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Play Therapy Techniques with Adults in an Inpatient Setting

Capstone Thesis

Lesley University

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Specialization: Expressive Arts Therapy

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Abstract

This research study explored the use of play therapy techniques with adults on an inpatient unit. Participants engaged with play figurines during a one-hour expressive art therapy session. A second-year expressive art therapy intern facilitated the groups. The intern guided the members through a warm-up activity, main directive and closing activity. The focus of the play therapy directives was on the current self and future self. Data was collected from three groups facilitated by the same group leader and involving two different hospital units. The play figurines chosen, environments created and participant's body language were noted. Overall, the usage of play figurines was well received and appreciated; group members found it helpful to use symbolism in expressing their emotions and hopes for their personal growth. There was little resistance to participating in the group and engaging with the figurines. Noticeable differences were observed in patients who had a psychotic disorder versus mood disorder.

Keywords: Play Therapy, adults, inpatient, trauma, miniatures, figurines, directive play therapy, group therapy, expressive art therapy

Play Therapy Techniques with Adults in an Inpatient Setting

“Adults need to play. We are working creatures, we are bonding creatures and we are playing creatures”- (Kelly, as cited in Schaefer, 2003, p. ix)

This research looked at the implementation of a play therapy approach with adults in an inpatient unit. Play therapy is a widely recognized evidence-based approach mainly used to treat mental illness in children and adolescents. However, the therapeutic medium can also be an effective treatment for adults. Very few studies recognize the potential play therapy has in treating adults with histories of trauma, mental illness and even fewer recognize its presence in inpatient units. Just like children, adults can benefit from the utilization of the two hallmarks of play therapy; symbols and creativity.

Play therapy and the creative arts can provide clients with the opportunity to express the self without relying solely on words. Play taps into creativity and imagination and leads naturally to the use of symbols. Words, themselves, are symbols, but it is easy to become constrained by words, perhaps believing that words are the only way to communicate, and thereby failing to make use of other symbols (Schaefer, 2003). According to Schaefer (2003), Using a variety of symbols is necessary to express feelings, gain a larger perspective, and connect to the inner world.

Miniatures can serve as a vehicle for communication through symbolism, where the client can create their own meaning and truth. Individuals place meaning on objects based on past experiences, and allowing someone to experiment with the process of labeling new symbols evokes a feeling of freedom. “Miniatures help trigger the inner experience and facilitate the expression of feelings, emotions, or situations” (Schaefer, 2003, p. 200). Miniatures require the use of imagination, creativity, and playfulness.

These features are not always present in typical therapeutic techniques used with adults. Introducing fun and fantasy can enliven and enrich therapeutic interactions between group members and the therapist (Schaefer, 2003). These elements tap into the client's inner child, opening up and allowing for a new way of being.

Literature Review

This review highlights the current literature as it pertains to the benefits of direct play therapy interventions with adults on an inpatient unit.

Play

“Play is a universal phenomenon for children around the world” (Niec & Russ, 2014, p.3). Play is not just another way of having fun but serves a larger purpose. According to Krasnor and Pepler's (1980) model, play is comprised of four components: nonliterality, positive affect, intrinsic motivation, and flexibility. They believed “pure play” involves all four of these components in varying degrees (as cited in Niec & Russ, 2014, p.3). Within this model both cognitive and affective processes are active. “Flexibility and the use of symbolism and pretend are important aspects of cognitive functioning” (Niec & Russ, 2014, p.4). While, positive affect and intrinsic motivation are important affective processes (Niec & Russ, 2014). Play provides an opportunity for both children and adults to practice skills.

Even though adults may feel as though they have lost daily permission to play, play is incorporated in subtler ways. For example, having conversations aloud with ourselves in preparation for a future talk with someone, or pretending to be someone else to better understand their point of view (Schaefer, 2003). Taking on new roles can help us gain self-awareness and understanding of how we navigate the world. Just as children

play to practice skills, role-play, solve problems and regulate emotions, adults can do the same (Gray, n.d.). Thus, the use of play in therapy could be just as beneficial for adults as it is with children.

Play Therapy

The International Association of Play Therapy's defines play therapy as, "the systematic use of theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (Association for Play Therapy n.d., as cited by Motin, 2011). Winnicott (1971) found that "It is in playing and only in playing that the individual child or adult is able to be creative and to use the whole personality, and it is only in being creative that the individual discovers the self" (p.54). Play therapy is the use of the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development (Kottman, 2014). Play therapy can include the usage of miniatures, sand tray, games, art supplies, and dolls (Schafer, 2003). It is closely related to the techniques used by expressive art therapists. Just as art, music, and movement touch knowledge that is outside of our conscious awareness, so does play (Bruner, 2000, p.334). For adults, play fosters numerous adaptive behaviors including creativity, role rehearsal, and mind/body integration. Engaging in play or personal creativity has been found to engage the right brain hemisphere.

