Building the Bridge:

Why Play Therapists Must Contribute to Research for Both Treatment Validation and Practice Excellence

Working Paper

Acknowledgments

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I. Introduction: The Evidence Imperative

Around the world there is an ever-increasing focus on evidence-based practice in mental health disciplines, with funding allocated to professions who have an established evidence-base and a reputation of delivering evidence-based practice. Emerging or smaller professions, like Play Therapy, continue to work hard to have their evidence recognised and articulate themselves as delivering evidence-based practice. Professions that work with children and adults have a wider catchment to draw on when designing and recruiting for research studies. Whereas paediatric-specific populations, like those who access Play Therapy, have a smaller pool to draw from for research, and as children are deemed a more vulnerable population, ethics is generally higher risk and consent/assent considerations more complex. This often results in smaller research participant numbers for clinical research studies, making statistical power and generalisability ongoing challenges.

The imperative for robust research evidence has real-world implications for practice. Recent policy developments, such as the 2024 NDIS review in Australia that resulted in Music Therapy and Art Therapy being initially removed from funded support, demonstrate how the absence of clearly articulated evidence can directly threaten service provision. After a nation-wide advocacy campaign, an independent review was announced to examine the evidence of effectiveness, practitioner qualifications, and cost-effectiveness of these therapies. This case illustrates that research is not merely an academic exercise; it directly impacts whether children and families can access therapeutic services.

Play Therapy, without specific recognition in many funding systems, faces similar vulnerabilities without a clearly articulated, accessible evidence base. When professions cannot clearly demonstrate their effectiveness through research, funding bodies may perceive them as lacking rigor, regardless of the actual clinical impact they deliver. This places the burden on the Play Therapy field to not only practice effectively but also systematically document and disseminate evidence of that effectiveness.

Play Therapists are inherently curious and open to a wide range of possibilities. These are natural research characteristics; yet despite this, many Play Therapists may think "I am not a researcher," "research is too hard," and "I don't like maths!" Ironically many Play Therapists are natural researchers and when we learn more about the different ways that research can contribute to Play Therapy it can be empowering. It may even open doorways and opportunities for us to gain insight and make valuable contributions, for example: it can inform and strengthen our practice; it can add to the robust nature of Play Therapy; and most importantly, grow recognition and respect for Play Therapy as evidence-based practice.

The Online Etymology Dictionary provides fascinating background on the word 'research,' which is believed to have originated from Latin circare to "go about, wander, traverse" through to the Old French and French recercher to "seek out, search closely".

These phrases may resonate strongly with Play Therapists and their clinical practice work. Additionally, the modern-day Cambridge Dictionary defines the word research as the "detailed study of a subject, especially in order to discover new information or understand the subject better". This description may connect both Play Therapists and Play Therapy researchers, demonstrating the strong crossover in the function of the way Play Therapists hypothesise, attune, observe, and integrate new information gained during therapy to convey understanding to their client.

This means that embedded within the professional identity of a Play Therapist is the Play Therapist Researcher. Stepping into the dual professional identity as: 1) Play Therapist and 2) Play Therapist Researcher can be a process nurtured through performing this dual role with the collaborative support of colleagues, professional peers, supervisors, and the community settings in which the Play Therapist works. Cornett et al. (2013) describe the process as follows: "Becoming from performing also contributed to the co-construction of professional identity through collaboration with other professionals within intra-professional and inter-professional communities of practice." Stepping into the professional identity of both Play Therapist and Play Therapist Researcher requires the performing of both therapy and research for becoming to be experienced with increasing confidence.

“Research is not merely an academic exercise; it directly impacts whether children and families can access therapeutic services.”

There are four integrated pillars of Evidence-Based Practice (EBP):

II. Understanding the Two Contributors to Evidence: Treatment Effects and Evidence-Based Practice

It is vital that the field of Play Therapy become more adept at articulating that there are two contributors to the evidence: A) Play Therapy is an evidence-based intervention that creates clinically significant change; and B) Play Therapists' practice is Evidence-Based Practice (EBP). Additionally, it is vital that Play Therapists understand why C) both the treatment effects (evidence-based research) and EBP matter for Play Therapy to flourish; and D) the context of bridging the Play Therapist practitioner-researcher divide. Understanding this distinction is fundamental; Play Therapy must demonstrate both that it works (treatment effects) and how to practice it effectively in real-world settings (EBP).

"Play Therapy demonstrates robust effectiveness across four domains."

A. Treatment Effects Research

What it is: Demonstrating that interventions create measurable change

Current state in Play Therapy

Play Therapy is "empirically supported with decades of research confirming its effectiveness" (Ray, 2018). Research conducted between 2000-2023 published 137 quality Play Therapy studies, including 4 Meta-analyses [Level 1 - hierarchy of evidence], 56 Randomized Control Trials (RCTs) [Level 2 - hierarchy of evidence], 20 quasi-experimental group designs [Level 3], 28 experimental single-case designs [Level 4], and 33 repeated measures of single-group designs [Level 5] (Ray, 2025; APT, n.d.). Play Therapy has a dedicated journal published by the American Psychological Association (APA), the 'International Journal of Play Therapy', demonstrating the field's commitment to rigorous research dissemination.

Meta-analytic findings provide robust treatment effect evidence:

- Bratton et al. (2005) found an overall effect size of 0.80 across 93 studies (large treatment effect).
- LeBlanc & Ritchie (2001) reported 0.66 across 42 studies (medium to large treatment effect).
- Lin & Bratton (2015) found 0.47 for child-centered Play Therapy across 52 studies (medium treatment effect).
- Parker et al. (2021) found moderate effect sizes (.48) for behavioral problems across 904 children, with particularly strong effects for young children (median age 6.0 years).
- Lin & Bratton (2015) found even higher effect sizes for children of color (.76).

Play Therapy treatment effect evidence is from diverse settings and populations:

- School-based interventions show statistically significant improvements.
- Effectiveness demonstrated in outpatient clinics, residential settings, and medical settings.
- Both individual and group therapy formats show similar effect sizes.
- Optimal effects occurring around 30-40 sessions when treatment is provided by mental health professionals (LeBlanc & Ritchie, 2001; Bratton et al., 2005).
- Parent involvement (Filial Therapy) associated with enhanced outcomes.

Play Therapy demonstrates robust effectiveness across four interconnected domains of child development and wellbeing: 1) mental health and wellbeing, 2) trauma and PTSD recovery; 3) developmental vulnerability; and 4) disability.

Four interconnected domains of child development and wellbeing

1. Mental Health and Wellbeing

Strong Play Therapy evidence exists for positive mental health outcomes across diverse presentations. Evidence highlights include moderate to large effect sizes for behavioural and emotional problems (Bratton et al., 2005; Lin & Bratton, 2015), effectiveness across age ranges (preschool through adolescence), benefits for both clinical and subclinical populations, and improvements reported by children, parents, and teachers.

Play Therapy effectively addresses internalising problems (anxiety, depression, social withdrawal, fear, emotional dysregulation); externalising problems (aggression, disruptive behaviours, self-control difficulties, attention challenges, oppositional behaviors); social-emotional difficulties (self-concept, emotional awareness, social skills, relationship stress, emotional wellness); and psychosocial difficulties (overall behavioural improvements, coping skills, problem-solving, decision-making, adaptive functioning) (Bratton et al., 2005; Lin & Bratton, 2015; Normandin et al., 2023).

2. Trauma and PTSD Recovery

Substantive evidence demonstrates trauma recovery outcomes in Play Therapy. Evidence highlights include systematic reviews showing promising results for trauma-focused Play Therapy, effectiveness when trauma co-occurs with other conditions, case studies demonstrating successful trauma processing, parent feedback confirming symptom reduction, and emerging evidence for complex trauma and adverse childhood experiences (Haas et al., 2020; Parker et al., 2021).

Play Therapy provides developmentally appropriate trauma interventions for children who have experienced abuse, neglect, domestic violence, community violence, natural disasters, medical trauma, loss and grief, bullying, traumatic separation, and complex developmental trauma. Trauma-specific outcomes include reduction in PTSD symptoms, decreased trauma-related anxiety and fear, processing through symbolic play, release of body-held stress and tension, restoration of safety and control, improved emotional regulation, and reconnection with caregivers (Stewart et al., 2020).

Four interconnected domains of child development and wellbeing

Play Therapy is particularly effective for trauma because children can express experiences too difficult to verbalise, play provides a safe symbolic distance, therapists follow the child's pace, it restores control and mastery, addresses body-based trauma responses, and works within the therapeutic relationship to rebuild trust. Special considerations include effectiveness for children with trauma and co-occurring disabilities (Renshaw & Scira, 2025), integration with trauma-focused therapy principles, systemic trauma-informed care, and neuro-affirming, culturally-responsive approaches.

