Play Therapy Evidence Summary

What is Play Therapy and how does it differ from 'just playing' or other play-based interventions?

Humans are neurologically hard-wired for play. Play is a necessity for childhood growth, development and wellbeing. Flourishing play brain circuitry is foundational for more complex neurological development of the cerebral cortex. The cortical region of the brain is responsible for learning and high-level neurological tasks such as thinking, reasoning, decision making, language and more. The biological, psychological and social benefits of play have been emphasized in over twenty disciplines evidenced through scientific research. A play-rich childhood is important for all children. Access to play is vital; however, there is a significant and important difference between play and Play Therapy (outlined below in Table 1.)

Table 1. Differences between play and Play Therapy

Category	Descriptor	Person/Practitioner
Play	Everyday play chosen and engaged in freely by children	Children, peers, siblings, family, community members (school, local area), etc.
Play-based learning	Learning through play in educative contexts	Teachers, teaching assistants, early childhood educators, playworkers, coaches, tutors, etc.
Therapeutic play	Everyday play has therapeutic qualities. Many health and allied health professionals recognise the importance of play and integrate play into their work.	Psychologists, occupational therapists, hospital play specialists, nurses, etc (Carrington et al., 2024).
Play Therapy	Play Therapy is a specialised form of child psychotherapy that encourages neuro-bio-psycho-social growth, development and overall wellbeing.	Play Therapists are postgraduate tertiary trained professionals, who are registered as Play Therapists, practice Play Therapy and engage in clinical supervision from an advanced Play Therapy clinician.

Access in childhood to a range of play experiences is especially critical for children when early childhood developmental concerns are identified and/or children are diagnosed with disabilities. Play-based learning and access to therapeutic play-based health services are recommended to ensure service delivery affirms a child's rights to developmentally sensitive service and neuro-affirming practices. Due to the unique and specialised skillset of Play Therapists, they are an important inclusion in multi-disciplinary supports for children with disabilities. NDIS listed supports, such as Psychologists and Occupational Therapists, may use play in their work with children (for example, Psychologists and Occupational). However, Play Therapists are specialists in "the mechanisms in play that actually produce the desired change", the therapeutic powers of play: 1) facilitating communication; 2) fostering emotional wellness; 3) increasing personal strengths; and 4) enhancing social relationships.

Play Therapy delivered by a trained and registered Play Therapist increases the intensity of play, benefiting brain and body. Play Therapy is "empirically supported with decades of research confirming its effectiveness", for a range of developmental domains, including wellbeing (see Appendix 1 for the summary table of Level 1 Play Therapy Evidence). Children with disabilities experience higher rates of behavioural, social, emotional and mental health difficulties. Play is the universal language of childhood; meaning that Play Therapy is a highly accessible, child-centred form of psychotherapy. In Play Therapy children can make gains in all six functional capacity areas as defined by the NDIS, namely: communication, social interaction, learning, mobility, self-care, and self-management. Factors that assist in functional capacity development include the Play Therapist's proficient psychotherapy skills, a safe and comfortable therapeutic environment (including toys and resources), a trustworthy therapist-child relationship, and skilled use of the therapeutic powers of play.

Who are the professionals that deliver this type of therapy (qualifications and registrations)?

The NDIS category "Other Professionals" currently recognises Play Therapists. Professionals in this category are stipulated to possess "a Bachelor's degree or higher in their relevant area and current registration or membership with their relevant registration and or professional body." Play Therapists must therefore have completed a Bachelor or Post Graduate studies in Play Therapy and be eligible for, and uphold, registration with a relevant Australian registering body (see APPTA and PACFA below).

International Play Therapy standards are defined by the International Consortium of Play Therapy Associations (IC-PTA). Currently, the Australasia Pacific Play Therapy Association (APPTA) is the only Australian Play Therapy association with an Organizational Membership with the IC-PTA.

In Australia, the Allied Health Professions Australia (AHPA) represents Play Therapy. Two Play Therapy associations - APPTA and the Play Therapy Practitioner's Association (PTPA) - are Affiliate Members of AHPA. Additionally, Australian Play Therapists may choose to be registered members with the Psychotherapy and Counselling Federation of Australia (PACFA). PACFA's College of Creative and Experiential Therapies (CCET) includes Play Therapy in their definition of Creative and Experiential Therapies. As APPTA is a self-regulating association, they hold Qualifying Membership with the National Alliance of Self-Regulating Health Professions (NASRHP).

