CHAPTER 13

Group Play Therapy

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Group play therapy combines the advantages of play therapy and group processes (Landreth & Sweeney, 1999; Ray, 2011; Sweeney et al., 2014). In contrast to individual play therapy, in which the play therapist is the primary facilitator of therapeutic effects, all group members serve as therapeutic agents for each other in the group play therapy process. Schectman and colleagues (1996) argued that group play therapy is an ideal intervention that addresses children's emotional, social, and learning impairments. Through interactions with other group members, each group member has opportunities to explore individual intra- and interpersonal issues (Landreth & Sweeney, 1999; Ray, 2011; Sweeney et al., 2014).

Play therapy, including both individual and group formats, comprises a range of theoretical orientations. Hence, it is the group play therapist's responsibility to explore their theory of guidance in play therapy to aim to understand and conceptualize the child and the system around them, conduct assessments, and plan treatment in a consistent and therapeutic manner. Moreover, there are different types of group play therapy based on the activities used, including expressive arts, sand trays, and puppetry. Distinctions exist in implementing group play therapy from one theoretical approach to another and from one type of group to another. It is not the goal of this chapter to provide a comprehensive discussion on the delivery of group play therapy based on different theories or types; rather, we hope to provide a framework that can be applied and modified to diverse philosophies, goals, structures, and settings to support play therapists.

Definition and Primary Concepts

Sweeney and colleagues (2014) defined group play therapy as a relationship between two or more children and a therapist and that occurs through expressive play. The

multilateral relationships in group play therapy—which can encompass a relationship between children, between a child and a therapist, or both—allow opportunities for catharsis, reality testing, insight, and sublimation (Ginott, 1961; Slavson, 1948). Axline (1969) stated that "group experience injects into therapy a very realistic element because the child lives in the world with other children and must consider the reaction of others and must develop a consideration of other individuals' feelings" (p. 25). Landreth (2023) correspondingly contends that group play therapy is "a psychological and social process in which children, in the natural course of interacting with one another in the playroom, learn not only about other children but also about themselves" (p. 42).

A group provides an opportunity wherein each member interacts with each other in reciprocal roles, for example, as a receiver and giver of help (Ginott, 1961). In group play therapy, children encounter opportunities to understand themselves; learn about themselves by perceiving regard from both the therapist and other group members; and explore the importance of individuality and uniqueness, cooperation and compliance, creativity, and originality (Sweeney et al., 2014). Moreover, the interactions in group play therapy are beneficial for strengthening children's senses of control, feelings of empowerment, and abilities to master overwhelming emotions (Landreth et al., 1996). With these foundational concepts in mind, the primary objective of group play therapy is to provide an environment in which children can increase their self-acceptance, learn coping behaviors and alternatives to self-expression, and connect group experiences to reality (Ray, 2011; Sweeney et al., 2014). Through relating to and interacting with each other in a group setting, children may help each other consider personal responsibility in interpersonal relationships that they can accordingly extend to other real-world relationships (Landreth, 2023). In particular, Ginott (1961) emphasizes that group cohesion is neither the focus of group play therapy nor the therapist's expectation of the group process, which is supported by Ray (2011), who notes that children are egocentric regarding their developmental stage. When the therapist seeks harmony between group members in the therapy process, they may unintentionally neglect individual needs and progress and discourage group members from engaging in activities unrelated to other members, which may limit each child's freedom for expression and exploration.

Rationale and Benefits

"Humans are social animals, and play is the gas that drives the engine of social competence" (Brown, 2009, p. 87). From the perspective of human development, Erikson (1963) believed that play facilitates children's understanding of their social world and permits them to practice new social skills. Piaget's cognitive developmental theory (1962) includes the idea that play interactions provide opportunities for children to learn that others have perspectives different from their own. Researchers and scholars have collectively asserted the importance of play in enhancing social development in children (e.g., Berk et al., 2006; Frost et al., 2008; Landreth, 2023; Piaget, 1962; Ray, 2011; Seefeldt & Wasik, 2002; Vygotsky, 1966). In addition, Slavson and Schiffer (1975) proposed the term *social hunger* as being embedded in human beings and pertaining to the potential to connect with others. Ginott (1961) supported this conviction by arguing that people desire to conform, gain acceptance by others, and maintain status in their groups. As children move through elementary school, peer relations become increasingly important to

them, and they learn to be aware of their own as well as others' abilities while working with peers in school (Frost et al., 2008). Overall, group play therapy embraces the crucial socializing influences of groups, reflects children's everyday worlds, and meets their developmental need for social acceptance, which makes it an appropriate mental health intervention (Axline, 1979; Ginott, 1961; Landreth & Sweeney, 1999; Ray, 2011, Sweeney et al., 2014).

