activity scheduling (i.e., a primary component of behavioral activation) inherently involves play. This behavioral skill is based on the notion that engaging in enjoyable activities improves mood. Pleasant activity scheduling involves having a client identify pleasurable activities (e.g., activities that have been fun for the client in the past, involve spending time with a friend, or involve helping others), schedule a day and time to do the activity, and monitor their mood before, during, and after the activity. Activity ideas for young children include playing with

Fig. 6.4 Comic depicting feelings and behaviors following a restructured thought. (CC BY 4.0 Alayna Park)

building blocks, drawing or painting, and partaking in dance parties. Activity ideas for adolescents include playing sports, cooking or baking, and volunteering at a local animal shelter. Clients are encouraged to schedule pleasurable activities for days in between psychotherapy sessions and/or in a psychotherapy session to highlight the relationship between feelings and behaviors.

Relatedly, therapists can schedule a fun activity for the last 5–10 min of psychotherapy sessions to positively reinforce a client's participation and, if needed, to help a client regulate their emotions after a difficult session (e.g., a session where a client's trauma history is discussed). End of session play should be unstructured, such as shooting basketball hoops, drawing or coloring, playing a quick card or board game, or watching lighthearted videos.

6.4.7 Problem Solving

Problem solving aims to teach a client how to solve problems more effectively. This skill involves identifying a problem, brainstorming a list of possible solutions, assessing the potential benefits and consequences of each of these solutions, implementing the solution perceived to be the best, and evaluating the effectiveness of that solution. Oftentimes, therapists teach problem solving through worksheets; however, therapists can easily demonstrate these steps through playful activities. For example, a therapist may propose a problem of needing to place a ball into a bucket without using their hands. The therapist and client may then brainstorm possible solutions (e.g., holding the ball with their elbows, bouncing it off their head), discuss the potential of each solution, and iteratively enact proposed solutions until one is successful.

6.4.8 Relaxation

There are a variety of relaxation skills that therapists can teach to children and adolescents to reduce physiological sensations of distress. If a client reports feeling muscle tension, then a therapist may employ progressive muscle relaxation. Progressive muscle relaxation involves tensing and relaxing muscle groups one at a time until the client feels a sense of calm. A therapist may use fun metaphors when teaching progressive muscle relaxation, such as directing the client to pretend that they are a turtle retreating into (and out of) their shell to tense (and relax) shoulder muscles. Please see Table 6.2 for a list of fun metaphors for progressive muscle relaxation.

Diaphragmatic breathing or "belly breathing" is another relaxation skill that therapists can teach playfully. Diaphragmatic breathing involves taking slow, deep breaths from one's diaphragm to counteract the quick, short breaths that one typically takes when distressed. A therapist may illustrate this relaxation skill by asking

Table 6.2 Playful instructions for progressive muscle relaxation

Muscle group	Tensing instructions
Feet	"Curl your toes, like your shoes are too tight"
Legs	"Stomp your feet, and press them into the ground"
Stomach	"Pretend that a baby elephant is passing you in the hallway and suck in your stomach so that they can get by"
Chest	"Puff out your chest, like a bird"
Hands	"Ball your hands into fists and pretend that you are squeezing all of the juice out of a lemon"
Arms	"Flex your biceps and show me your muscles"
Shoulders	"Raise your shoulders and pretend that you are a turtle going into your shell"
Jaw	"Open your mouth as wide as you can, like a cat yawning"
Forehead	"Raise your eyebrows as high as you can, like you are really surprised"

their client to pretend that they are inflating and deflating a balloon in their belly by taking slow, deep breaths in through their nose and exhaling through their mouth. This relaxation skill can also be taught through imagining that one is blowing on a steaming cup of hot chocolate to cool it or having a client practice blowing bubbles, where short and fast breaths produce a stream of small bubbles and slow and steady breaths produce a single large bubble.