At this time, there are two associations that Australian Play Therapists can register with that are members of both NASRHP and AHPA:

- APPTA
- PACFA

Current Bachelor or Post Graduate studies in Play Therapy training accepted by APPTA and PACFA:

- Deakin University Master of Child Play Therapy (MCPT) - 2 years full-time/2400-hour volume of learning (inclusive of clinical placements and clinical supervision).
- Internationally completed Bachelor or Post Graduate studies in Play Therapy can be assessed for AQF equivalence (see Appendix 2. for information on AQF, TEQSA, and ASQA).

There are two further AQF level 8 Australian courses in development:

- Queensland Institute of Play Therapy (QIPT) is developing a Graduate Diploma in play therapy to be accredited by ASQA. Entry requirement for this program will be a Bachelor or Masters in mental health and registration with either PACFA or ACA.
- Play Therapy School is developing a Graduate Diploma in play therapy to be accredited by ASQA. Entry requirement for this program will be a bachelor's degree in education, psychology, occupational therapy, speech pathology or similar.

Additionally, in Australia there is one association that Play Therapists can register with that is a member of AHPA:

- PTPA

Members of PTPA hold an undergraduate degree in Human Services or Education (or similar) and Play Therapy training (from TEQSA accredited and non-TEQSA accredited training providers). A Bachelor or Post Graduate study in Play Therapy is not currently a requirement of PTPA membership. Instead, 200 hours of Play Therapy training from either a TEQSA accredited and non-TEQSA accredited training provider is required, 300 clinical practice hours, and 40 hours clinical supervision (total volume of learning = 540 hours).

And, in Australia there is one association that mental health professionals can register with:

- APTA
- Members of this association practice under their mental health designation, for example a mental health social worker.

Members of the Australian Play Therapists Association (APTA) hold qualifications in: Psychology (Post Graduate Degree or Masters level), Social Work (Dip SW, Bachelor or Masters level), Occupational Therapy (Bachelor or Masters level), Mental Health Nursing (Grad Dip RN, Post Grad Dip or Masters level), Counselling (Bachelor or Masters level), or Creative Art Therapy or Art Therapy (Masters level), along with registration with a regulation body related to their primary Mental Health qualification: Level 3 ACA, Clinical Member PACFA, AASW, AHPRA, or ANZACATA. A Bachelor or Post Graduate study in Play Therapy is not currently a requirement of APTA membership. Instead, 150 hours of Play Therapy training from either a TEQSA accredited or non-TEQSA accredited training provider is required, 300 clinical practice hours, and 50 hours of clinical supervision (total volume of learning = 500 hours).

Evidence of the benefit of Play Therapy in improving disability-related functional capacity (highlight Level 1 evidence, peer reviewed and evaluation reports, and other forms of evidence)

For this Play Therapy Evidence Summary, a rapid scoping review of Play Therapy Level 1 research evidence was conducted. Play Therapy meta-analyses and systematic reviews from 1999-2024 (25 years) were included in this review. 13 Level 1 Play Therapy studies were reviewed, including eight meta-analyses and seven systematic reviews, two studies conducted both a systematic review and a meta-analysis (see Appendix 1). **Note:** article number 12 and 13 share a data set so will be counted as one data set; this means data is presented on 12 studies (n=12). Five studies were disability focused reviews on: 1) disabilities; 2) Autism Spectrum Disorder and developmental language disorder; 3) intellectual disability; and 4) vision impairment. Additionally, three studies focused on early childhood concerns including: behavioural problems, sense of relational attachment, and school settings. The remaining seven studies covered a wider range of reasons for engaging in Play Therapy in various settings. The eight meta-analyses reported a range of significant Effect Sizes (ES): three studies reported large ES, five studies reported medium ES, and one study reported small but significant ES. In total 415 studies were included in the 12 meta-analyses and systematic reviews. With studies covering an age span of birth-19 years.