Play Therapy and The Brain

From infancy through the life span, the right hemisphere is dominant for the non-conscious reception, expression, and communication of emotion and the cognitive and

physiological components of emotional processing (Schoore, 2009). Research shows, engaging in the creative exploration of play activates the right brain hemisphere (Schaefer, 2003). Play is a holistic experience that invites one's total being into the process (O'Connor, 1991). "Play uses both hemispheres of the brain. The left, analytical side is essential in deciding what to do next and how to express oneself. The right, artistic side allows individuals to enjoy the experience of creativity" (Hoffman, 2003 p.5). However, not all play engages this right side of the brain. For play to help address developmental trauma it must engage the right brain, where the original wounding occurred (Gordon, 2014). Not only does play provide critical resources for dealing with stress and the wellbeing of adults, but also repeated play can rewire the brain. Play establishes and reinforces the neural pathways that lead to the development of playfulness (Gordon, 2014). Considering the right hemisphere's role in self-awareness, empathy, identification with others and the processing of self-related material we might hypothesize right-brained play would have beneficial effects (Gordon, 2014).

Directive Play Therapy

Play therapists practice under several different theoretical orientations. These may include; client-centered, Adlerian, cognitive behavioral, integrative, directive and non-directive. Directive play therapy is the approach used in the following intervention with adults on two inpatient units. Other names for this integrative approach include: structured, prescriptive, focused, and non-humanistic (Boswell & Leggett, 2017). "Counselors use directive play therapy to focus attention, stimulate further activity, gain information, interpret, or set limits" (Jones, Casado, & Robinson, 2003). The counselor purposely structures activities in order to elicit imaginative responses from the client

(Boswell & Leggett, 2017). The activities chosen cannot be randomly selected and must come with rationale for being used (Hambidge, 1955; Jones et al., 2003). Directed play therapy can be more appropriate for hesitant or ‘concrete’ adult clients who may fear or not value creative expressiveness or for clinical work when time is limited (Garrett, 2014). Directive play therapy with more literal adult clients also works better in short-term, solution focused or cognitive-behavioral- based work which can often have a more interpersonal focal point of change (La Bauve et al., 2001 as cited by Garret, 2014).

Play Therapy with Adults

Hoffman (2003) explores play therapy’s ability to cultivate emotional expressiveness in adults through qualitative research. The researcher used unstructured interviews, observations, and documents to come to their conclusion. Emotional expression was defined as, “the ability to voice one’s feelings to another individual” (Hoffman, 2003, p.12). The study included eight participants who engaged in a series of five, 20 minutes play therapy activities using the “Bag of Feelings” (Hoffman, 2003 p.4). The “Bag of Feelings” is a play therapy tool that uses 8 different balls that has one of eight primary emotions written on it (Hoffman, 2003). Each subject was instructed to select a ball and tell a story of when they have felt this feeling. The story had to include the use of the subject, be a real-life experience, contain a beginning, middle and end, and include the actual subject’s experience when this life event occurred (Hoffman, 2003). Hoffman (2003) claimed, “Play therapy helped the participants become more adaptable and flexible “in the moment” of the play therapy sessions and overall more expressive of some emotions as a result of the play therapy activities” (Hoffman, 2003, p.5). This claim could be connected to the neuroplasticity of the brain, the creation or generation of new

connections between neurons due to practicing more emotional expressiveness. Another factor that contributed to the participant's sense of playfulness and emotional expression was their desire to become more emotionally expressive (Hoffman, 2003). "Additional opportunities to practice and to repeat experiences could result in greater emotional expressiveness" (Hoffman, 2003, p. 5). Providing these instances for adults to be more expressive and play with emotions could benefit their overall wellbeing and ability to express them fully. Motin (2011) found similar results in using CBT Play Therapy with adults with depression.