3. Developmental Vulnerability

Play Therapy supports children experiencing developmental vulnerabilities across multiple domains including global developmental delay, speech and language delay, motor delays, cognitive delays, social-emotional developmental delays, and adaptive functioning delays (Renshaw & Scira, 2024; Renshaw & Scira, 2025).

Play Therapy demonstrates effectiveness in promoting development across communication and language (verbal expression, emotional language, non-verbal communication, receptive understanding); motor development (fine and gross motor skills, motor planning, body awareness); cognitive development (problem-solving, cause-and-effect understanding, symbolic thinking, memory, attention); social-emotional development (emotional recognition, social skills, peer interaction, empathy, self-regulation); and play skill development (progression through play stages, symbolic and pretend play, social engagement, imaginative play) (Renshaw & Scira, 2024; Renshaw & Scira, 2025).

Research evidence highlights that children with developmental vulnerability follow similar developmental pathways as neurotypical peers but often more slowly (Rathnakumar, 2020), benefit from play's capacity to create and strengthen neural pathways (Siviy, 2016), show greater improvement with play interventions compared to non-play interventions (Mora et al., 2018), and demonstrate improvements in overall functioning, self-confidence, and competence (Dougherty & Ray, 2007).

Four interconnected domains of child development and wellbeing

4. Disability

Play Therapy demonstrates robust effectiveness with children diagnosed with disabilities (Renshaw & Scira, 2025). Evidence exists for Autism Spectrum Disorder (Levels 2 and 3), Intellectual Disability, Down Syndrome, Cerebral Palsy, Hearing Impairment, Vision Impairment, Psychosocial disability, and Neurodevelopmental disorders.

Children with Autism who participated in Play Therapy experienced significantly reduced difficulties including externalising problems, attention difficulties, and aggression (Renshaw & Scira, 2025). Comparative studies in specialist schools showed therapeutic play interventions to be most impactful for children with Intellectual Disability, with outcomes including improved language, play skills, and social connectedness (Mora et al., 2018).

Play Therapy demonstrates effectiveness across six functional capacity domains essential for children with disabilities (Renshaw & Scira, 2024): mobility (fine and gross motor skill development, whole-body integration); learning (neural pathway development, hands-on learning, coping skills, competence, cognitive flexibility); communication (connecting sensations to emotions and words, emotional expression, verbal and non-verbal communication, self-advocacy, co-regulation to self-regulation); self-care (independence in daily tasks, competence building, mastery experiences); social (perspective-taking, empathy, social role exploration, interpretation of social cues, negotiation, pro-social development, community participation); and self-management (executive functioning, sustained focus, cognitive and emotional flexibility, frustration tolerance, task completion).

> “Play Therapy demonstrates effectiveness across six functional capacity domains essential for children with disabilities”

Four interconnected domains of child development and wellbeing

Research demonstrates that Play Therapy is developmentally appropriate and neuro-affirming, making it particularly effective because it is accessible (children do not need to rely on words alone), developmentally appropriate (meets children where they are), neuro-affirming (respects neurodivergent ways of being), effective when verbal therapies fail (Renshaw & Scira, 2024), and rights-based (recognising children's rights to communicate through their preferred mode: play) (United Nations, 1989).

Children with disabilities are more likely to experience co-occurring emotional, behavioral, and mental health difficulties (Mora et al., 2018). Play Therapy effectively addresses mental health challenges that co-occur with disability, trauma experienced by children with disabilities (Commonwealth of Australia, 2023), emotional and behavioural responses to disability-related experiences, social isolation, and identity development (Packman & Bratton, 2003). These functional capacity improvements translate directly to enhanced independence, community participation, and quality of life.

Core Frameworks: Common Elements Across All Four Areas of Child Development and Wellbeing

Several important Play Therapy frameworks are common across all four interconnected domains:

The **Therapeutic Powers of Play** harness the four domains regardless of presenting difficulties (Association for Play Therapy, n.d.): facilitating communication, fostering emotional wellness, increasing personal strengths, and enhancing social relationships.

The Therapeutic Relationship provides safety through attuned, responsive connection; supports emotional and behavioural regulation through co-regulation; builds self-worth through unconditional acceptance; and offers a secure base for exploration and growth (Norcross & Wampold, 2011).

Systemic and Family-Centered Approach demonstrates that parent involvement enhances outcomes (Bratton et al., 2005). Filial Therapy and parent coaching are effective forms of family capacity-building that create sustainable change, and collaboration with broader care teams maximises impact.

Developmental Sensitivity ensures developmentally appropriate interventions, meets children where they are, acknowledges and respects individual developmental timelines, and uses play as children's natural mode of expression, processing and healing.

Intersectionality recognises that trauma and mental health frequently co-occur, developmental vulnerability and disability often overlap, mental health difficulties are common in children with disabilities, and trauma impacts development. Play Therapy's holistic and systemic approach can address interconnected needs simultaneously.

Gaps and Limitations in the Existing Play Therapy Research

While Play Therapy has accumulated significant evidence across mental health, trauma, developmental delay, and disability, critical gaps remain spanning five categories:

1. Methodological Limitations:

Study design issues include small sample sizes typical in paediatric research (limited statistical power), lack of adequate control or comparison groups in some studies, and variable treatment fidelity. Lin & Bratton (2015) found significantly larger effect sizes (0.58) for rigorous protocols compared to lower fidelity studies (0.21). Measurement challenges include inconsistent outcome measures across studies, limited use of play-based and arts-based assessment tools, few studies measuring mechanisms of change, and child voice rarely captured.

2. Knowledge Gaps Requiring Further Research:

Mechanisms of action studies are needed to understand: active therapeutic ingredients; which therapeutic powers of play address which outcomes; neurological changes during Play Therapy; how mental health, trauma processing, developmental growth, and functional capacity influence each other; and how play activates neural pathways differently for different needs.

Complex co-occurring conditions require research on: mental health co-occurring with developmental delay; trauma in children with disabilities; developmental vulnerability resulting from trauma; intersections like Autism + PTSD + Speech/Language Delay; optimal approaches for complex presentations; and prioritising intervention targets with multiple needs.

Dosage and intensity questions remain about: optimal treatment for children with complex trauma requiring extended processing; children with developmental vulnerabilities or disabilities who may progress more slowly; whether optimal dosage varies by age, diagnosis, or severity; minimum effective dose for different concerns; and session frequency impact.

3. Implementation Science Gaps:

Research needed on real-world effectiveness in: community mental health; under-resourced settings; implementation barriers and facilitators; factors affecting engagement and retention; cultural adaptation while maintaining fidelity; and delivery in real-world versus research conditions. Workforce questions include: required qualifications and training; specialised training for different populations; and training and supervision effectiveness. System integration questions involve: how Play Therapy functions within multidisciplinary teams; coordination with other services; value-add within comprehensive systems; and models for effective collaboration.

“Play Therapy has accumulated significant evidence across mental health, trauma, developmental delay, and disability”

Gaps and Limitations in the Existing Play Therapy Research

4. Economic Research Gaps:

Cost and value analysis needed comparing Play Therapy to alternatives, costs of not providing Play Therapy, return on investment for early intervention, costs saved through prevention, optimal resource allocation, and comparative costs of play-based versus talk-based versus behavioral approaches.

5. Dissemination and Implementation Gaps:

Translation gaps exist where evidence is not effectively translated into policy and funding decisions, scattered evidence is not compiled accessibly, research findings don't reach practitioners in usable forms, and gaps exist between what research shows and what systems fund. Awareness gaps mean existing evidence is not widely known among decision-makers, practitioners may not know the evidence base for specific populations, families are unaware of Play Therapy as evidence-based, and funders are unaware of the breadth of Play Therapy evidence. Dissemination challenges include research published in inaccessible academic journals, need for evidence summaries in policy-friendly formats, lack of case examples and practice guidelines, and insufficient plain-language resources for families.

Future research focusing on these five critical gaps will further enhance the standing of Play Therapy around the world.

Play Therapy Treatment Effects Evidence Summary

Areas of Strong Evidence:

✓ **Mental Health:** Effectiveness for behavioural and emotional problems (effect sizes 0.47-0.80); evidence for anxiety, depression, externalising behaviors, social-emotional development (Bratton et al., 2005; Lin & Bratton, 2015; Parker et al., 2021).

✓ **Trauma:** Promising evidence for trauma processing, PTSD symptom reduction, effectiveness when trauma co-occurs with other conditions.

✓**Developmental Vulnerability:** Effectiveness for communication, motor, cognitive, social-emotional, and play skill development; evidence that play strengthens neural pathways (Rathnakumar, 2020; Siviy, 2016).

✓ **Disability:** Robust evidence for Autism, Intellectual Disability, Down Syndrome, Cerebral Palsy, and other disabilities; functional capacity improvement across six domains (Mora et al., 2018; Renshaw & Scira, 2024, 2025).