Landreth and Sweeney (1999, p. 53) identified various dimensions of group play therapy that make it an appropriate method of intervention for children:

1. It is less threatening for the child to enter the new experience in the company of two or three other children.
2. It facilitates the establishment of desired relationships.
3. It diminishes tension and stimulates activity.
4. It increases spontaneity.
5. It provides peer reactions from which children can reevaluate their behavior.
6. It ties the therapy to the child's real world.
7. It provides models and opportunities for vicarious and direct learning.

In the group play process, individual catharsis may be induced by observations from other group members. Slavson (1948) notes that group settings allow patterns of behaviors and struggles of children that are not present in individual sessions to arise. In the group play setting, therapists have the opportunity to observe and gain an understanding of children more holistically than they do in individual therapy (Ray, 2011). With facilitation and reflections from therapists in group play, children experience an environment with "interactions coupled with awareness" that may increase "positive experiences with peers" (Ray, 2011, p. 185).

The Role of the Therapist

Group play therapy provides ample opportunities for self-exploration and self-discovery, for not only children but also the play therapists themselves (Ray, 2011). The role of the therapist in group play varies across theories. Some directive approach-based therapists may incorporate more psychoeducation or therapist-led activities into the group play process (e.g., Meany-Walen & Kottman, 2019; Stutey et al., 2020a), whereas humanistic therapists may allow group members to take the lead without inserting much direction (e.g., Cheng & Ray, 2016). Regardless of approach, some responsibilities exist that group play therapists may need to pay attention to.

First, group play therapy is an advanced approach that requires the therapist to gain training and experience in both play therapy and group therapy (Ray, 2011). Second, addressing confidentiality with the caregivers and group members early in therapy is essential (Sweeney et al., 2014). In consultations with caregivers, the therapist should focus on the child of the caregiver without disclosing information about other group member(s). In the beginning of the first one or two sessions, the therapist should convey the importance of confidentiality using developmentally appropriate language. For example, a practitioner may say, "We keep what everyone says and does here in here," or collaborate with group members to structure group rules, including confidentiality.

Due to the complexity of group play, the therapist is encouraged to seek ongoing supervision or consultation to process internal experiences or practical issues regarding the process of facilitating group play. Ginott (1961) stressed that group play therapy "provides many opportunities for testing the stability of the therapist and for bringing even the most accepting adult to the brink of his endurance" (p. 128). Ray (2011) highlights the advanced commitment that group play therapy requires of therapists, including a certain level of comfort with simultaneous activities, interactions, and dynamics occurring between children and with the therapist, as well as the belief that children can be therapeutic agents for one another. The therapist may sometimes adopt an observer role instead of being the focus of the child's attention or the sole relationship for the child, which may be less comfortable for some therapists. Lastly, the therapist's role resides in their ability to utilize verbal and nonverbal responses therapeutically. Through such responses, group play therapists strive to develop a therapeutic relationship with each child in the group, facilitate relationships between group members, cultivate a safe environment in which all group members are able to explore individuals' intra- and interpersonal strengths and challenges, experiment with new socially acceptable skills and ways of interacting with others, and manage multiple group interactions in the presence of group members (Ginott, 1961; Ray, 2011; Ray & Cheng, 2018; Sweeney et al., 2014).

Considerations for Group Composition

The more experiences we have with practicing group play therapy, the more we realize that it is difficult to follow a set of absolute rules for composing a group. Children's uniqueness and potential, as well as uncontrollable environmental factors, may contribute to the difficulty of group selection. Group play may not be an ideal modality for all children and requires additional considerations (Ray, 2011). Presenting issues, personality traits, developmental stages, behavioral and cultural characteristics, progress in individual play therapy (if applicable), and/or the interconnections of all of the above may support or limit the positive effects of group play therapy on an individual child or an entire group. Moreover, the therapist's theoretical orientation and the purpose and type of the group must be considered. Deciding whether a child is appropriate for group play therapy is not a linear process and requires ongoing assessment, given that each child's needs may differ across time and that unexpected events may occur in their lives. To maximize the likelihood of appropriate decisions, facilitating at least one individual play therapy session as a screening tool prior to initiating group play, conducting observations and assessments, and setting up ongoing consultations with primary caregivers and/or teachers could be helpful. The therapist must continuously and intentionally monitor how the presence of each group member promotes or hinders the others' development and growth (Ray, 2011).