Motin (2011) created a treatment manual using CBT Play Therapy intended for adults with depression ages 18 and up. The manual combines cognitive behavioral therapy, play therapy and other contributing theories from art therapy, psychodrama and cognitive behavioral play therapy. The ten-week treatment manual includes an extensive literature review presenting theory, existing research, and detailed week-by-week sessions. The benefits of art within play therapy is named and appreciated throughout the dissertation. The ability to express emotions verbally can be a difficult task for someone who is unable to or unknowingly unable to express themselves through words (Mortin, 2011). "According to Odell-Miller, Hughes, & Westacott (2006), art therapies provide a psychotherapeutic intervention that enables patients to affect change and growth using art materials to gain insight and promote the resolution of difficulties" (As cited by Motin, 2011, p.51). Motin brings to light the strong connection between what occurs in play therapy, art therapy and psychodrama; claiming that combined they can create an effective treatment for depression in adults. If children are able to overcome emotional distress through play, it can be presumed that what was once utilized as a child should

still hold significant value as an adult (Motin, 2011). “Play can help in getting the person through the obstacles that he or she is facing within themselves preventing them from getting to the next stage in their development. The foundation of play is important for development not only in youth but adulthood as well” (Motin, 2011, p.65). By reintegrating play into an adult’s life one could potentially reinforce their ability to overcome depressive states by utilizing old methods of problem solving and expression that were once used in their childhood play (Motin, 2011). This is closely related to the findings of Hoffman (2003), in that play therapy can create another means for communication of emotions and allow for greater expression of emotional states.

Katharina S. Bruner (2000), MA, ATR shares her first-hand experience leading a play therapy group with adults on a short-term inpatient unit, her findings are presented as a case-study. The group of adults she worked with “were mostly going through depression or stress due to a life crisis” (Bruner, 2000, p.333). The five women and one man who came to the group had known each other for at least a week when the session occurred. The members had attended music, art and talk therapy groups together where they shared personal stories and struggles. They were invited to engage in a playgroup where Bruner (2000) provided them with different shaped blocks, little animals, people and toy furniture. She invited them to sit around the toys laid out on the floor and do whatever they wanted. As the play began and the group members started creating their very own worlds, Bruner (2000) asked questions that guided the play. These questions explored the strengths of the scenes created and asked what they could learn from the miniatures in front of them. She pointed out the “child’s delight” she saw in their eyes,

and patients remarks such as, “This was fun” or “I thought we were just going to play” (Bruner, 2000, p.336).

The paper provides specific details regarding the client’s experiences within the play; what they created with the blocks, and what was said or discovered within the play. Bruner (2000) states, “In a setting like our hospital, where people generally stay for a short period of time, the important issues become evident in just one play session. You get to the heart of the matter right away. That is one aspect that makes play therapy such a powerful tool” (p.337). Bruner recognizes the opportunities for growth and movement play therapy provides. In the first session a man used a black panther to express death and his suicidal ideation. In the second session the panther became the symbol of protection guarding his fortress. Finally, in the third session the panther became the symbol of life and hope. This experience illustrates the shift within the self that can be communicated through the usage of miniatures. Bruner (2000) was able gain knowledge about the internal world of her clients, by making symbols and play techniques available. The following research by Marston and Szeles-Szecsei (2000), also shares this benefit of getting to know clients better through play. Observed behavior during play can provide the therapist with valuable information.

Marston and Szeles-Szecsei (2000) present play therapy interventions that were used with older adults in residential settings. The play therapy approaches discussed were helpful in overcoming obstacles in therapy and assessment (Marston & Szeles-Szecsei, 2000). The obstacles could have stalled progress in treatment indefinitely, and the usage of play directly confronted many of these problems. Each of the approaches mentioned included playing games (checkers and cards) with the residents; in specific instances this

helped with expression, decreasing resistance, and cognitive assessment. Marston & Szeles-Szecsei (2000), presented a time where playing cards with a resident gave the therapist a clearer picture of where their anger and frustration came from. The resident was upset with his recent changes in cognitive functioning, and the card game served as an example of this problem. He had trouble comprehending the rules he had previously understood. This allowed the therapist to better help the resident adjust to their cognitive losses and inform the staff of more useful ways to help him express anger. The researchers mention the importance of sharing the purpose of play to the clients and others involved in their care. “Otherwise, there may be some difficulty if the resident describes the therapy session to these people as a time when the resident and therapist “play games” (Marston & Szeles-Szecsei, 2000, p.124). This is an important difference to note in the usage of play therapy with adults versus children. Similarly to Marston and Szeles-Szecsei (2000), Olson-Morrison (2017) took a less directive approach in the treatment of their client. They too take into account developmental age and building mastery through card games.

Olson-Morrison (2017), demonstrates the application of Integrative Play Therapy (IPT) with a 43-year-old woman with a history of childhood interpersonal trauma. IPT incorporates evidence-based, directive methods in trauma treatment with developmentally appropriate, insight-oriented, and nondirective models of play therapy (Drewes et al., 2011; Green & Myrick, 2014, as cited by Olson-Morrison). This approach allows the therapist to adopt both nondirective and directive approaches to play therapy. Using non-directive techniques in the beginning stages can be helpful in handling initial resistance to play. “The play is not imposed on the adult, just as talk therapy is not

imposed on children in the play room” (Olson-Morrison, 2017, p.176). The therapist allows the client to take the lead yet still provides options for using play to meet therapeutic goals. A directive approach helps structure therapy in order to teach coping skills or affect regulation.