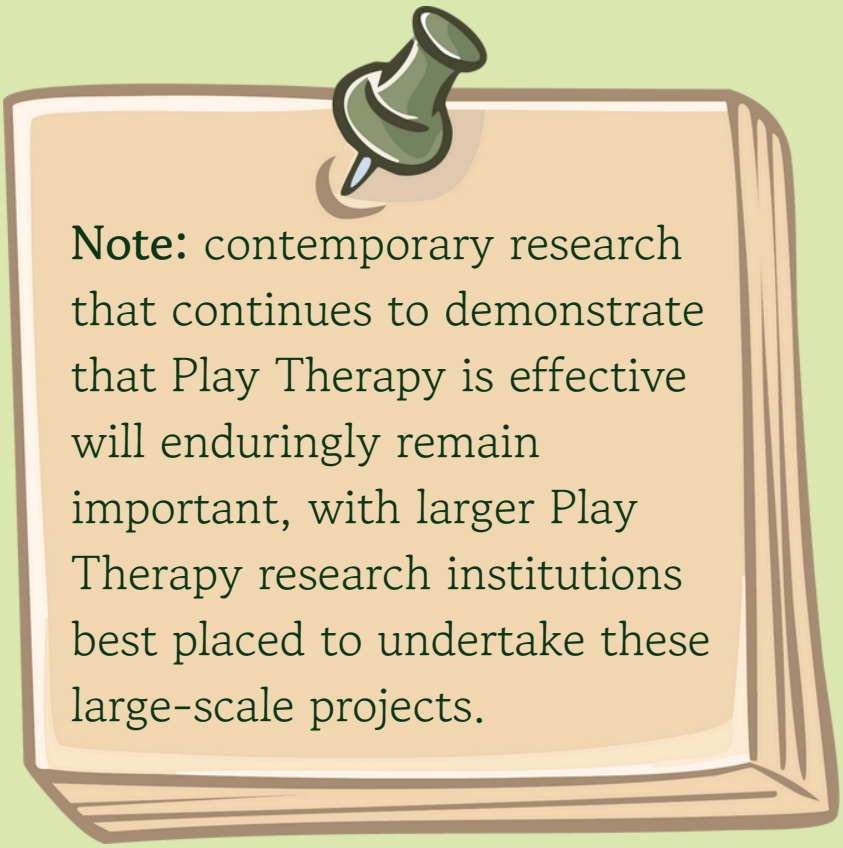
✓ **Settings:** Effectiveness across settings (school, clinic, community).

✓ **Format:** Both individual and group formats are effective, and parent involvement (Filial Therapy) further enhances outcomes (Bratton et al., 2005).

Research Imperative for Play Therapy

The research imperative for Play Therapy is not about proving it works; we have substantial evidence of effectiveness across mental health, trauma recovery, developmental delay, and disability. Instead the Play Therapy research imperative is about deepening understanding of mechanisms and optimal approaches, extending knowledge to understudied populations and settings, improving implementation for real-world delivery and access, demonstrating value through economic and comparative analyses, translating existing evidence to reach decision-makers, funders, and families, and understanding intersections between mental health, trauma, development, and disability.

This means that practitioner-researchers do not need to focus on proving basic effectiveness, but rather on refining, optimising, and ensuring access to an evidence-based intervention that addresses the holistic needs of children across mental health, trauma, development, and disability.



B. Evidence-Based Practice Research

Definition: Integrating the best available evidence, clinical expertise, client values, and practice context information to inform clinical decision-making.

Current state in Play Therapy

Play Therapy adheres to Evidence-Based Practice (EBP) definitions from multiple authoritative bodies including Effective Child Therapy, California Evidence-Based Clearinghouse (CEBC), and the American Psychological Association (APA). The Association for Play Therapy (APT) considers EBP to be treatments or approaches that use scientific evidence to demonstrate improvements with needs or difficulties, implemented by an expert clinician, in a client-centred, culturally sensitive way (Association for Play Therapy, n.d.).

There are four integrated pillars of EBP:

1. Best evidence – relevant research with robust methodology

2. Clinical expertise – a combination of the clinician's experience, education and clinical skillset

3. Client values – including personal preferences, expectations and concerns

4. Practice context information – the characteristics of the setting in which the client is receiving therapeutic support from the practitioner

Play Therapists Integrate the Four Pillars of EBP into Their Clinical Practice

Play Therapists are continuously required to upskill throughout their careers. As practice experience grows, so too does the likelihood of encountering novel and high-stakes situations (MacDonald et al., 2024), requiring new knowledge through professional development and training to meet the client's needs. Career-long clinical supervision by a more experienced and highly trained senior therapist is critical to knowledge development and application to practice. In clinical supervision, Play Therapists are supported to case-conceptualise and discuss treatment approaches specific to individual cases. The role of the clinical supervisor is to educate, and to oversee the ethical application of clinical skills by integrating and applying relevant research to support the supervisee's clinical decision-making.

In some regions, like Australia, clinical supervision hours are mandated by professional registering bodies depending on level of experience and number of face-to-face contact hours. All Play Therapy associations must consider this standard of practice as an easy to mandate way of ensuring Play Therapy is EBP.

Play Therapists Integrate the Four Pillars of EBP into Their Clinical Practice cont...

Another method of fostering implementation science is access to good quality, research informed, professional development. Play Therapy associations reviewing professional development for endorsement can promote professional development that will help bridge the gap between latest research and practice. However, barriers for research informed professional development providers should be considered to simplify this process, thus promoting good quality professional development to be put forward for review and endorsement.

 (Renshaw & Scira, 2025)

C. Why Both Treatment Effects Research (Evidence-Based) and EBP Matter

Evidence-Based (Treatment Effects Research)

Treatment effects research establishes credibility and efficacy, which demonstrates that Play Therapy creates measurable change. This evidence is essential for professional credibility and recognition, funding and reimbursement decisions, inclusion in treatment guidelines, and training program accreditation.

Evidence-Based Practice (EBP Research)

EBP research ensures real-world effectiveness and sustainability by demonstrating how interventions work in actual practice settings with real-world complexity. This includes implementation factors and barriers, cultural and contextual adaptations, cost-effectiveness and sustainability, and client engagement and satisfaction.

The distinction matters in policy and funding decisions. For example, in Australia, the current NDIS independent review criteria illustrates what decision-makers are looking for (National Disability Insurance Agency, 2024): 1) The evidence of effectiveness (treatment effects research); 2) The qualifications and registrations of providers (professional standards); 3) The pricing and cost-effectiveness of supports (implementation and sustainability).

This real-world example demonstrates that treatment efficacy alone is insufficient. The field must also demonstrate real-world implementation effectiveness, practitioner competency standards, and sustainable delivery models.

This means that both treatment effect research and EBP research streams are essential for professional recognition and service sustainability. Play Therapy associations and Play Therapists alike confidently articulating both the evidence-base for Play Therapy and Play Therapy as EBP strengthens the position of Play Therapy in the child therapy landscape.

III. Why We Need Play Therapists to Also Be Research Contributors

The field of Play Therapy needs practitioner-researchers for three critical reasons:

1. **Unique clinical insights** that only practitioners possess
2. **Practice-based evidence** generation essential for EBP research
3. **Professional credibility** necessary for field advancement

Each of these contributions is irreplaceable and collectively essential.

Play Therapists to Also Be Research Contributors: Reason One

1.Unique Clinical Insights

Play Therapists possess valuable clinical assets like their understanding of child development that informs their developmentally sensitive therapeutic approach. Additionally, their real-world insights are vast due to their work across a wide range of clinical and community contexts with diverse client populations. This means that the novel perspective and special skills of a Play Therapist would be an asset to any child focused research project; and it is critical that Play Therapy practice insights are shared with the world.

A Holistic Understanding of Child Development

As paediatric specialists, Play Therapists integrate attachment, neuroscience, child development, play, child assessment, and therapeutic skills into their practice. This transdisciplinary integration is informed by research from numerous disciplinary fields including behavioural science and neuroscience that explain the holistic and vital benefits of play (National Institute for Play, n.d.).

Play is pre-wired into human neurobiology, with play neural circuitry in the midbrain vital for the wiring of the brain's cortical region (National Institute for Play, n.d.). In Play Therapy, children connect with their therapist and express themselves through their natural mode of communication, play. Play Therapists are highly trained to re-create optimal conditions for growth and development, healing and wellbeing; essentially amplifying the neurobiological potential of play.

A whole child developmental transdisciplinary perspective is a unique Play Therapy research asset.

“A whole child developmental transdisciplinary perspective is a unique Play Therapy research asset.”