Favourable outcomes of Play Therapy include:

- Improved: language skills (increased receptive and expressive vocabulary, and symbolic play skills promoted functional language abilities); social skills (social-interactive play that increased social competence in young children, increased interaction and social participation), social adjustment, self-concept, self-efficacy, social relationships, social adjustment, family functioning, family adjustment, communication skills, promotion of growth abilities, emotional adjustment, mental health, fine and gross motor skills, cognitive skills, attention, functional vision, balance orientation and vestibular system, developmental/adaptive behaviours, academics, development, and functional status of children.
- Reduced: internalising and externalising difficulties, disruptive behaviours, behaviour problems, total behaviour difficulties, anxiety, aggression, reaction to traumatic event/s, trauma symptoms, and caregiver-child relationship stress.

Specific childhood populations that benefit from Play Therapy include children with a range of diagnoses, namely: dual diagnoses, developmental disabilities, Autism Spectrum Disorder, intellectual disability, physical disability, Attention Deficit and Hyperactivity Disorder, physical ill-health, mental ill-health and trauma. Play Therapy factors identified as beneficial for children with disabilities include: the non-verbal nature of the psychotherapy approach and the positive holistic impacts of play-based approaches on child development. Play Therapy Level 1 evidence demonstrates benefits across the NDIS defined six areas of functional capacity (see Table 2 below).

Table 2. Play Therapy increases functional capacity

Functional Capacity	Play Therapy benefits for disability-related functional capacity	Level 1 Research
1. Mobility	• Play Therapy improves fine and gross motor skill development, balance orientation and vestibular system, and physical activity levels. • Play Therapy is a holistic child development approach, activating both the brain and body through play.	5. (12. & 13.)
2. Learning	• Play Therapy improves academics, developmental/adaptive behaviours, attention and the functional status of children. • Play Therapy develops self-confidence and provides opportunities for hands-on learning and problem solving, compensatory skills, development of socio-emotional, and coping skills.	2. 3. 4. 5. 6. 7. 8. 9. 10. 11. (12. & 13.)
3. Communication	• Play Therapy increases language skills, dialect, play skills, and communication skills. • In Play Therapy direct, two-way communication is enhanced through toys and play. • Play therapy promotes capacity for self-expression with children learning to connect body sensations to emotions, words, gestures and adaptive communication methods. • Play Therapy is aligned with United Nations Convention on the Rights of the Child (UNCRC), ensuring access to communication in a child-centred and developmentally sensitive way.	1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. (12. & 13.)
4. Self-care	• Play Therapy boosts self-concept, self-efficacy, and self-help skills. • Rich opportunities for indirect self-care skills practice are promoted through pretend play in Play Therapy. • Play Therapy encourages children to independently perform self-care tasks, with therapist support where needed.	5. 8. 9. 10. 11. (12. & 13.)
5. Social	• Play Therapy improves social skills, social adjustment, and family functioning/ adjustment. • In Play Therapy, pretend play boosts empathy through character roles and peer interaction. • Pretend play narratives in Play Therapy develop capacity to interpret and respond to verbal and non-verbal social cues, negotiate with peers, regulate through disappointment and advocate for self.	1. 2. 5. 6. 7. 8. 9. 10. 11. (12. & 13.)
6. Self-management	• Play Therapy improves emotional adjustment, navigation skills, flourishing mental health, and promotes growth abilities. • Play Therapy amplifies the intensity of play and capitalizes on its neurological qualities to facilitate sustained engagement and focus, flexible thought cognition and emotion, overall frustration tolerance and responsiveness to challenge. • In Play Therapy opportunities to play out everyday scenarios create important rehearsal time for real-life daily task completion.	1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. (12. & 13.)

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Appendix 1 – Level 1 Play Therapy Evidence

Play Therapy Level 1 Research from the last 25 years [1999-2024] (n=12)

Article number	Authors	Article Title	Study design / Sample size	Population	Mean age or age range	Effect Size (*ES is statistically significant) or Key findings	Favourable outcomes
1.	Bent et al. (2024)	Systematic review of common and specific factors in play therapy for young people with intellectual disability	Systematic Review / 26 studies	Young people with a mild intellectual disability	Young people aged of 10-18 years	Evidence was found in the review for common and specific factors in Play Therapy for young people with an intellectual disability. Common factors identified: the therapeutic relationship in Play Therapy and therapeutic use of skills by the Play Therapist. Specific factors identified: play used as a language in Play Therapy, and opportunities for children to connect to their inner world through play.	The specific factors identified for young people with a mild intellectual disability are activated in Play Therapy through the non-verbal nature of this psychotherapy approach.