Olson-Morrison’s (2017) case presentation of Antonia included her background and phases of therapy. The therapeutic phases were: safety, relationship building, mastery, integration of traumatic events and termination. Antonia was diagnosed with Bipolar Disorder and Borderline Personality Disorder, her chief complaints were feeling depressed, irritable and anxious. Creating safety for Antonia was marked as the first therapeutic task. This was done through an initial nondirective approach where she was free to explore the play space and engage in play on her own. Once safety was established within the therapeutic relationship it was time to work on Antonia’s treatment goals. Emotional regulation and stabilization was worked through with the usage of feeling cards and play figurines. “With minimal prompting, Antonia decided to use feeling cards. She chose a card with a face and associated feeling, and she played out a story related to the feeling with the miniature figurines of her choosing” (Olson-Morrison, 2017, p. 179). This led to her being able to label her own feeling states and accompanying bodily sensations. Within Antonia’s treatment card games were introduced to build mastery and neutralize the intensity of her emotions so she was able to verbalize her feelings and connect with the therapist (Olson-Morrison, 2017).

By the sixth month of their time together Antonia was ready to approach the topic of traumatic events. With sand tray and miniature figurines Antonia played out her trauma stories, where she was able to include sensory and emotional content in her

narrative. Play served as the primary medium through which she was able to gain confidence and mastery over her trauma (Olson-Morrison, 2017). “This case study highlights the importance of choice and collaboration throughout the treatment process” (Olson-Morrison, 2017, p.180). As the client regained developmental milestones she was able to tolerate more directive and talk-based therapeutic approaches. Integrating play therapy into trauma treatment with adults addresses developmental deficits resulting from complex trauma. Play therapy has the capacity to be a safe, nonthreatening and expressive medium within a strong therapeutic relationship. Doyle and Magor-Blatch (2017), conducted similar research with the addition of sandplay therapy.

Doyle & Magor-Blatch (2017), explore the therapeutic tool of sandplay, which uses figurines placed into a tray of sand. This technique creates a dialogue between the client’s conscious and unconscious pieces of the psyche. Sandplay is described as a versatile tool that can be used with many client groups even though much of the literature focuses on use with children (Doyle & Magor-Blatch, 2017). It has been used effectively with adult survivors of trauma, and PTSD, dementia, and substance use (Doyle & Magor-Blatch, 2017). Using a case study design they examined the efficacy of sandplay therapy for a 52-year-old woman who presented with a range of difficulties stemming from childhood abuse.

The client, Mrs. A, had a diagnosis of bipolar disorder and reported dissociation, depression, anxiety, a poor sense of self, and an inability to “sit with stillness” (Doyle & Magor-Blatch, 2017). Overall, the researchers found that the client’s measured psychological well being increased after 10 weeks of sandplay therapy. The study took into account both quantitative and qualitative measures, including the clients own

perception of the therapy's efficacy and value. Mrs. A reported an overall decrease in depression with a 12.6% improvement on the BDI-II. She also had a 4.7% reduction on the DASS Depression Scale and her stress score improved by 23.8%. She did however show a small increase in symptoms of PTSD (4.7%) and anxiety (17.4%). These increases were attributed to two highly stressful family events during the break of completing therapy and the quantitative measures.

Mrs. A "reported sandplay to be less intrusive than other therapies," and it provided a form of expression beyond verbal language (Doyle & Magor-Blatch, 2017). Sandplay allowed her to find a place outside of herself to explore and place her issues. As she left sessions she noted, something in her subconscious had "shifted" and often felt "happy" (Doyle & Magor-Blatch, 2017, p.19). The play miniatures allowed Mrs. A to externalize her issues without words in a way that made them believable and feel safe. The quantitative and qualitative approach in this research is appreciated and valued. It gives a greater picture of what the client's experience of the 10-week sandplay therapy was. The researchers noted that the study was only one participant and therefore, the findings cannot be generalized (Doyle & Magor-Blatch, 2017). Due to the successful results of this study it supports the notion for future practice of sandplay therapy with adults.