6.4.9 Social Skills

Social skills training aims to provide children and adolescents with concrete skills for developing healthy relationships. This psychotherapy practice involves skills for communicating effectively (e.g., entering a conversation, listening, taking turns speaking), asserting one's needs, taking another's perspective, and exhibiting prosocial behaviors (e.g., sharing toys with others). Children and adolescents are often taught social skills in small groups to allow for in-vivo practice. For example, youth may practice several social skills through an informal game of catch. By initiating a game of catch with a couple of group members, the remaining youth can practice joining the game. They may practice their verbal and nonverbal communication skills as they indicate who they plan to throw the ball to next. Youth may also practice prosocial behaviors, such as passing the ball to different group members or praising other group members for a "good throw" or "good catch." If social skills are to be practiced in a small group, then group rules should be established at the outset (e.g., therapist will pre-assign groups; score will not be kept; aggressive behavior will not be tolerated). Children and adolescents should also be encouraged to use previously learned cognitive and behavioral skills to manage their emotions and behaviors as they practice their social skills (e.g., generating adaptive thoughts if they were not thrown the ball as often as they would have wanted).

6.4.10 Maintenance

Maintenance refers to the practice of reviewing a client's treatment progress and brainstorming ways to maintain treatment gains. This involves discussing the client's progress toward achieving treatment goals, reviewing cognitive and behavioral skills covered in psychotherapy, identifying and planning for challenges that may interfere with continued skill use, and expressing confidence in the client's ability to cope with problems on their own, including recognizing if or when it may be helpful to re-enroll in psychotherapy. Maintenance is typically done during the final sessions of an episode of psychotherapy. To reinforce client's cognitive and behavioral skills learned in psychotherapy, a therapist can set up a game where the client must choose which skill(s) to use in various situations. For example, a therapist may write all of the skills covered in psychotherapy on a whiteboard, then state various situations, and ask the client to tag the skill(s) that can help them in each situation (e.g., the client would be expected to tag the relaxation skill if the therapist states the situation of experiencing stomachaches before a big test). As another idea, if the client was directed to draw themselves as a superhero and their problem as a villain at the start of psychotherapy, then a fun activity may be to ask the client to re-draw themselves and their problem at the end of psychotherapy.

6.4.11 One-on-One Time

Play is also a promising avenue for teaching caregivers skills for managing their child's behaviors and promoting family well-being and functioning. One-on-one time, or special play time, refers to a 5- to 15-min period of time each day where a caregiver plays with their child to increase attachment, promote prosocial behaviors, and decrease the frequency of destructive or aggressive behaviors. One-on-one time is beneficial for younger children, particularly those with disruptive behavior problems. During one-on-one time, caregivers are encouraged to praise their child's appropriate behavior (e.g., "I'm proud of you for sharing your crayons"), reflect appropriate speech (e.g., responding to a child's comment that they drew a cat by saying "you *did* draw a cat"), imitate appropriate play (e.g., "I'm going to draw a cat, just like you"), describe appropriate behavior (e.g., "You are putting your crayons back after using them"), and enjoy time with the child (e.g., "I'm having fun drawing together") (e.g., Eyberg & Funderburk, 2011). Caregivers are also taught to ignore inappropriate behaviors (e.g., screaming, making demands, refusing to play or to share toys, playing roughly with toys), avoid giving commands (e.g., "Let's draw a dog now"), avoid asking questions (e.g., "What are you drawing?"), and avoid criticizing (e.g., "That's not what a cat looks like"). Although many of these parenting skills should be applied beyond one-on-one time, play provides a natural opportunity for caregivers to practice these skills while building a warm and secure relationship with their children.