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Article number	Authors	Article Title	Study design / Sample size	Population	Mean age or age range	Effect Size (*ES is statistically significant) or Key findings	Favourable outcomes
2.	Francis et al. (2022)	Play-based interventions for mental health: A systematic review and meta-analysis focused on children and adolescents with autism spectrum disorder and developmental language disorder	Systematic review and Meta analysis / 10 studies	Children and adolescents with Autism Spectrum Disorder and developmental language disorder who engaged in play-based interventions (Play Therapy listed as an included intervention).	Children aged 0-19 years	"Meta-analysis of 5 studies addressing positive mental health outcomes (e.g. positive affect and emotional functioning) found a significant overall intervention effect (Cohen's d = 1.60 (95% CI [0.37, 2.82], p = 0.01)."	Noted the considerable evidence on the effectiveness of play-based interventions on holistic child development (for the identified population); with a main focus on: language (improved language skills, increased receptive and expressive vocabulary, symbolic play skills promoted functional language abilities); social (social-interactive play increased social competence in young children, decreased play deficits and reduced disruptive behaviours), and communication skills. Presented the evidence on the effectiveness of play-based interventions on the mental health outcomes of children (for the identified population).

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3.	Money et al. (2021)	Review: The effectiveness of Theraplay for children under 12 – a systematic literature review	Systematic Review / 6 studies	Children aged 12 years and under with any presenting difficulty who engaged in Theraplay	Children aged 12 years and under	"The review highlighted the small evidence base, mixed quality research methodology and high levels of heterogeneity in how Theraplay is practiced and evaluated." "Theraplay's effectiveness could not be established."	From the small number of studies eligible for inclusion, "Theraplay was found promising in its effectiveness when used with internalising and externalising difficulties, dual diagnoses and developmental Disabilities." **Note:** Theraplay is a Play Therapy model but other professionals such as, Speech Therapists and Occupational Therapists can train in this approach and use this approach within their professional practice (but not as a Play Therapists nor delivering Play Therapy.

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Article number	Authors	Article Title	Study design / Sample size	Population	Mean age or age range	Effect Size (*ES is statistically significant) or Key findings	Favourable outcomes
4.	Parker et al. (2021)	Exploring the Impact of Child-Centered Play Therapy for Children Exhibiting Behavioral Problems: A Meta-Analysis	Meta-Analysis / 27 studies	Children who exhibiting behavioural problems	Median age of participants in this study was 6 years old, with a range from 3-11 years of age.	"Results revealed medium Hedges's g effect sizes for externalizing and overall problem behaviors compared to alternative treatment and waitlist controls, and small Hedges's g effect sizes for aggressive behaviors."	Results indicated that in addition to a reduction in disruptive behaviours, children also experienced a reduction in total behaviour problems.

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Article number	Authors	Article Title	Study design / Sample size	Population	Mean age or age range	Effect Size (*ES is statistically significant) or Key findings	Favourable outcomes
5.	Ghasemifard et al. (2020)	Characteristics and Efficacy of Play Therapy Interventions in Visually Impaired Children and Adolescents: A Systematic Review Study	Systematic Review / 9 studies	Visually Impaired Children and Adolescents	Children and adolescents (0-21 years)	Play Therapy "interventions were effective in improving cognitive, visual, physical, communicative and vestibular skills of the children." "...improved some characteristics in children including play skills, visual functions, physical activity levels, navigation skills, functional state of vestibular system, and cognitive, dialect, compensatory, self-help, community, fine motor, and gross motor skills positively."	"...improvement in promotion of growth abilities" "...interventions had a positive effect on the balance and vestibular system and functional status of children."