The Therapist

Successful therapy begins with the therapist. The therapist's approach in introducing and using play therapy within group and individual therapy is crucial for its success and positive impact on clients. According to the literature, there are several key qualities a therapist should exude when running play therapy sessions. These qualities

include empathy, genuineness, unconditional acceptance of the client, consistency, courage, confidence, and relaxation (Axline, 1947). These qualities can be shown in nonverbal and verbal ways. The nonverbal core skills include leaning forward to demonstrate openness, appearing interested and comfortable, making eye contact and head nodding. Attunement is another skill the therapist must hone; this includes showing expression and tone congruent with the client (Boswell & Leggett, 2017). “The play space, the group setting and the presence of the therapist provide the limitations, the boundaries, the container” (Bruner, 2000, p.337). The creation of safety by the therapist enhances the client’s freedom to play. The therapist sets the tone, provides the materials, defines the play space and invites creativity to flow (Bruner, 2000, p.337). Within the play expressions of the imagination can manifest and be received, understood and appreciated by the therapist (Stone, 1980). The therapists approach needs to be taken into account when looking at the use of play therapy techniques with adults. The approach will affect whether the client(s) feel(s) safe and willing to participate.

Therapeutic Approach

Resistance is to be expected in the introduction of play therapy to adults due to its association with children. Establishing an environment where the client feels safe and accepted is the first step in building the relationship between therapist and client. Therefore, it is important to give the client permission to choose play as a course of healing, giving them choice in their treatment course (Olson-Morrison, 2017). This is a large distinction between how play therapy is approached between adults and children. Clients should feel a part of their treatment plan and in control of its course. Olson-Morrison (2017) states, “the therapist upholds developmental sensitivity in that when

adults progress through treatment, the therapist may offer play-based activities to support social, emotional, and cognitive developmental remediation” (p.176). The therapist must accept the client exactly how they are and support the use of both talk and play modalities for healing and growth (Olson-Morrison, 2017). The therapists approach and selection of materials are to be purposeful and appropriate for the population being treated.

Selecting Materials

Materials provided must be chosen purposefully and include a variety of symbols from varied categories (Leggett & Boswell, 2017). However, according to Landreth (2012), limiting the number of toys and materials does not stifle the range of feelings and messages that can be communicated. The selection of toys and materials will vary depending on a number of issues including the counselor’s theoretical orientation, personal values and ideas, space and budget (Nash & Schaefer (2011), As cited by Leggett & Bosewell (2017), p.4). The key to the selection of toys and materials for directive play therapy is a focus on the need of the client. The therapist needs to be aware of the goal of the session and what it is meant to provide.

Methods

Before running the very first play therapy group on the unit it was decided how data would be collected. Notes were to be taken directly after each session to ensure their accuracy and leaving minimal room for error. These notes would include the figurines chosen for both the warm-up and main directive. The environments the clients chose for their directive would also be recorded. Lastly, it was important to record any remarkable responses or body language observed. These sessions were also discussed within clinical supervision once a week. This was where the group facilitator could express any concerns

or work to solve problems with another expressive art therapy clinician. Supervision was used to ensure there were no major changes that needed to be made to the group curriculum.

This research was conducted over the span of four weeks collecting data from four different groups. After each group clinical notes were taken noting the patients behavior and presenting mood. Personal notes were also made to note more specific responses such as what figurines were chosen body language and remarks about the overall use of play. The data collected was then placed into a table noting the number of times each figurine was used. For three of the sessions all of the same figurines were provided to the group participants. During the fourth session the clients were deliberately given pieces of paper with the description of the figurine rather than the physical object. Differences and similarities in responses were observed and recorded for further discussion.

Designing the Intervention

In the process of designing the group play therapy intervention several pieces of research were considered following the literature review. Each piece of the intervention was carefully selected with clinical reason. The intervention begins with a warm-up question that places them into the play space and invites them to experiment with role.

In general, drama therapists begin group or individual session with a warm-up. The purpose of the warm-up is twofold. First, it helps to move the individual into a creative, playful state, loosening up the body, engaging the imagination, and establishing connections among group members. Second, it helps each individual invoke or locate a role (Schaefer, 2003, p. 21).

The intervention utilizes structured play therapy, which includes specific

directives giving permission for the participants to play (Casado, Jones & Robinson, 2003). The group was planned with the purpose of offering the opportunity for self-exploration, engaging with play, and using one's creativity and imagination. The directives given during each session provided structure as well as freedom for expression. Miniature figurines allow for a level of distance between self and its suffering. The group provides the opportunity for feelings and emotions to be placed onto a symbol chosen by the participant.