Case Example. Noah[2] is a 5-year-old, non-Hispanic, White boy. Noah was referred for individual psychotherapy by his mother, Betty, for frequent temper tantrums at home, noncompliance with adult requests at home and school, and repeated physical aggression (i.e., kicking and hitting) towards family members. After completing an initial assessment, the family's therapist determined that Noah and Betty could benefit from behavioral parent training for disruptive behavior and collaboratively developed a treatment plan with the family. The family's therapist introduced one-on-one time skills to Betty and decided to use play to reinforce her skill use. To achieve this session objective, the family's therapist planned for Noah and Betty to play with building blocks (i.e., one of Noah's favorite unstructured play activities) while the family's therapist observed their interaction and provided discreet coaching on Betty's use of one-on-one time skills. As Noah and Betty played, the family's therapist noticed that Noah often knocked down structures that Betty built and that Betty would consequently become upset and make comments such as, "You're being mean," and "Why can't you be nice like your brother?" The family's therapist coached Betty to ignore Noah's destructive behaviors and to continue building her own structures while subtly watching for Noah to resume appropriate behavior (e.g., adding more blocks to his own structures) to immediately praise (e.g., "You're doing a good job building that truck"). To provide Betty with additional opportunities to practice her one-on-one time skills, the family's therapist continued to coach Betty as she and Noah played for the next several sessions. At the beginning of each session, the family's therapist prompted Betty to report the number of temper tantrums from the previous week; and at the close of each session, the family's therapist privately rated Betty's use of one-on-one time skills. After six sessions of one-on-one time coaching, the family's therapist noted a decrease in the number of Noah's temper tantrums and an increase in Betty's use of one-on-one time skills. The family's therapist considered this activity to be a success, topped with Betty reporting that she and Noah have been having fun building towns during one-on-one time at home.

6.5 Multicultural Considerations

When incorporating play into your psychotherapy sessions, it is important to consider the family's cultural norms, beliefs, and values. Families differ in their worldviews about the importance of play in child development (e.g., European-American caregivers tend to view play as more important for physical, cognitive, and social development than Asian-American caregivers; Parmar et al., 2004). There are diverse conceptualizations of appropriate play activities (e.g., European-American families engage in more pretend play than Argentine, French, and Japanese families; Roopnarine & Davidson, 2015; Asian-American caregivers are more

[2] This case example is a composite of several clients, and the names have been changed.

likely to engage their children in preacademic activities, such as number games, than European-American caregivers; Parmar et al., 2004). Caregiver involvement in play also varies by culture (e.g., approximately 60% of mothers in the United States report playing with their children compared with 24% of mothers in India and 7% of mothers in Guatemala; Roopnarine & Davidson, 2015). Additionally, cultures have distinct play settings (e.g., youth in the United States commonly get together for play dates in each other's homes, whereas youth in Korea commonly hang out in the community; Yoo et al., 2014). Furthermore, humor perception and usage differ across cultures (e.g., "knock-knock" jokes are common in the United States, whereas "panda jokes" are common in Hong Kong; Shum et al., 2019). Accordingly, therapists should ask about the family's established play activities at the outset of psychotherapy. For example, what does the client do for fun? Who participates in those fun activities with the client? When and where do those fun activities take place? Using this information, therapists can craft play activities in collaboration with the family to increase the likelihood that play will not only promote therapeutic skill acquisition but will also align with the family's cultural norms, beliefs, and values. For instance, therapists may consider initially recommending 5 min (rather than 15 min) of one-on-one time for caregivers who usually engage in little to no play with their children, while challenging caregivers who frequently play with their children to incorporate multiple one-on-one time skills (e.g., praising desired behaviors, reflecting respectful speech, and imitating appropriate play).

It is also important to consider the family's resources, especially when assigning therapeutic play activities outside of sessions. For instance, when scheduling pleasant activities for the client to complete for homework, therapists should consider activities that are free or low-cost, such as drawing or coloring, cooking or baking, going for a walk, visiting the local library during story time, or attending a concert in the park. Similarly, one-on-one time can involve inexpensive toys and games, such as engaging in pretend play, building structures with Play-Doh, or playing a game of catch. Another consideration is the common expectation for adolescents in low-income families to contribute through working a part-time job or babysitting younger siblings. When working with a client who is balancing multiple roles, then it can be beneficial to schedule time for the client to practice their cognitive and behavioral skills, including their engagement in mood-boosting pleasant activities. Relatedly, caregivers working multiple jobs, night shifts, or extended hours can plan therapeutic play activities in short but frequent increments (e.g., 5 min each weekday) or can consider involving other family members in therapeutic play activities (e.g., teaching older siblings to praise a child client's appropriate play).