Developmental Sensitivity as Clinical Expertise

Play Therapists possess specialised knowledge about developmental processes that is often missing from paediatric service and child and family centred research design. Children are not always able or willing to communicate through words; play is comfortable and universal because it is a child's primary language. Integrating play into research is neuro-affirming, developmentally sensitive and upholds children's rights (United Nations, 1989). Play Therapists are trained to communicate with all children, regardless of neurotype, communication preferences, chronological age, developmental needs, cultural diversities, or other differences. Play Therapists' clinical expertise can be an asset for researchers wanting to expand the ways they collect data, and code and interpret child perspectives. Additionally this expertise can be used to design workplace systems that integrate child perspectives into assessments, goal setting, tracking clinical progress and program evaluation.

Real-World Implementation Identifies Challenges and Creates Solutions

Play Therapists working in community settings encounter implementation factors that controlled research studies may not capture: system coordination barriers, family engagement challenges, funding limitations, and other real-world required adaptations. Community-based Play Therapy clinicians may be critical for both research design and engagement, as well as implementation for both research and research into practice success.

Identification and Implementation of Cultural and Contextual Adaptations

Children with disabilities are more likely to experience emotional, behavioural and mental health difficulties. Without access to developmentally sensitive therapies like Play Therapy, interventions risk being inaccessible and ineffective. Children most naturally communicate through toys, creative resources, and play; they may not always be able nor wish to express themselves using words. Play Therapy is therefore a developmentally appropriate form of child psychotherapy that is both neuro-affirming and accessible for all children, upholding Article 13 of the UNCRC, the right to freedom of expression (United Nations, 1989).

Play Therapists to Also Be Research Contributors: Reason Two

2.Practice-Based Evidence Generation

Play Therapists routinely monitor child outcomes and collect data to document and report on progress to families, care teams and allied health professionals. Play Therapists regularly engage in case-conceptualisation where the child's history, family context and therapeutic needs are woven into a coherent case study to formulate a therapeutic treatment plan. Play Therapists work systemically and often carry out assessments and observations that may include parent-child relationships. Both quantitative and qualitative assessments inform therapeutic treatment plans and may also be used in de-identified formats to inform care teams to support collaborative decision making. Data may also be used in workplace quality improvement initiatives.

Assessment and Documentation

Play Therapists are highly trained in child assessment, tracking therapeutic progress, and clinical report writing. As child development specialists, they assess, monitor, and report on whole child developmental domains and wellbeing indicators. Play Therapists formulate individualised, culturally sensitive assessment schedules based on a child's life history, chronological age, developmental presentation, and neurotype. They use both standardised measurements, systematic observation, and play or arts-based assessments to assess, monitor and report on outcomes.

Systemic Data Collection

Play Therapists work systemically, carrying out assessments and observations of the child, the parent-child relationships, family relationships, and other system functioning (e.g. school-based relationships with teachers and peers). Both quantitative and qualitative assessments inform therapeutic treatment plans and may be used in de-identified formats to inform care teams for collaborative decision-making, or support child advocacy with relevant agencies.

(Renshaw & Scira, 2025) Page 24

Case Examples Can Be a Bridge from Clinical Practice to Research Contribution

Case examples are a rich source of information ripe for showcasing the unique expertise of Play Therapy; from how an intervention is planned, to how progress is monitored and change tracked. Rich case data is routinely collected in Play Therapy practice, including:

Initial Assessment Information: Complete medical, developmental, and family history; standardised quantitative and qualitative assessments establishing baselines.

Treatment Planning: Collaboratively develop measurable goals aligned with evidence-based frameworks; document intervention approach based on child's initial assessment information and therapeutic goals.

Ongoing Monitoring: Weekly session notes categorise and track progress through play-based observation and recording of thematic content. Regular parent consultations document tailored psychoeducation delivery and parent feedback. School-based assessment and monitoring, through in-school child observations and teachers completing brief pre and post assessment measurements, can assist in holistic intervention monitoring.

Systemic Documentation: Case notes of meetings with a child's multidisciplinary support team (that may include: Speech and Occupational Therapists, Psychologist, Paediatrician, etc.) can track the coordinated treatment approach.

Outcome Measurement: When requesting additional funding or reporting on the Play Therapy intervention, Play Therapists produce clinical reports that document an overview of the intervention, treatment goals, progress, and recommendations.

A single case study can generate a wealth of practice-based data, including pre-post quantitative assessment data, systematic observational data across multiple settings, treatment fidelity documentation, family engagement and satisfaction data, functional capacity change across multiple domains, holistic health and mental health indicators, implementation factors in real-world settings, and collaborative care effectiveness data.

This comprehensive data set, generated through routine clinical practice, illustrates how practitioner-researchers contribute to evidence without requiring separate research protocols that burden clinical workflow.

When systematically collected and processed, such routine clinical documentation becomes valuable practice-based evidence requiring minimal additional burden while contributing meaningful insights about treatment effectiveness, optimal therapeutic dose, and implementation factors.

Play Therapists to Also Be Research Contributors: Reason Three

3.Credibility and Professional Advancement

Responding to evidence-based practice mandates: Funding bodies, insurance providers, and service systems increasingly require evidence-based practices. Without continual robust research contribution, and accessible current Play Therapy documentation to demonstrate treatment effects and EBP, Play Therapy risks exclusion from funded services (National Disability Insurance Agency, 2024).

Securing insurance coverage and institutional support: Many insurance providers and government funding systems require evidence of effectiveness before approving coverage. Both robust Play Therapy research summary documentation alongside active research contributions strengthens the case for Play Therapy inclusion.

Professional legitimacy in interdisciplinary settings: Play Therapy's professional credibility is strengthened by its recognised position within broader health systems. In Australia, Play Therapy is represented by Allied Health Professions Australia (AHPA), with multiple associations maintaining affiliate membership (Allied Health Professions Australia, n.d.). Internationally, Play Therapy is represented through the International Consortium of Play Therapy Associations (IC-PTA), which defines international standards (International Consortium of Play Therapy Associations, n.d.). This professional infrastructure supports research dissemination, training standardisation, and advocacy for evidence-based practice recognition.

> “Play Therapy's professional credibility is strengthened by its recognised position within broader health systems.”

IV. A Practical Framework for Practitioner Research Contribution

A. Start with Low-Barrier Entry Points

Many Play Therapists already engage in activities that constitute research; they simply need systematic processes to formalise what they already do. Setting up systems to track quality improvement is a practical starting point for practitioner-researchers and their organisations. Six practice-based sources of quality improvement data that Play Therapists can use are outlined below. A brief example highlights how systematically collecting data using consistent measurements can support reporting on goals aligned with functional capacity domains.

1. Standardised Outcome Measurements

Play Therapists' use of standardised assessment tools at intake, mid-treatment and discharge allows for continuous outcome measurement monitoring and aligns with both clinical practice and research frameworks. When identifying standardised outcome measurements that align with the client population, there will be different measurements to monitor mental health, trauma recovery, functional capacity, and developmental vulnerabilities. Choose measurements that are appropriate for the client populations; for example, measurements that are sensitive to specific age ranges and culturally sensitive. Brief, validated measures at intake, mid-treatment, and discharge can be an effective way to start an implementation routine.

2. Systematic Case Documentation

Structured session notes with the consistent inclusion of pre-identified categories, for example, play themes, emotional content, child responses, therapeutic interventions used, relevant practice frameworks (e.g. therapeutic powers of play) and progress toward goals, can create qualitative data amenable to analysing and reporting of trends.

3. Parent/Caregiver Feedback

Play Therapists can monitor the quality of their service provision through brief satisfaction survey data and qualitative feedback that captures the subjective impact of therapy. As child rights' advocates, Play Therapists can also model the collection of children's perceptions of Play Therapy through play and arts-based methods. These types of evaluation data can provide important stakeholder perspectives and real-world impact data.

4. Therapeutic Process Documentation
Documenting the therapeutic process by recording data on different practice frameworks connects clinical practice to theoretical mechanisms. For example, noting which of the therapeutic powers of play are activated by the child and the therapist provides therapeutic process data that can be reported for both the child's therapeutic process and the therapist factors that activate/facilitate this process (Association for Play Therapy, n.d.).

5. Implementation Tracking
Documenting and addressing aspects that facilitate engagement in treatment and also any barriers to treatment (e.g. attendance, engagement, system coordination) can inform the implementation science of improved service delivery.

6. Participation in Practice-Based Research Networks
Joining collaborative research initiatives allows individual practitioners to contribute to larger datasets while receiving methodological support. Practice-based research networks may be local or even international, Play Therapy specific or transdisciplinary, and vary in size from small-scale networks to large-scale networking opportunities.