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Article number	Authors	Article Title	Study design / Sample size	Population	Mean age or age range	Effect Size (*ES is statistically significant) or Key findings	Favourable outcomes
6.	Drisko et al. (2020)	Is Individual Child Play Therapy Effective?	Systematic review / 17 studies	Children who have participated in individual play therapy	Children aged 4–12	"...effect sizes ranging from d = −0.04 to g = 3.63 (most ranged from .35 to .80). Across most concerns play therapy was affirmed as an empirically supported therapy." Effect sizes and number of studies: • Aggression (6/7 studies medium-large ES) • Attention/ADHD (all 6 studies medium – large ES) • Anxiety (6/9 studies medium – large ES) • Externalizing Behaviours (5/6 medium – large ES) • Internalizing Behaviours (2 studies medium ES) • Trauma Symptoms (2 studies- 1 medium and 1 large ES)	"A wide range of concerns, and a wide range of measures, were used to assess the effectiveness of play therapy." "This and prior work demonstrate that play therapy meets American Psychological Association criteria as an EST. It fits very well with children's styles of communication and growth." "Across most concerns, play therapy was affirmed as an empirically supported therapy."

Appendix 1 – Level 1 Play Therapy Evidence

Play Therapy Level 1 Research from the last 25 years [1999-2024] (n=12)

Article number	Authors	Article Title	Study design / Sample size	Population	Mean age or age range	Effect Size (*ES is statistically significant) or Key findings	Favourable outcomes
7.	Hillman (2018)	Child-Centered Play Therapy as an Intervention for Children With Autism: A Literature Review	Systematic review / 4 studies	Children with Autism Spectrum Disorder (ASD)	4 – 11 years	"Child-centered play therapy is promising in increasing social and emotional behaviors of individuals with ASD."	Play therapy assists in addressing "many behaviors that children with ASD often need help with such as social interaction, emotional regulation, and joint attention."

Appendix 1 – Level 1 Play Therapy Evidence

Play Therapy Level 1 Research from the last 25 years [1999-2024] (n=12)

Article number	Authors	Article Title	Study design / Sample size	Population	Mean age or age range	Effect Size (*ES is statistically significant) or Key findings	Favourable outcomes
8.	Jensen et al. (2017)	A Meta-Analytic Review of Play Therapy With Emphasis on Outcome Measures	Meta-analysis / 100 studies	Children who have participated in play therapy	Children – age range not specified	"...a significant moderate effect for play therapy interventions across all outcomes (d = .44).	A significant moderate effect on a variety of outcomes, including: developmental/adaptive, behaviour, self-concept, social relationships, family functioning, and more.

Appendix 1 – Level 1 Play Therapy Evidence

Play Therapy Level 1 Research from the last 25 years [1999-2024] (n=12)

Article number	Authors	Article Title	Study design / Sample size	Population	Mean age or age range	Effect Size (*ES is statistically significant) or Key findings	Favourable outcomes
9.	Lin & Bratton (2015)	A Meta-Analytic Review of Child-Centered Play Therapy Approaches	Meta-analytic review / 52 studies	Children who have participated in play therapy	6.7 years	Effect size was .47 with a standard error of .06, which was statistically significantly larger than zero (t ratio = 7.660, p < .001; 95% CI [0.35, 0.59]), indicating a moderate treatment effect. "...the 42 studies with a mean participant age of 7 years and younger yielded an average effect size (.53) that was statistically significantly higher" Mean Effect Size: • Global behaviour problems .48 • Internalizing behaviour problems .42 • Externalizing behaviour problems .33 • Caregiver–child relationship stress .59 • Self-efficacy .63 • Academic performance .46 • Other behaviour problem .52	A significant moderate effect on a variety of outcomes, including: Externalizing and internalizing behaviour problems; caregiver-child relationship stress; self-efficacy. More beneficial on younger children. An effective early intervention.

Appendix 1 – Level 1 Play Therapy Evidence

Play Therapy Level 1 Research from the last 25 years [1999-2024] (n=12)

Article number	Authors	Article Title	Study design / Sample size	Population	Mean age or age range	Effect Size (*ES is statistically significant) or Key findings	Favourable outcomes
10.	Ray et al. (2015)	Child-Centered Play Therapy In The Schools: Review And Meta-analysis	Systematic Review and Meta-Analysis / 23 studies	Child centred play therapy (CCPT) conducted in elementary schools	Range 4-13 yrs No Mean Reported	.21-.38 "Results revealed statistically significant effects for outcome constructs, including externalizing problems (d = 0.34), internalizing problems (d = 0.21), total problems (d = 0.34), self-efficacy (d = 0.29), academic (d = 0.36), and other behaviours (d = 0.38)."	Externalizing and internalizing behaviour problems; self-efficacy; academic; other