A majority of the expressive art therapy groups facilitated on these units have a specific objective and directive planned beforehand. Having similarities between each group provides clients with a feeling of safety and containment. This is due to knowing what is expected of them. Each group begins with introducing yourself and answering an opening question, and ends with answering a closing question. The intervention used was designed with this group structure in mind. When planning more specifically the play therapy intervention, it had to be developmentally appropriate for clients to receive the most benefits from the experience.

Participants

The play therapy intervention was carried out on two hospital inpatient units for adults presenting with severe depression, anxiety, or psychotic disorders. The participant's ages ranged from 17 to 60 years old and the group size ranged from four to seven members. Within the groups there was also a range in cognitive functioning and the presence of developmental delays. While there was some diversity in race, gender and sexuality, majority of the group members were Caucasian cisgender heterosexual females. Group attendance and full participation in the activity were not required during

the session. Groups are a large portion of the treatment provided on these units and patients are encouraged to attend. The group was offered as an “expressive art therapy group” and “art therapy group.” These groups are placed on the weekly calendar available to all patients on the unit and are announced at the time of the group over an intercom system. The participants had no prior knowledge of the contents of the intervention.

Materials

The materials provided to the group members were all borrowed from a fellow art therapist and carefully selected to represent a broad range of options for expression. The participants were provided with all of the materials needed to complete the play therapy intervention. The room was set up with 33 play figurines (see list below), markers, colored pencils, plastic gems, glue and 8.5 x 11” white paper for each participant. The group was held in two different rooms, each of them having a large table and 8 chairs.

Play Figurines included (33):

Character driving in a carrot
Peacock
Snow white
Golden retriever
Lobster
Rhino
Robber with gun
Small monkey
Cupid
Bride
Cruella de Ville
Mario in cloud holding star
Pig
Cow
Mickey mouse
Ghost dog
Dragon
Skeletal spine

Shark
Green fairy
Lion
Buzz Lightyear
Sleepy
Whale
Body builder
Metal strong man
Buddha
Giraffe
Monkey scratching head
Mike Wazowski
Starfish
Wicked Witch
Little Mermaid

Figure 1. Play figurines that were provided.

Results

Session Outline

Warm-up.

Each of the sessions began with an opening activity where participants were asked to select a figurine that represented or symbolized how they were feeling in the moment. Once each participant chose their figurine they were asked to have the figurine introduce the client to the group. This was met with confusion and was explained further; have your figurine let us know how you are feeling today, what would they like to share about you? A few of the participants were prompted with more questions to better understand why they chose the figurine. After each person had their turn the group members were asked to place their figurine back into the center of the table.

Directive.

The participants were then invited to select a figurine that represented or symbolized how they would like to feel. Once everyone decided on a figurine they were each handed a piece of white paper and invited to draw an environment for the figurine to

live in using the art materials provided. The group members were asked to think about where their character would like to spend time, and what kind of things they would want to be surrounded by. Each of the groups wanted to listen to music as they worked on this portion of the activity. The members were asked if they had any song requests, and if so those were played first. This directive took about 20-25 minutes of the 45 minutes allowed for group. After the participants were asked to make their final marks of color on the paper they were invited to share what they had created and why they chose the figurine. Follow-up questions were asked by the therapist to see if further clarification was needed. This then led to a group discussion about what it was like to use the figurines and go through this process.

Closing.

After each group member had the opportunity to share their artwork they were given the following closing question; if your figurine could make a wish for you, what would that be? As the participants were ready to answer they shared their wishes. The group was encouraged to keep their drawings, and thanked for coming.

Warm-up	#	Directive	#
Wicked Witch	1	Mickey Mouse	1
Giraffe	1	Little Mermaid	1
Monkey	1	Pig	1
Sleepy	2	Buddha	3
Dog Ghost	2	Golden Retriever	2
Cow	1	Lion	2
Dragon	1	Green Fairy	1
Mario	1	Peacock	1
Buzz Lightyear	2	Mike Wazowski	1
Green Fairy	1	Dragon	2
Peacock	1	Cow	1
Carrot Car	1	Snow White	1
Octopus	1		
Starfish	1		
Blue Marker	1		

Figure 2. Number of times each play figurines was used and when.

Figure 2 displays the number of times each play figurine was used, and whether it was selected for the warm-up or directive. This table only includes the three groups that used the physical play figurines. Some figures were chosen two or three times, others were not chosen at all. During each group some members were inclined to pick a couple figurines up to get a closer look before selecting them. Several participants were also determined to figure out who the characters were if they recognized them from a movie. The therapist always responded the same way, “It can be whoever or whatever you’d like.”