A Brief Example of Tracking Functional Capacity

Play Therapists working with children who access NDIS support (in Australia) for developmental vulnerabilities or disabilities may already be tracking functional capacity across the six reportable domains: mobility, learning, communication, self-care, social functioning, and self-management (National Disability Insurance Agency, n.d.). This routine clinical documentation is a good example of clinical source information that can be systematically coded and processed to contribute toward practice-based evidence. Play Therapists might monitor functional capacity through tracking fine motor skill development through play activities (threading, drawing, painting, play dough manipulation), documenting social skill progression through pretend play engagement, monitoring emotional regulation capacity through co-regulation experiences, and recording communication development as children develop verbal and non-verbal methods for expressing emotions.

This data, when systematically collected using consistent measures, can become valuable practice-research evidence with minimal additional burden to clinical practice.

B. Collaborative Research Projects

Practice-research that is activated through collaborative research opportunities can provide practical ways for Play Therapists and organisations to kick-start their research contributions. Three ways to engage in collaborative research projects are: 1) academic-practice partnerships; 2) multi-site studies; and 3) community-based participatory research.

Academic-practice partnerships with universities can be mutually beneficial for practitioner and institution. Universities require practice partners to capture real-world research, and practitioners benefit from academic expertise.
Multi-site effectiveness studies that pool data across multiple practice sites can be an effective way to increase sample sizes and generalisability while sharing the research burden.
Community-based participatory research engages families, schools and communities as research partners. This type of research can ensure relevance and meaning for stakeholders.

C. Building Research Capacity

There are a few ways you can start building your or your organisation's research capacity. Here are three ideas:

Look for training opportunities for practising Play Therapists. Ongoing education and training focused on research methods, outcome measurements, and data collection and analysis builds practitioner confidence and competence.

Consider mentorship programs that pair less experienced researchers with seasoned researcher-practitioners, providing hands-on learning and support. If these programs are not accessible, consider research supervision as a mentorship option.

Utilise technology tools for data collection and analysis. Digital platforms for outcome measurement, electronic health records with built-in data tracking, and user-friendly analysis software can reduce barriers to research participation and improve speed and accuracy of analysis and reporting.

V. Addressing Barriers and Facilitating Solutions

Understanding common barriers that Play Therapists face when considering engaging in practice-research, especially those unique to Play Therapy, is vital in making field-wide Play Therapy research progress. Identifying initial solutions that can be facilitated by practitioners, organisations, associations and training providers can positively contribute to overcoming barriers.

Common Barriers to Engaging in Play Therapy Practice-Research

Time and resource constraints: Practitioners face competing demands of direct service delivery, documentation, billing, scheduling clinical supervision, and attending professional development.

Lack of research training: Many Play Therapists did not receive research training in their initial training programs or have limited exposure to research methods. This can contribute to beliefs that they are not researchers and impact practitioner confidence to engage in data collection.

Institutional support limitations: Private practices and small agencies often lack research infrastructure, access to ethics review processes, or efficient data management systems.

Ethical and consent considerations: Working with children requires complex consent/assent procedures, parental involvement, and heightened ethical scrutiny. When undertaking research with vulnerable populations (like children), practitioners should expect more complex research procedures and heightened ethical requirements. Specialised populations (i.e., children with disabilities or trauma backgrounds) add additional complexity that can further deter practitioners from research.

"Streamlined research protocols and technology integration can reduce barriers."

(Renshaw & Scira, 2025)

Play Therapists Face Unique Research Challenges

Emerging Profession Status: In many regions, Play Therapy lacks established infrastructure for research support. Unlike Psychology or Medicine with dedicated research institutes, Play Therapists often lack access to research mentorship, funding mechanisms, or institutional support.
Small-N Reality: Paediatric-specific populations are smaller than general mental health populations and have additional ethical constraints compared to research with adults. A specific focus on child therapy can result in smaller sample sizes that may not reach statistical significance in traditional analyses, despite clinical significance.
Registration Diversity: Multiple registration pathways and professional associations both internationally and nationally in some regions can create variability in training standards, clinical competencies, and research preparedness. This registration diversity contributes to making field-wide research initiatives challenging to coordinate.
Workplace Structure: Many Play Therapists work in private practice or small agencies without easy access to research infrastructure, unlike hospital or university-based practitioners with built-in research support.

Solutions for Engagement in Play Therapy Practice-Research

Streamlined research protocols: Developing brief, user-friendly protocols that can be easily integrated into routine practice rather than adding to practitioner burden.
Technology integration: Using existing electronic health record systems and cloud-based platforms for data collection and storage. Access to e-storage that meets both clinical practice standards and is compliant with human research ethics may be a barrier for some Play Therapists who work alone or for small organisations.
Funding and incentive structures: Professional associations offering research grants, reduced conference fees for research presentations, and research recognition programs.
Professional development opportunities: Workshops, webinars, and courses focused on practice-based research methods, quality improvement and program evaluation frameworks, and data-rich assessment/monitoring measurements.

VI. Research Priorities: What We Need Most

For the field of Play Therapy to continue to grow and flourish, ongoing research contributions are needed across both treatment effects research and EBP research.

A. Treatment Effects Research Needs

Rigorous RCTs with diverse populations: Well-designed randomised controlled trials with adequate sample sizes, representing diverse cultural, socioeconomic, and diagnostic populations would build on the current Play Therapy treatment effects research.
Mechanism of action studies: Further research is needed examining how Play Therapy works, for example what therapeutic factors mediate change, what physiological and/or neural mechanisms are activated, and what processes lead to best outcomes.
Comparative effectiveness research: Direct comparison of interventions to further refine suitability for different populations, providers and systems. Building on the literature comparing Play Therapy to other therapeutic approaches and examining which children benefit most from which approaches would be beneficial to the field.
Long-term follow-up studies: Longitudinal Play Therapy studies that track outcomes months and years after treatment completion will add to our understanding of how therapeutic gains are sustained and if future difficulties are prevented or the severity reduced. Although follow-up studies exist in the Play Therapy literature, more studies, especially longer-term longitudinal studies, would provide outcome information across the lifespan.

B. EBP Research Needs

Training and supervision effectiveness: Research on how therapists develop competency, what supervision approaches are most effective, and how training translates to practice outcomes is emerging as a research priority. Further investment in this area of EBP research is warranted, especially from Play Therapy training providers.

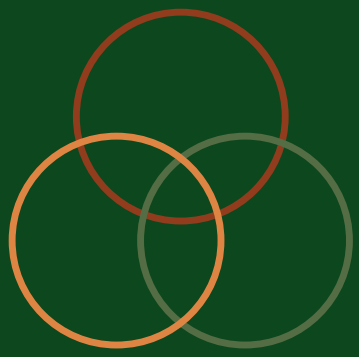
Adaptation and cultural responsiveness: Existing studies have examined how Play Therapy adapts across cultures, languages, and contexts while maintaining fidelity and effectiveness. However, Diversity, Equity, and Inclusion (DEI) Play Therapy research remains enduringly important.

Cost-effectiveness and sustainability: There are currently limited Play Therapy-specific economic analyses demonstrating value for investment, optimal dosage, and sustainable delivery models, so more are needed. Currently, Play Therapy clinical effectiveness studies provide the predominant source of inferred economic value, rather than direct economic measurements. The cost-effectiveness and sustainability of Play Therapy is currently strengthened through alignment with economic research from:

- **Early childhood:** Heckman's research established the gold standard for demonstrating long-term ROI from good quality early childhood supports/interventions using rigorous economic methodology (Heckman, 2008; García et al., 2020). Additionally, the Perry Preschool Study demonstrated lifetime economic benefits for early intervention (García et al., 2023), and Heckman et al. (2021) reported on multi-generational benefits. Aligning Play Therapy investments in early years with the Heckman research and the Perry Preschool research would suggest substantial economic returns for Play Therapy delivered within early childhood and intergenerational benefits.
- **Child health:** Research on play in health settings conducted by the National Health Service (NHS, 2025) has demonstrated actual cost savings data with real patients in operational settings, providing direct evidence that play-based interventions reduce healthcare costs. Play Therapists can undertake this type of work that would yield tangible cost savings; however, Play Therapists have expert knowledge and skills that are still largely not embedded or utilised in health settings that may further enhance economic value when integrating playful therapeutics into health settings.
- **Mental health promotion and prevention:** Benefits exceed costs for early childhood development programs (Knapp et al., 2011), and preventative parenting programs show ROI for childhood mental health disorders (National Mental Health Commission, 2019). Play Therapy is an early childhood mental health support and Filial Therapy (delivered by Play Therapists to parents and families) is a preventative parenting approach. Regarding Play Therapy as an early childhood developmental approach and parenting approach means benefits exceeding costs that demonstrate economic value can be inferred.
- **The cost of late investment:** Teager et al. (2019) reported on how investment in children (i.e., prevention and early intervention investments) can economically return more, supporting the economic case for Play Therapy interventions being integrated in prevention and early intervention services for children and families.

Client preference and engagement studies: While there is growing Play Therapy research on client perspectives and engagement, further research is needed to examine more broadly what children and families value in and about Play Therapy, factors affecting engagement and retention, and satisfaction with services.