Ginott (1961), Ray (2011), and Ray and Cheng (2018) provided suggestions for group composition, which should be considered holistically rather than individually. First, group play may be less effective for children with a lack of awareness of others or a low degree of desire for social interactions or acceptance (Ray, 2011). Second, children with presenting issues that require individualized attention and a consistent sense of safety

may benefit from individual play therapy to begin with, such as children who are acting out sexually due to having been abused, are physically aggressive and impulsive, or are struggling with severe attachment issues with primary caregivers (Ray, 2011). Third, group play may be more appropriate for children who are 5 or 6 years old and older (Ray & Cheng, 2018). Younger children, at a developmental stage characterized by a lower desire for socialization, makes individual play therapy a more appropriate modality. Another recommendation related to age is to match group members within a 12-month psychological age range, rather than grouping children based on a chronological age. This consideration is dictated by the distinctive developmental needs, expressions, and cognitive functions of children across ages and psychological states (Landreth & Sweeney, 1999; Ray, 2011). The fourth consideration involves group size, which has been inconsistent throughout previous group play therapy studies. Axline (1969) recommended group sizes of up to eight children in each group led by a play therapist, whereas Landreth and Sweeney (1999) and Ray (2011) proposed two or three children per group. Ray stresses that group size is crucial in group play therapy because a play therapist's capability to be attuned to all members and to communicate verbal and nonverbal responses is affected by the presence and interactions of multiple children. We suggest that play therapists consider how their theoretical orientation and the nature of the group impact their decisions regarding group size. For example, a play therapist may have more children in a group that is based on a structured or directive approach than a group that is child-centered. Finally, play therapists may need to consider the role gender plays in group processes. Landreth and Sweeney propose that prior to 9 years of age, mixed-gender groups are appropriate; Ray also indicates that gender is not an issue in children's play and verbalization before they reach the age of 6. Beyond this age range, group play therapists may consider same-sex groups to maximize expression, understanding, and acceptance among members (Ray, 2011). Although the forementioned ideas are supported by child development, they are based on the classification of gender as binary. As early as 3 years of age, children may be able to express their gender identity (Rafferty, 2018). Research has shown that gender-normative children of both sexes interact with same-sex peers more often than with other-sex peers, while gender-nonnormative children engage in activities with other-sex peers more often (Martin et al., 2012). As such, we encourage play therapists to incorporate the concept of gender-expansive identities into their practice. If applicable, based on each child's developmental stage and self-expression, we also suggest that play therapists strive to understand how children define their gender identity and their comfort level in being in a group with people who share a similar gender identity, different gender identity, or both similar and different gender identity with them.

Another common question often posed by play therapists is whether a heterogeneous (i.e., children in the group differ in terms of cultural background, presenting issues, personality characteristics) or homogeneous (i.e., children in the group are similar in terms of cultural background, presenting issues, personality characteristics) group would be more beneficial for children. There is no definite answer to this question, and various aspects must be considered. Here, we encourage the therapist to ponder the following factors: (1) how strong the child's need is for connecting with people who are similar to/different from them; (2) to what extent and in what ways the child's cultural background, personality traits, presenting issues, and so on affect their views

of self and the sense of safety with others in the world; and (3) if applicable, whether the purpose of the group is to provide opportunities for children to explore diversity and inclusion through interacting with people who differ from them or to strengthen their own identity or validate their life experiences by connecting with people who are similar to them.

Multicultural Considerations

A detailed discussion on diversity and multiculturalism in play therapy is presented by Taylor and Turner (Chapter 15, this volume). Here, we discuss how diversity and multiculturalism may be exemplified in group play therapy. The multiple cultural identities and relationship dynamics in group play may reflect the larger societal system in which group members and the therapist reside, as some identities tend to lead to positions of privilege, while others to marginalization or oppression (Sweeney et al., 2014). Understanding how these elements interact with the group play therapy process is crucial. Ray and colleagues (2022) introduce the concept of *multicultural orientation* (i.e., cultural humility, cultural comfort, cultural opportunity) into play therapy practice and note the importance of cultivating cultural humility and comfort and attending to cultural opportunities while expanding cultural competence (e.g., attitudes, awareness, knowledge, skills).

A fundamental understanding that all play therapists must gain is the relationship between play and culture (Holmes, 2013). Play is both universal and culture-specific (Brown, 2009; Lancy, 2007). Children's play behaviors and interactions with others through play are affected by culture. Meanwhile, children learn and gain culture-specific values and skills through playing with peers and caregivers (Holmes, 2013). Cultural differences are also reflected in children's views and use of play materials and activities.