6.6 Telehealth Considerations

Telehealth, or the use of videoconferencing or other information and communication technologies to support the delivery of mental health services, has become increasingly prevalent over the past two decades (Perle & Nierenberg, 2013)—most

prominently during the COVID-19 outbreak (Zhou et al., 2020). There is a rapidly growing literature on telehealth applications and effectiveness (e.g., Boydell et al., 2010; Goldstein & Glueck, 2016; Myers et al., 2008; Nelson & Patton, 2016), which is outside of the scope of this chapter to summarize. However, we offer the following considerations regarding incorporating play into CBT via telehealth. One consideration is that the family will often attend telehealth sessions from their home—allowing the therapist to teach the family cognitive and behavioral skills in a naturalistic environment, which may lead to greater skill generalization. The therapist can also capitalize on resources available in the family's home, such as teaching one-on-one time by having the child and caregiver play with the child's own toys or promoting social skills by having the child practice trading information with their siblings.

One disadvantage of telehealth is that the caregiver rather than the therapist will often need to prepare the play activity for the session. Therefore, telehealth sessions require play activities to be planned in advance and coordinated with the caregiver prior to session. Another option is for the therapist to consider online games. For example, the popular videoconferencing platform, Zoom, has a whiteboard feature that allows the therapist and client to draw together. Since many online games are open to the public and/or may contain mature content, we recommend that therapists preview any online games before playing with their clients. A final consideration is that engaging clients via telehealth may be more difficult than in-person psychotherapy. For instance, youth, particularly younger children, are unlikely to remain attentive for an entire telehealth session. Accordingly, therapists should consider interspersing brief play activities throughout the telehealth session, such as having periodic stretch breaks or dance breaks.

6.7 Conclusion

Incorporating play activities into CBT for youth can benefit both client experience and outcomes. Through strategic design and implementation, play can facilitate rapport building (e.g., gathering information about the client's presenting problem while coloring together), boost mood (e.g., playing an enjoyable game of catch to highlight the relationship between feelings and behaviors), and promote CBT knowledge and skill acquisition (e.g., teaching parents to praise their child's positive behaviors during unstructured play time). Play is part of the art of psychotherapy, which when merged with the science behind CBT, can promote the well-being and functioning of youth and families in need.

References

Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond*. Guilford.

Becker, K. D., Boustani, M., Gellatly, R., & Chorpita, B. F. (2018). Forty years of engagement research in children's mental health services: Multidimensional measurement and practice elements. *Journal of Clinical Child and Adolescent Psychology, 47*, 1–23.

Beidas, R. S., Benjamin, C. L., Puleo, C. M., Edmunds, J. M., & Kendall, P. C. (2010). Flexible applications of the coping cat program for anxious youth. *Cognitive and Behavioral Practice, 17*, 142–153.

Borntrager, C., & Lyon, A. R. (2015). Client progress monitoring and feedback in school-based mental health. *Cognitive and Behavioral Practice, 22*, 74–86.

Boydell, K. M., Volpe, T., & Pignatiello, A. (2010). A qualitative study of young people's perspectives on receiving psychiatric services via televideo. *Journal of Canadian Academy of Child and Adolescent Psychiatry, 19*, 5.

Bratton, S. C., Ceballos, P. L., & Ferebee, K. W. (2009). Integration of structured expressive activities within a humanistic group play therapy format for preadolescents. *Journal for Specialists in Group Work, 34*, 251–275.

Briggs, K. M., Runyon, M. K., & Deblinger, E. (2011). The use of play in trauma-focused cognitive-behavioral therapy. In *Play in clinical practice: Evidence-based approaches* (pp. 168–200). Guilford Press.

Bunge, E. L., Mandil, J., Consoli, A. J., & Gomar, M. (2017). *CBT strategies for anxious and depressed children and adolescents: A clinician's toolkit*. Guilford.

Chorpita, B. F., & Daleiden, E. L. (2014). Structuring the collaboration of science and service in pursuit of a shared vision. *Journal of Clinical Child and Adolescent Psychology, 43*, 323–338.

Chorpita, B. F., Daleiden, E. L., Ebesutani, C., Young, J., Becker, K. D., Nakamura, B. J., Phillips, L., Ward, A., Lynch, R., & Trent, L. (2011). Evidence-based treatments for children and adolescents: An updated review of indicators of efficacy and effectiveness. *Clinical Psychologist, 18*, 154–172.

Eyberg, S. M., & Funderburk, B. (2011). *Parent-child interaction therapy protocol*. PCIT International.