The last group that was held used only the written descriptions of the play figurines. The activity was met with laughter as they read the objects names, they appeared obscure and random without the physical figure. Only until the very end of the

group were the members told where these descriptions came from. This group was then met with critique; one member said they wished they could have used the actual figurines instead. Many of the group members found it harder to get started on their environment; they were more inclined to include a drawing of the figurine in the environment.

Therefore, it appeared to be daunting to feel required to draw the figure. Participants said things like, "I'm not a good artist," or "I can't draw." While, in the previous three groups this happened rarely; they usually just placed the figurine onto the paper as if it was living in the environment they created.

The group was held on two different units, the short-term unit primarily for individuals with depression and the anxiety and the psychotic disorders unit. The responses to the figurines varied between the two units. Individuals on the psychotic disorders unit had already been exposed to play therapy before, thanks to their current group art therapist. They were noticeably more willing to engage with the figurines in a playful or child-like manner. One individual took the dragon and flew it through the air as if it was flying and breathing fire. Another took the character in a carrot car and drove it around the table. This behavior put smiles on other group members faces, including the group therapists. It was refreshing to see adults capable of being playful and child-like.

Another unique occurrence on the psychotic disorders unit was an individual choosing a blue marker as their figurine. This marker was set out for use during the artistic portion of the activity and was not intended for use in the play directive. However, the individual chose it as their warm-up figure, and did not provide a clear reason as to why. Hypotheses can be made about why there are differences between these two different units or populations. There are two factors at play, the fact that they have

already been exposed to play therapy thus, they are already comfortable with the materials. Secondly, they have been diagnosed with a different mental illness, which might suggest a tendency to live more often in the imaginative realm.

Despite these differences there were also similarities in both units' difficulty with the warm-up. Each unit struggled with being able to step into the role of the figure and introduce themselves as such. Only two participants followed the direction to introduce yourself as the figure and share how you are doing today. An example was never given by the group therapist, nor were participants corrected if they did not follow the prompt exactly. This could perhaps suggest the need to give an example to show the expectations of the exercise.

Buddha was the only figure chosen three times for the directive (Figure 2.). Each time the Buddha was described as a positive symbol of enlightenment, wisdom, and peace. All of the group members who selected the Buddha depicted him in an environment outdoors for example, near a pond, or sitting on a picnic blanket. The other most popular figure chosen three times was the dragon. This figurine was much larger than the others, was breathing plastic fire that lit up and had large wings that could move. The dragon was chosen once for the warm-up and twice for the directive. When chosen for the warm-up it was used as a symbol of anger; the participant was feeling angry due to an altercation with their family. The other two participants who chose the dragon for the directive associated it with strength and confidence. They wished to build their own strength and resiliency.

Due to the design of the group and the current situation of the participants it was expected that negative symbols would be used for the warm-up and positive symbols for

the directive. For the majority of the participants this was the case. This can be seen clearly when comparing the same figurines chosen for the warm-up and directive. Such as the dragon (mentioned above) and the green fairy. The green fairy for the warm-up symbolized old age, and being crotchety, while for the directive it symbolized being wise, knowledgeable, and magical. This shows the versatility of figurines symbolism, and people's ability to ascribe their own meaning to objects. The same figurine could hold numerous meanings depending on the individual.

During the sessions individuals who were typically quiet on the unit were able to more freely and easily express themselves. They did not have to make eye contact with the group, and were able to direct their attention and gaze onto the object in front of them. Having a specific object and drawing to refer to while talking appeared to make it easier to share with the group. Throughout all four of the groups none of the participants asked to not share their responses. During all of the groups only one individual requested to leave early due to feeling anxious.

Discussion

Entering this research the major question was if adults on an inpatient unit would positively respond to play therapy techniques. What would happen when adults were invited to engage with toys? There was an expectation of resistance to using a technique often associated with the treatment of children. However, it was found if the directive is developmentally appropriate participants are willing and open to engage in the activity (Olson-Morrison, 2017). The therapist's demeanor and approach also needs to be taken into account when looking at the success of these groups. Unfortunately, no surveys

could be collected asking the participants thoughts of the directive. Thus, the only measurement of its success is based on the group therapist's own observations.

Due to the limitations on data collection, conclusions on whether or not the intervention stimulated the right brain hemisphere cannot be made. However, based on observation, the activity appeared to boost several individuals' mood (smiling, laughing, brightened affect). Similar to Bruner's (2000) experience, I too noticed the "child's delight" in some participants' eyes, and patients remarked, "This was fun" or "I liked this." Given the seriousness surrounding patient's treatment and mental illness, introducing a playful element into their day can be uplifting and refreshing. One individual appeared to connect greatly to the directive figure they had chosen and made it a point to remember the figures smiling face and keep their drawing. This moment connected greatly to Bruner's (2000) client and the panther. Although, progress with the figurines could not be noted over time, a shift was seen when comparing their previous presentation to their current presentation. The client was more willing to share, appeared to have a more positive outlook and their affect brightened as they described their drawing. It appeared as though something had shifted internally. Symbols can be powerful and provoke intense emotion; they can also stay with us.