Appendix 1 – Level 1 Play Therapy Evidence

Play Therapy Level 1 Research from the last 25 years [1999-2024] (n=12)

Article number	Authors	Article Title	Study design / Sample size	Population	Mean age or age range	Effect Size (*ES is statistically significant) or Key findings	Favourable outcomes
11.	Bratton et al. (2005)	The Efficacy of Play Therapy With Children: A Meta-Analytic Review of Treatment Outcomes	93 studies	Play Therapy with children	7 years	"...mean effect size was 0.80 ± 0.04 (significantly greater than 0, p < .001), revealing a large treatment effect for play therapy interventions with children." Target problem behaviours (mean effect sizes): • Internalizing only 0.81 • Externalizing only 0.78 • Internalizing and externalizing 0.93 • Other 0.79 Type of outcome measure (mean effect sizes): • Behaviour 0.81 • Social adjustment 0.83 • Personality 0.80 • Self-concept 0.51 • Anxiety–fear 0.69 • Family functioning/relationships 1.12 • Developmental–adaptive 0.90 • Other 0.55	Behaviour problems; social adjustment; self-concept; anxiety; development; relationships; other

Appendix 1 – Level 1 Play Therapy Evidence

Play Therapy Level 1 Research from the last 25 years [1999-2024] (n=12)

Article number	Authors	Article Title	Study design / Sample size	Population	Mean age or age range	Effect Size (*ES is statistically significant) or Key findings	Favourable outcomes
12.	LeBlanc & Ritchie (2001) **Note:** same data set as 1999 study below	A meta-analysis of play therapy outcomes	Meta-analysis / 42 studies (1966-2001)	Play Therapy with children	7.8 years	Average treatment effect .66	Favourable outcomes reported: emotional adjustment; social adjustment; reaction to traumatic event; academic; behaviour problems; family adjustment From a title/abstract analysis: §Five studies focused specifically on children with disabilities (physical and/or intellectual disability) - significant improvements in personal, social and behavioural aspects, and gains in IQ, fine motor, adaptive, language, and gross motor were reported (would need to read articles or abstracts to decipher further specifics). §A further 22 studies reported improvements with difficulties that children with disabilities may also require additional support with.

Appendix 1 – Level 1 Play Therapy Evidence

Play Therapy Level 1 Research from the last 25 years [1999-2024] (n=12)

Article number	Authors	Article Title	Study design / Sample size	Population	Mean age or age range	Effect Size (*ES is statistically significant) or Key findings	Favourable outcomes
13.	LeBlanc & Ritchie (1999)	Predictors Of Play Therapy Outcome	Meta-analysis / 42 studies	Play Therapy with children under the age of 13	7.9 years	"Treatment groups performed 0.66 (SE = 0.09) standard deviations better than nontreatment groups" Reported on significant and non-significant factors in effective Play Therapy. The significant factors, "two characteristics of play therapy were significantly correlated to therapy outcome: the involvement of parents in play therapy and the number of therapy sessions." The non-significant factors, meaning Play Therapy was equally effective across: gender, age, presenting problems.	"Play therapy appears to be as effective as therapy with adults and nonplay therapy with children." "The duration of therapy also appears to be correlated to efficacy, with maximum benefits occurring at about 30 to 35 therapy sessions."

Appendix 2. AQF, TEQSA and ASQA

The Australian Qualifications Framework (AQF) is the national policy for regulated qualifications in education and training, "incorporating qualifications from each education and training sector into a single comprehensive national qualifications framework." The Tertiary Education Quality Standards Agency (TEQSA) accredits and certifies AQF Bachelor or Post Graduate level courses and qualifications.

At a national level, TEQSA is responsible for:

- Registering higher education providers and universities
- Accrediting qualifications for non-self-accrediting providers
- Authorizing universities and other higher education providers to self- accredit qualifications

The Australian Skills Quality Authority (ASQA) accredits vocational education and training (VET) in alignment with national standards, such as the AQF. An AFQ Graduate Diploma is recognised in the Australian VET sector. ASQA states that 'training providers need to apply the appropriate AQF volume of learning to programs they deliver and should develop and implement strategies for training and assessment consistent with the AQF." A Graduate Diploma's volume of learning is set at 1-2 years/ 1200-1400 hours.

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