These research priorities are not exhaustive but represent high-impact areas where Play Therapy research can meaningfully advance the field. Individual practitioners could select priorities aligned with their practice context, population, and interests, and aim to contribute where they are positioned to generate the most valuable insights.



VII. A Call to Action: Practical Next Steps

Building the bridge between research and practice requires action in **three spheres** of the Play Therapy landscape:

1. For Individual Play Therapy Practitioners

Start with systematic outcome measurement: Choose 1-2 brief, validated measures relevant to your population and use them consistently with every client.
Document successful adaptations and innovations: When an approach is modified for a specific child or context, document what you did, why, and what happened. This contributes to knowledge about adaptation.
Join professional research initiatives: Participate in association-sponsored research projects, multi-site studies, or practice-based research networks.
Pursue additional research training or research supervision: Take continuing education courses on research methods, outcome measurement, or data analysis. Seek supervision from a researcher-practitioner.
Implement annual data collection, coding and reporting: Set aside time annually to review your outcome data, identify patterns, and report findings for quality improvement monitoring and/or evaluation of service.

2. For Play Therapy Training Programs

Integrate research methodology into curricula: Integrate research design, outcome measurement, statistics, and Evidence-Based Practice (EBP) into coursework.
Establish practice-research partnerships: Create formal relationships between academic programs and practice settings for collaborative research and student training.
Create supervised research experiences: Require students to complete practice-based research projects, such as quality improvement monitoring. This can be simulated in a small-scale way during training to support students to gain confidence in collecting systematic outcome measurement data, coding and reporting to their clinical supervisor.
Develop research mentorship programs: With the support of the university or institution, faculty researchers offer ongoing research mentorship beyond graduation.

3. For Professional Organisations

Professional associations can facilitate research contribution through: research recognition and incentives, infrastructure development, training and support, advocacy and policy engagement, and encouragement to integrate quality improvement frameworks into practice.

Research Recognition and Incentives:

- Create research awards and recognition programs
- Establish research interest groups and mentorship matching
- Highlight practitioner-researchers in association communications

Infrastructure Development:

- Recommend standardised assessment protocols for members' use
- Promote/facilitate multi-site research networks for collaborative studies
- Establish data repositories for de-identified practice data (e.g. organisational quality improvement reporting and case studies)
- Provide research consultation services to members

Training and Support:

- Integrate practice-based research into continuing education requirements
- Offer workshops on outcome measurement and data collection and reporting
- Develop resources on ethical research with children
- Create research methodology content in association publications such as newsletters, magazines or journals

Advocacy and Policy Engagement:

- Commission evidence summaries for policymakers
- Engage in reviews of funding criteria (such as the independent NDIS review in Australia)
- Collaborate with universities on practice-research partnerships
- Advocate for research-friendly policies in service systems

Quality Improvement Integration:

- Frame outcome monitoring as quality improvement (often exempt from full Human Research Ethics Committees [HRECs]/IRB review)
- Provide templates for systematic case documentation
- Support workplace research capacity building

"Together, we build a bridge between research and the playroom."

VIII. A Vision for the Future of Play Therapy

Imagine a future where Play Therapy research culture looks like this:

- Every Play Therapist routinely contributes to EBP through systematic outcome monitoring.
- Children and families actively participate in research as partners, with their voices included in research.
- Professional associations promote opportunities for multi-site effectiveness studies, pooling data to answer questions no single practice could address alone.
- Funding bodies recognise Play Therapy as an essential, evidence-based intervention for children with health, mental health, developmental vulnerabilities, disabilities and a lived experience of adversity or trauma (State of Victoria, 2022; Commonwealth of Australia, 2023).
- Universities and practice settings maintain active partnerships, with practitioners contributing real-world expertise to research design and academics providing methodological and research support.
- Play Therapy is explicitly recognised in funding frameworks with dedicated support categories.
- Research evidence clearly demonstrates not just that Play Therapy works, but how it works, for whom, under what conditions, and at what cost.
- Play Therapists are recognised as leaders in child mental health research, uniquely positioned as child rights advocates and experts in children's primary language: play (United Nations, 1989).

This vision requires collective action: individual Play Therapy practitioners embracing research as a professional responsibility; training programs building research capacity; and professional organisations creating infrastructure for collaborative research. These collective efforts are our best pathway towards strengthening the bridge between playroom and published research one contribution at a time.

This vision is achievable. It requires neither revolutionary changes nor unprecedented resources, only collective commitment to integrating research into practice as standard care, one Play Therapist, one workplace, one association at a time.

“Imagine a future where every Play Therapist contributes to evidence-based practice.”

Roadmap to Recognition

Today → Collaboration → Research Integration → Recognition

IX. Conclusion: Research as Professional Responsibility

Play Therapy, like any other therapy, must continue to demonstrate both that it works through treatment effect research (evidence-based) and how it works in real-world practice through Evidence-Based Practice (EBP). These two research streams are complementary and equally essential to the field of Play Therapy. The case for Play Therapy research contribution is strengthened by understanding what Play Therapists already do and how this can become the bridge between practice and research.

Play Therapists, Play Therapy workplaces, and Play Therapy training providers have an ethical obligation to contribute to the evidence base for the profession. As child rights advocates, and in keeping with the UN Convention on the Rights of the Child (United Nations, 1989), Play Therapists are uniquely positioned to contribute research that upholds children's rights to express themselves through play, access healthcare, and enjoy opportunities for rest, leisure, and play. We have a professional and ethical obligation to demonstrate the effectiveness of our work, ensure we are providing the best possible care, and contribute to knowledge that benefits all children. This obligation extends beyond individual practitioners to training programs that prepare future Play Therapists and organisations that support the profession.

The evidence is clear: Play Therapy works (Bratton et al., 2005; Lin & Bratton, 2015; Parker et al., 2021; Renshaw & Scira, 2024; Renshaw & Scira, 2025). Now the profession must ensure this evidence is visible, accessible, and continuously strengthened. Every Play Therapist has a role in this collective responsibility.

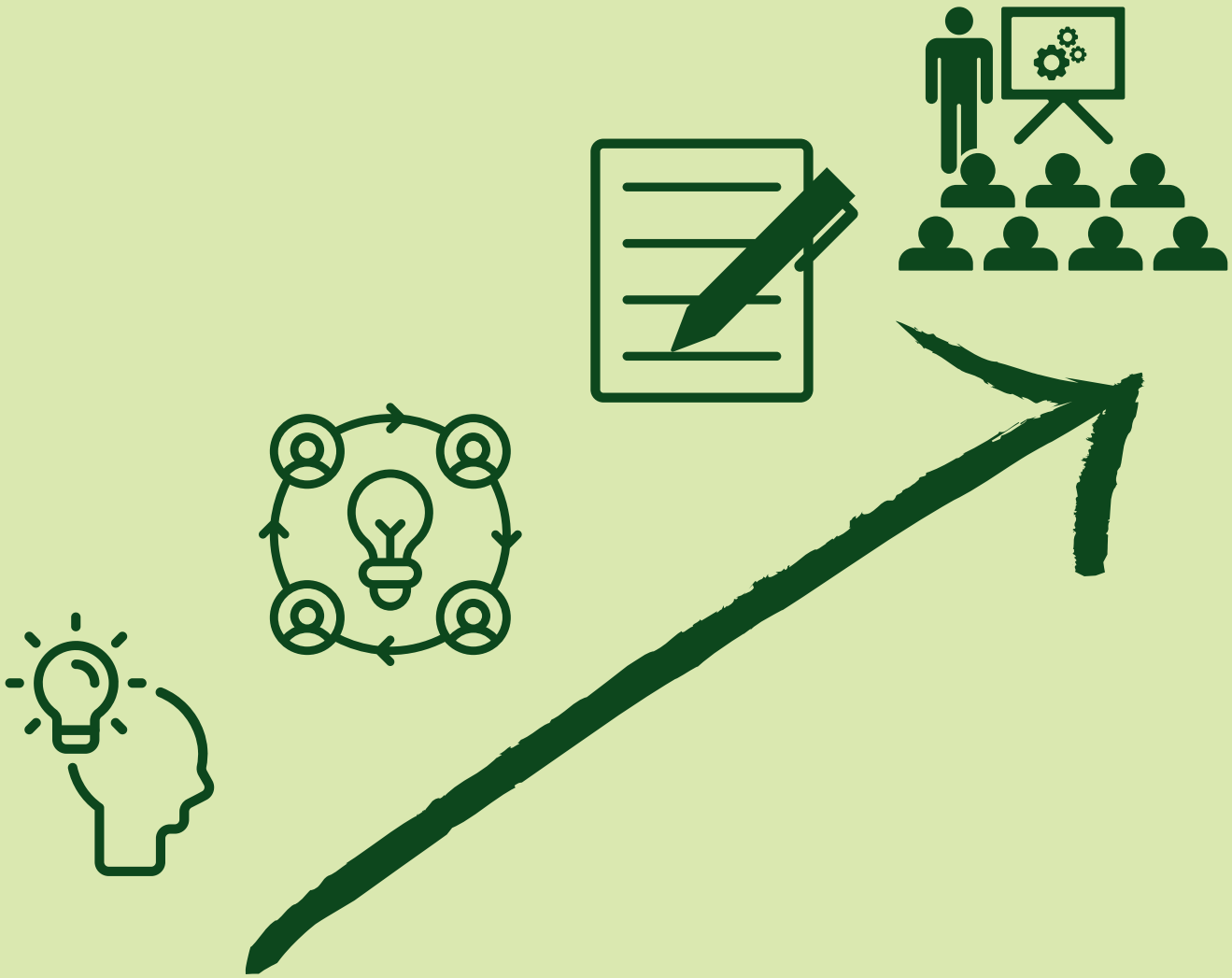
Building the bridge between playroom and published research requires all Play Therapists to begin embracing research as integral to their professional identity. This may initially mean reflecting on the needs of the community, families and children you work with, where identifying their needs could help you to establish some initial research priorities. The initial priorities may be in-house quality improvement or program evaluation, or may be identified as more formal research. You or the organisation you work for might then reach out to establish academic-practice