The therapist took a non-judgmental, supportive and empathic approach. They responded both non-verbally and verbally to what the participants shared. The group members were also encouraged to share feedback with the group leader. Based on recorded observations, members who expressed their opinion of the group had nothing but positive remarks for the directive and figurines. The only critique came from the last group that was run without the figurines and only the written descriptions of the

characters. This group showed the importance of having the physical object of reference and symbolism (Doyle & Magor-Blatch, 2017). It was hypothesized that individuals would be more creative without having an object in front of them. Without having the visual component of the object they would then have to imagine the object on their own. However, this deemed to be more frustrating versus creatively stimulating. Their inner critic that told them they were not a good enough artist became louder and perhaps affected their creative process.

After the data was collected it became more obvious that the hospital's culture must be taken into account. This is a hospital that regularly offers expressive art therapy groups, and has on staff five expressive art therapists. Patients are used to being introduced to new ways of exploring the self through other modalities such as, drama, art, and music. Introducing play therapy techniques was a new concept but, not unlike other directives that push them outside of their comfort zone. Therefore, this directive may be received differently on inpatient units that do not already provide the usage of the arts in therapy. Having an expressive art therapist or play therapist to facilitate such a group is also crucial in ensuring the proper usage of the arts in therapy. During the sessions, the group leader never interpreted participant's work, and figurines were never referred to as their character name. For example, if someone chose a witch and referred to her as a princess the participant would not be corrected. These are important features of both art and play therapy (Doyle & Magor-Blatch, 2017). They allow for the participant to use their own imagination and place their own meaning onto the projective objects.

Martin (2011) mentioned, the ability to express emotions verbally can be difficult for someone who is unable or unknowingly unable to express themselves through words.

Incorporating the art portion of the directive was essential for this very reason. The drawing gave them another modality to express themselves through. It also promoted further insight into why they chose the figurine they did, what that figurine needs, and how it connects to them. Each participant had the opportunity to then process the image verbally. Taking this extra step to create the environment for the figurine might have fostered individual's ability to express their emotions and hopes for the future.

The play therapy directive also aided the group therapist in getting to know individuals better. Marston & Szeles-Szecsei (2000) mentioned a time where playing cards with a resident gave the therapist a clearer picture of the client. This then allowed the treatment team to better support the individual. During these session's new concerns, wishes and aspirations were brought to light. Topics that were not otherwise touched upon with the participants were being processed with the group. This kind of information is essential in short-term care where daily updates are given and changes are noted. The treatment team looks for the patient's ability for insight, and self-awareness. This directive appeared to foster that ability, or point out the patient inability for self-reflection. It can be assumed that perhaps some participants just did not want to engage with this part of themselves due to their current state.

Against Olson-Morrison's (2017) recommendation, the play was in fact imposed on the group members. Olson-Morrison (2017), suggests the therapist allow the client to take the lead and provides play therapy as an option to meet their therapeutic goals. The distinct difference between Olson-Morrison's (2017) experience and this research is their subject was engaging in one-on-one long-term therapy. This allows for the slow creation of a therapeutic relationship, and thus calls for different therapeutic approaches. On a

short-term unit there is not much time for the group therapist to build safety, connection and group cohesion. Thus, the use of directive play therapy and the therapeutic approach creates the containment, and the group expectation to engage with the play figurines altogether lowers the feeling of awkwardness or hesitation.

Conclusion

Further research could take into account the effect of using different figurines on participant's responses. What if participants were provided with trees, and rocks only or in addition to the other figurines? Does the usage of figurines that already come with a story affect overall creativity and engagement with the character? After completing a thorough literature review, the need for further research in this area became apparent. Very little research exists looking at group play therapy with adults, especially in an inpatient unit. Based on current research, it appears the potentially beneficial modality of play therapy is not being utilized as much as it should be with the adult population.

According to existing research, play therapy holds potential to diminish active symptoms, stimulate the right brain hemisphere, and provide another means of communication for clients. After the implementation of the directive created it was also found that play therapy can bring light and humor back into people's lives, even if just for a moment. The child-like enjoyment and lighthearted nature observed in each session gave the therapist and participants glimmers of hope for the future. It showed that moments of joy and playfulness are still possible, even among the road to recovery.

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