Goldstein, F., & Glueck, D. (2016). Developing rapport and therapeutic alliance during telemental health sessions with children and adolescents. *Journal of Child and Adolescent Psychopharmacology, 26*, 204–211.

Huibers, M. J. H., & Cuijpers, P. (2015). Common (nonspecific) factors in psychotherapy. In *The encyclopedia of clinical psychology* (pp. 1–6). American Cancer Society.

Kendall, P. C., & Frank, H. E. (2018). Implementing evidence-based treatment protocols: Flexibility within fidelity. *Clinical Psychologist, 25*, e12271.

Lau, A. S. (2006). Making the case for selective and directed cultural adaptations of evidence-based treatments: Examples from parent training. *Clinical Psychologist, 13*, 295–310.

Laugeson, E. A., & Park, M. N. (2014). Using a CBT approach to teach social skills to adolescents with autism spectrum disorder and other social challenges: The PEERS® method. *Journal of Rational-Emotive & Cognitive-Behavior Therapy, 32*, 84–97.

Lieneman, C. C., Brabson, L. A., Highlander, A., Wallace, N. M., & McNeil, C. B. (2017). Parent-child interaction therapy: Current perspectives. *Psychology Research and Behavior Management, 10*, 239–256.

Martinez, J. I., Lau, A. S., Chorpita, B. F., Weisz, J. R., & Health, R. N. (2017). Psychoeducation as a mediator of treatment approach on parent engagement in child psychotherapy for disruptive behavior. *Journal of Clinical Child and Adolescent Psychology, 46*, 573–587.

Myers, K. M., Valentine, J. M., & Melzer, S. M. (2008). Child and adolescent telepsychiatry: Utilization and satisfaction. *Telemedicine and e-Health, 14*, 131–137.

Nelson, E. L., & Patton, S. (2016). Using videoconferencing to deliver individual therapy and pediatric psychology interventions with children and adolescents. *Journal of Child and Adolescent Psychopharmacology, 26*, 212–220.

Parmar, P., Harkness, S., & Super, C. M. (2004). Asian and euro-American parents' ethnotheories of play and learning: Effects on preschool children's home routines and school behaviour. *International Journal of Behavioral Development, 28*, 97–104.

Perle, J. G., & Nierenberg, B. (2013). How psychological telehealth can alleviate society's mental health burden: A literature review. *Journal of Technology in Human Services, 31*, 22–41.

PracticeWise. (2020). PracticeWise evidence-based youth mental health services literature database. Retrieved from https://www.practicewise.com/pwebs_1/index.aspx

Ray, D. C., Lee, K. R., Meany-Walen, K. K., Carlson, S. E., Carnes-Holt, K. L., & Ware, J. N. (2013). Use of toys in child-centered play therapy. *International Journal of Play Therapy, 22*, 43–57.

Roopnarine, J. L., & Davidson, K. L. (2015). Parent-child play across cultures: Advancing play research. *American Journal of Play, 7*, 228–252.

Shum, K. K. M., Cho, W. K., Lam, L. M. O., Laugeson, E. A., Wong, W. S., & Law, L. S. (2019). Learning how to make friends for Chinese adolescents with autism spectrum disorder: A randomized controlled trial of the Hong Kong Chinese version of the PEERS intervention®. *Journal of Autism and Developmental Disorders, 49*, 527–541.

Weisz, J. R., Kuppens, S., Eckshtain, D., Ugueto, A. M., Hawley, K. M., & Jensen-Doss, A. (2013). Performance of evidence-based youth psychotherapies compared with usual clinical care: A multilevel meta-analysis. *JAMA Psychiatry, 70*, 750–761.

Yoo, H. J., Bahn, G., Cho, I. H., Kim, E. K., Kim, J. H., Min, J. W., Lee, W. H., Seo, J. S., Jun, S. S., & Bong, G. (2014). A randomized controlled trial of the Korean version of the PEERS® parent-assisted social skills training program for teens with ASD. *Autism Research, 7*, 145–161.

Zhou, X., Snoswell, C. L., Harding, L. E., Bambling, M., Edirippulige, S., Bai, X., & Smith, A. C. (2020). The role of telehealth in reducing the mental health burden from COVID-19. *Telemedicine and e-Health, 26*, 377–379.