partnerships to foster collaborative research. Academic-practice partnerships may be with, but not limited to, a research institution or a university. For example, accessing research supervision can be a starting point for refining your ideas. Alternatively, connecting with an independent organisation that is aligned with the research topic in which you are interested may be a fruitful collaboration. Academic-practice partnerships can open a gateway to research-practice partnerships that may evolve into collaborative research projects. It is important for Play Therapy training programs to prepare student Play Therapists to become research-capable graduates and for professional organisations to consider research capability when accrediting Play Therapy training programs and when endorsing professional development. Practice-research guidance is important infrastructure that Play Therapy associations must consider in the services they offer to their members.

The future of Play Therapy depends on our collective commitment to research. Every contribution matters, from the practitioner documenting outcomes systematically to the training program developing research curriculum. Together, we build a bridge between research and the playroom that will ensure children and families have access to evidence-based, effective, developmentally appropriate therapeutic support when they need it most. This Working Paper is a call for collective action to strengthen the field of Play Therapy!

"Building the bridge between playroom and published research requires all Play Therapists to begin embracing research as integral to their professional identity."

“Every Play Therapist has a role in this collective responsibility.”



Reflect → Collaborate → Contribute → Share

X. Key Play Therapy Practice Research Touchstones

Accessible

Relevant

Quality

Impact

Sustainable

Accessible – Make research contribution feasible for busy practitioners
Relevant – Ensure research addresses real-world practice needs
Quality – Maintain methodological rigour while increasing participation
Impact – Connect research to improved outcomes for children and families
Sustainable – Build long-term capacity for ongoing research contributions

XI. Myth-Busting: Common Misconceptions About Practice-Based Research

Myth #1: "Research is only for academics with PhDs"

Reality: Practice-based research encompasses many activities that Play Therapists already do, for example: systematic case documentation, outcome tracking, and reflective practice. A doctorate (PhD) is not required in order to participate in organisation-based quality improvement or program evaluation, or collaborative research studies.

Myth #2: "I need HREC/IRB approval for everything"

Reality: Many practice-based research activities fall under quality improvement or routine outcome monitoring, which may not require full Human Research Ethics Committee (HREC)/IRB review. Simple outcome measurement, case documentation, and organisation-based service evaluation often qualify as standard practice improvement rather than formal research.

Myth #3: "Research takes too much time away from clients"

Reality: Well-designed practice-based research can integrate seamlessly into and complement clinical work. Brief outcome measures, digital data collection, and systematic documentation can effectively enhance service evaluation and clinical decision-making while contributing to the evidence base.

Myth #4: "My small practice can't produce meaningful research"

Reality: Single-case study designs, small-n studies, and participation in multi-site networks allow small practices to contribute valuable evidence. Even one well-documented case can provide important insights for the field.

Myth #5: "Research must be perfect to be valuable"

Reality: Practice-based evidence embraces real-world messiness. Studies with practical limitations still provide valuable information about what works under typical conditions, which complements more controlled research studies.

Myth #6: "I don't have skills in statistical analysis"

Reality: Many research contributions don't require complex statistics. Descriptive data, systematic observation, and participation in collaborative studies where others handle analysis are all valuable forms of research contribution.

Myth #7: "Research stifles clinical creativity"

Reality: Practice-based research supports innovation by providing systematic ways to document when creative, therapeutic adaptations work. This then helps identify which modifications improve outcomes and should be replicated.

Myth #8: "Parents won't consent to research"

Reality: Many families appreciate the contribution they can make to improving treatment and service access for other children. When research is framed as quality improvement and outcome tracking, consent rates are typically high.

Myth #9: "Research results won't change anything anyway"

Reality: Practice-based research directly influences treatment guidelines, funding and insurance coverage decisions, and training standards. The 2024 NDIS review of Music Therapy and Art Therapy demonstrates how research evidence (or the perception of a lack thereof) directly impacts whether services are funded. Practitioner contributions help ensure that policies reflect real-world practice rather than just research conditions.

Myth #10: "I'm just one person; my data won't matter"

Reality: Individual practices provide crucial pieces of the larger evidence puzzle. The unique population, setting, or approach of individual Play Therapists may fill important gaps in the research base that larger studies miss. Case examples demonstrate how a single, well-documented case can illustrate treatment processes, implementation factors, and outcomes across multiple domains, information that can benefit the entire field.

Take Action: Challenge yourself to identify which myths you've believed. Consider starting with one small practice-based research activity this month; even tracking outcomes for five clients can begin building your research confidence and skills.

References

Allied Health Professions Australia (AHPA). (n.d.). About AHPA. Retrieved from https://ahpa.com.au/

American Psychological Association (APA). (n.d.). Evidence-Based Practice in Psychology. Retrieved from https://www.apa.org/practice/resources/evidence

American Psychological Association (APA). (n.d.). International Journal of Play Therapy. Retrieved from https://www.apa.org/pubs/journals/pla

Association for Play Therapy. (n.d.). Research. Retrieved from https://www.a4pt.org/page/PublicResearchResource

Association for Play Therapy (APT). (n.d.). Therapeutic Powers of Play. Retrieved from https://cdn.ymaws.com/www.a4pt.org/resource/resmgr/education_&_training/therapeutic_powers_of_play_2.pdf

Bratton, S. C., Ray, D., Rhine, T., & Jones, L. (2005). The efficacy of play therapy with children: A meta-analytic review of treatment outcomes. Professional Psychology: Research and Practice, 36(4), 376-390.

California Evidence-Based Clearinghouse for Child Welfare (CEBC). (n.d.). Home. Retrieved from https://www.cebc4cw.org/

Commonwealth of Australia. (2023). Final Report: Executive Summary, Our vision for an inclusive Australia and Recommendations. Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. Retrieved from https://disability.royalcommission.gov.au/system/files/2023-11/Final%20report%20-%20Executive%20Summary%2C%20Our%20vision%20for%20an%20inclusive%20Australia%20and%20Recommendations.pdf

Cornett, M., Palermo, C., & Ash, S. (2023). Professional identity research in the health professions—A scoping review. Advances in Health Sciences Education, 28, 589–642. https://doi.org/10.1007/s10459-022-10171-1

Dougherty, J., & Ray, D. (2007). Differential impact of play therapy on developmental levels of children. International Journal of Play Therapy, 16(1), 2–19. https://doi.org/10.1037/1555-6824.16.1.2

Effective Child Therapy (ECT). (n.d.). Home. Retrieved from https://effectivechildtherapy.org/

Evidence-Based Child Therapy. (n.d.). Meta-Analyses and Reviews. Retrieved from https://evidencebasedchildtherapy.com/meta-analyses-reviews/

García, J. L., Heckman, J. J., & Ronda, V. (2023). The lasting effects of early-childhood education on promoting the skills and social mobility of disadvantaged African Americans and their children. Journal of Political Economy, 131(6), 1477-1506.

García, J. L., Heckman, J. J., Leaf, D. E., & Prados, M. J. (2020). Quantifying the life-cycle benefits of an influential early-childhood program. Journal of Political Economy, 128(7), 2502-2541.

References

Haas, S. C., & Ray, D. C. (2020). Child-centered play therapy with children affected by adverse childhood experiences: A single-case design. International Journal of Play Therapy, 29(4), 223–236. https://doi.org/10.1037/pla0000135

Heart Play Institute. (n.d.). APT Research Infographic. Retrieved from https://www.heartplayinstitute.com/research

Heckman, J. J. (2008). Schools, skills, and synapses. Economic Inquiry, 46(3), 289-324.