When I (Y. C.) was in my graduate program, I provided group play services in local schools to kindergarten children struggling with social–emotional competencies. I had one group comprising one child who is White and one who is Latinx, according to the intake information. These two children did not interact with each other much in the first two sessions but maintained awareness of each other's movements throughout. I remember vividly that in our third session, the Latinx child focused on creating scenarios where two different colors of soldiers were fighting each other and started speaking Spanish. The other child, who is White, looked at the first child and started mimicking the sound of the language they spoke. In the moment, I did not respond with any reflection but waited until the moment passed. I was not able to embrace my cultural discomfort to attend to the cultural opportunity in front of me. When I was watching the recording under supervision, I became aware that my negative self-perception as an international student whose first language is not English and who speaks with an accent limited my ability to facilitate this powerful cultural encounter between these two children. The Latinx child was so focused on their play that they comfortably spoke the language that they were familiar with, and the White child noticed something unfamiliar and tried to build a connection by mimicking; the mimicry from the White child seemed to be based on curiosity and recognition, which might be interpreted or misunderstood as mockery by adults.

The above example illustrates how variation in the cultural backgrounds and experiences of the group members and the therapist may lead to meaningful cultural interactions, which in turn serves as an opportunity for the therapist to gain awareness of the group dynamics and each group member's perceptions of themself and of others in a cultural way. More importantly, the therapist must understand how children learn and process cultures and diversity to recognize and respond to these moments therapeutically.

Verbal and Nonverbal Responses in Group Play Therapy

Even though play therapists operating from different theoretical orientations may utilize specific techniques or activities in group play therapy, we propose that some verbal and nonverbal responses are fundamental across all theoretical practices. The primary goal of both verbal and nonverbal responses is to effectively communicate understanding and acceptance of each child's expressions and the therapy process in the moment, as well as to enable all children to become more aware of themselves, others, and the environment. Next, we present descriptions and examples of responses that could be applicable across theoretical approaches (Ray & Cheng, 2018).

Nonverbal Responses

The nonverbal expressions of the play therapist are as important as verbal responses in regard to communicating a warm and welcoming attitude for children in group play therapy (Ray, 2011). Often, the complexity of the interactions and processes occurring simultaneously in the group play process may make it challenging for play therapists to remain relaxed and focused, which accordingly affects their nonverbal communication. A high degree of noise, messiness, or additional forms of stimulation could test the therapist's acceptance and appreciation for children's intense interactions when playing together (Ray, 2011; Ray & Cheng, 2018). For example, a play therapist who is overwhelmed by the activity level in group play may disconnect themself from the group process by becoming quiet and sitting back in their chair, which conveys a nonaccepting attitude to the children. This challenge highlights the need for play therapists to engage in self-exploration to process their experiences and how they may have impacted their way of being, their perceptions of group members, and the group process as a whole.

Verbal Responses

Play therapists' verbal responses serve as a way to reach children; communicate sensitivity and validation; and facilitate freedom, responsibility, and self-regulation (Landreth, 2023; Ray, 2011). The neuroscience research of Walbrin and colleagues (2023) suggests that children may need to think about the intentions and feelings of others to understand social scenes due to a lack of social experiences. This perspective supports the idea that the verbal reflections and facilitations of the therapist could help children gain an understanding of their social encounters.

Building on Axline (1947), Ginott (1961), Landreth (2023), and Ray's (2011) therapeutic play therapy responses including tracking, reflecting feeling and content,

encouraging, facilitating creativity, returning responsibility, facilitating relationship, and limit setting, Ray and Cheng (2018) further applied these categories to the group play therapy setting and include two additional verbal responses necessary for therapeutic communication with group members: facilitating relationships among children and bridging. We suggest play therapists adapt these responses to align with their theoretical orientations in group play work. In the following section, we focus on the two responses specific to group play.

Facilitating Relationships among Children

In addition to facilitating the therapist's own relationship with each child, they must also attend to the feelings and dynamics occurring among children in their immediate responses. The purpose of these responses is to recognize and empathize with each child's desire and readiness for connection and help them become aware of where they are in the development of relationships with each other, respectively—for example, "Wendy, you want Lisa to play with you by asking her to join you to the sandbox"; or "Lisa, you are not sure about that, and you decided to continue playing with the playdough over there"; or "Wendy, you seem sad that Lisa is not ready to play with you." Such responses could also cultivate the giving and receiving of understanding between group members.

Bridging

Bridging is a unique response in group play therapy, in which the therapist seeks opportunities to reflect on interactions between group members that highlight their similarities and strengthen their relationships with each other (Ray & Cheng, 2018). The therapist may note a shared interest or reflect on similar feelings, thoughts, needs, or behaviors to initiate a bridge of commonality for relationships. Bridging responses may include "Millie, you are showing me your drawing, and Mike, you are showing me what you can do with the Bobo. Both of you want me to pay attention to you"; or "Ping, you like horses, and Logan, you like lions. Both of you know what animals you like"; or "Alia, you are painting over there, and Tulia, you are building blocks over there. Both of you are focusing on what you are doing"; or "Arya and Elliot, you both look excited about the sandbox."