Heckman, J. J., García, J. L., Bennhoff, F., & Leaf, D. E. (2021). The dynastic benefits of early childhood education. University of Chicago, Becker Friedman Institute for Economics Working Paper No. 2021-77.

International Consortium of Play Therapy Associations (IC-PTA). (n.d.). About IC-PTA. Retrieved from https://www.ic-pta.com/

Knapp, M., McDaid, D., & Parsonage, M. (2011). Mental health promotion and mental illness prevention: The economic case. Department of Health London. Retrieved from https://eprints.lse.ac.uk/39300/1/Mental_health_promotion_and_mental_illness_prevention%28author%29.pdf

LeBlanc, M., & Ritchie, M. (2001). A meta-analysis of play therapy outcomes. Counseling Psychology Quarterly, 14, 149-163.

Lin, Y., & Bratton, S. C. (2015). A meta-analytic review of child-centered play therapy approaches. Journal of Counseling and Development, 93(1), 45-58. https://doi.org/10.1002/j.1556-6676.2015.00180.x

MacDonald, J. B., Quinlan, E., Truong, M., & Lazarus, M. (2024). Managing uncertainty in professional practice: practice guide. The Australian Institute of Family Studies. Retrieved from https://aifs.gov.au/sites/default/files/2024-06/2404_Managing-uncertainty-in-professional-practice.pdf

Mora, L., van Sebille, K., & Neill, L. (2018). An evaluation of play therapy for children and young people with intellectual disabilities. Research and Practice in Intellectual and Developmental Disabilities, 5(2), 178–191. https://doi.org/10.1080/23297018.2018.1442739

National Disability Insurance Agency (NDIA). (2024). Quarterly Report January to March 2024. Retrieved from https://www.ndis.gov.au/media/7183/download

National Disability Insurance Scheme (NDIS). (n.d.). Changes to NDIS legislation. Retrieved from https://www.ndis.gov.au/changes-ndis-legislation

National Disability Insurance Scheme (NDIS). (n.d.). Does your impairment substantially reduce your functional capacity? Retrieved from https://ourguidelines.ndis.gov.au/home/becoming-participant/applying-ndis/do-you-meet-disability-requirements/does-your-impairment-substantially-reduce-your-functional-capacity

References

National Institute for Play (NIFP). (n.d.). Play: The Basics. Retrieved from https://nifplay.org/what-is-play/the-basics/#children-critical

National Institute for Play (NIFP). (n.d.). Scientific Disciplines Researching Play. Retrieved from https://nifplay.org/play-science/scientific-disciplines-researching-play/

National Mental Health Commission. (2019). Parenting interventions for the prevention of anxiety disorders in children. Sydney, Australia. Retrieved from https://www.mentalhealthcommission.gov.au/publications/parenting-interventions-prevention-anxiety-disorders-children

NHS England. (2025). Reducing the use of general anaesthetics in paediatric MRI: A play-led approach at North Devon Hospital. In Play well: Guidelines for commissioning and designing health play services. Retrieved from https://www.england.nhs.uk/long-read/play-well-guidelines-for-commissioning-and-designing-health-play-services/

Normandin, L., Bate, J., Bégin, M., Fonagy, P., & Ensink, K. (2023). Play completion predicts fewer child psychological difficulties: A longitudinal study of mentalizing processes. International Journal of Play Therapy, 32(2), 122–133. https://doi.org/10.1037/pla0000195

Norcross, J., & Wampold, B. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. Psychotherapy, 48, 98-102. https://doi.org/10.1037/a0022161

Packman, J., & Bratton, S. C. (2003). A school-based group play/activity therapy intervention with learning disabled preadolescents exhibiting behavior problems. International Journal of Play Therapy, 12(2), 7-29. https://doi.org/10.1037/h0088876

Parker, M. M., Hunnicutt Hollenbaugh, K. M., & Kelly, C. T. (2021). Exploring the impact of child-centered play therapy for children exhibiting behavioral problems: A meta-analysis. International Journal of Play Therapy, 30(4), 259–271. https://doi.org/10.1037/pla0000128

Porticus. (n.d.). New policy research on the value of Whole Child Development. Retrieved from https://www.porticus.com/en/articles/new-policy-research-on-the-value-of-whole-child-development

Psychotherapy and Counselling Federation of Australia (PACFA). (n.d.). College of Creative and Experiential Therapies (CCET). Retrieved from https://pacfa.org.au/Portal/About/Colleges/creative_and_experiential_therapies.aspx

Rathnakumar, D. (2020). Play Therapy and Children with Intellectual Disability. Shanlax International Journal of Education, 8(2), 35–42. Retrieved from https://files.eric.ed.gov/fulltext/EJ1256044.pdf

Ray, D. C. (March 2018). The Evidence-Base Determination: A Moving Target. Association for Play Therapy Magazine. Retrieved from https://www.modernpubsonline.com/Play-Therapy/PlayTherapyMarch2018/html/index.html?page=22&origin=reader

References

Ray, D. C. (2025). Research in play therapy. In D. Crenshaw, A. Stewart, & D. Ray (Eds.), Play therapy: A comprehensive guide to theory and practice (2nd ed., pp. 259-269). Guilford.

Renshaw, K., & Scira, N. (2024). Play Therapy and the NDIS: How Play Therapists support NDIS child participants and their families. Play and Filial Therapy and Playroom Therapy. Retrieved from https://www.playandfilialtherapy.com/_files/ugd/c223a1_f39d37e1acad40319795feae91ba64e5.pdf

Renshaw, K., & Scira, N. (2025). Play Therapy Evidence Summary. Play and Filial Therapy and Playroom Therapy. Retrieved from https://www.playandfilialtherapy.com/_files/ugd/c223a1_2763b4443a38455390bf17bde1180091.pdf

Siviy, S. M. (2016). A Brain Motivated to Play: Insights into the Neurobiology of Playfulness. Behaviour, 153(6-7), 819–844. https://doi.org/10.1163/1568539X-00003349

State of Victoria, Australia, Department of Families, Fairness and Housing (March 2022). Inclusive Victoria: state disability plan (2022–2026). Retrieved from https://www.vic.gov.au/sites/default/files/2023-03/Inclusive-Victoria-state-disability-plan-2022-2026.pdf

Stewart, A., Ray, D., Dugan, E., Vander Dussen, K., Dyson, P., Grant, R. J., Langen, T., Lilly, J. P., Riviere, S., & Lefebre, J. (June 2020). Why Play Therapy is Appropriate for Children with Symptoms of PTSD: 6 Reasons Why Play Therapy is an Effective Treatment Choice for Children with Trauma. Association for Play Therapy Magazine. Retrieved from https://cdn.ymaws.com/www.a4pt.org/resource/resmgr/publications/Why_Play_Therapy_is_Appropri.pdf

Teager, W., Fox, S., & Stafford, N. (2019). How Australia can invest early and return more: A new look at the $15b cost and opportunity. Australia: Early Intervention Foundation, The Front Project and CoLab at the Telethon Kids Institute. Retrieved from https://colab.thekids.org.au/siteassets/media-docs---colab/coli/how-australia-can-invest-in-children-and-return-more----final-bn-not-embargoed.pdf

United Nations (UN). (1989). Convention on the Rights of the Child. Retrieved from https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child

United Nations (UN). (2006). Convention on the Rights of Persons with Disabilities. Retrieved from https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf

Additional Resources for Play Therapist-Researchers to Get Started with Research

🌐 Websites:

- Association for Play Therapy Research Resources https://www.a4pt.org/page/ResearchResource
- Evidence-Based Child Therapy https://evidencebasedchildtherapy.com/
- International Journal of Play Therapy https://www.apa.org/pubs/journals/pla
- International Journal of Play https://www.tandfonline.com/journals/rijp20
- American Journal of Play https://www.museumofplay.org/journalofplay/
- Global Play Lab https://www.globalplaylab.com/

📊 Outcome Measurement Tools:

- Review frameworks aligned with your practice setting (e.g., NDIS Outcomes Framework, school-based monitoring tools)
- Brief, validated measures appropriate for children and families
- Play-based and arts-based assessment resources

🎓 Professional Development:

- Research methodology workshops offered by Play Therapy associations or providers
- Webinars on practice-based research, outcome monitoring, and program evaluation
- Conference sessions focused on research translation to practice

🤝 Networking and Collaboration:

- Engage in private research supervision to discuss your ideas
- Join Play Therapy association research committees or interest groups
- Connect with university-based researchers for partnership opportunities
- Participate in multi-site research networks

⚖️ Ethical Guidance:

- Your professional association's ethics guidelines
- Human Research Ethics Committees (HRECs)/Institutional Review Board (IRB) resources and templates
- Decision-making frameworks to assist in identifying if the project is quality improvement or research requiring ethical approval

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