Considerations for Limit Setting

We discuss limit setting in group play specifically due to its importance and the challenges associated with having more than one child in the room. The play therapist may sometimes set more limits than necessary because of the need to control the therapy course or children's behaviors or because of the therapist's low tolerance for messiness or noise or the intensity of play behaviors and interactions. These personal needs may serve as a barrier to creating an environment where children can freely express and explore themselves through symbolic actions, no matter whether they are deemed constructive or destructive. Other times, a child may continue an unpleasant play behavior toward another child who does not explicitly express their frustration, to the point where the therapist feels a need to set a limit to protect the child. How the therapist

intervenes (perhaps with a tendency to rescue) in moments like this might deprive children of opportunities where they feel empowered enough to stand up for their needs.

Limit setting is based on the principle that feelings and needs are validated and accepted, yet certain behaviors are limited in group play therapy to ensure the physical and psychological safety of group members and the therapist (Ray, 2011; Ray & Cheng, 2018; Sweeney et al., 2014). Play behaviors that are acceptable to the play therapist may not always be tolerable by group members, which complicates limit setting in group play (Sweeney et al., 2014). Ray (2011) and Sweeney and colleagues (2014) provide helpful guidelines on limit setting in group play. Yet, approaches to limit setting in group play vary based on theoretical orientations; no one set of limits is applicable to all groups in all situations (Sweeney et al., 2014). Effective limit setting stems from the therapist's own self-regulation and genuine acceptance of the child, leading to the child's inner ability to regulate their emotions and develop new coping skills and acceptable behaviors when experiencing rejection, disapproval, or other overwhelming situations. Group play therapists aim to consistently, fairly, and promptly implement limit setting in groups, especially when there is a possibility of physical or emotional harm to another child in the midst of a rapid rate of activities.

Considerations for Playroom Setup

An appropriate playroom size for group play should allow and support high activity levels, a variety of activities, and simultaneous intense emotional expressions from all group members. It is important to consider whether each child in the group can move around the room freely without bumping into each other; whether there is room for personal space when a child needs to disconnect from the group or be alone; and whether the therapist can comfortably see, observe, and facilitate the therapy process. Insufficient or excessive space can hinder the development of a sense of security for everyone in the group, including the play therapist.

Therapists from all theoretical orientations are suggested to intentionally select materials when conducting group play. The toys in the playrooms must be appropriate for group members' developmental age, facilitate relationship building between group members and between the members and the therapist, and allow for exploration via various play behaviors. Toys can represent categories facilitating different emotional expressions, such as mastery, nurturing, aggression, power and control, security, imaginary, creative expression, and relationship (Landreth, 2023; Ray, 2011). In addition, it is crucial for play therapists to ensure that the play materials in the room reflect the diverse cultural backgrounds of group members. Both Ray and colleagues (2013) and Stutey and colleagues (2020b) discuss the role that culture plays in children's play behaviors. Furthermore, Ray and colleagues (2022) conducted a Delphi study exploring 22 play therapist experts' views on the construction of a multicultural playroom. These studies highlight the importance of not only a culturally inclusive play therapy room that includes materials to which children feel a sense of connection but also the play therapist's cultural awareness, intentionality, and cultural humility in the process of assembling such a play therapy environment. It is neither practical nor possible to purchase toys from various cultures; however, an appropriate selection of representation is encouraged.

Clinical Case Example

Maya is a White girl from a middle-class household, and according to her father, all her developmental milestones seemed appropriate. He shared that Maya had been struggling with assertiveness in social settings. Maya's father reported that he and Maya's mother had divorced about a year and a half previously and that he had sole custody of Maya. He reported that Maya had seen another play therapist for about 9 months when the divorce occurred to process the grief and loss and that Maya had been showing progress since then. Maya's father completed a children's behavioral instrument, and I (Y. C.) asked his permission to have the teacher complete the teacher's form of the instrument. The results from both forms showed that all subscales fell within a normal range.

Lucy's parents had also divorced about a year previously. They shared custody of Lucy and agreed to joint caregiver consultations throughout the course of therapy. Based on their report, Lucy was a White girl and split her time between the two middle-class households provided by her parents. They reported that Lucy seemed to react to the divorce and adjust to the corresponding life changes well, which was why they had not considered seeking mental health services for her. They shared that a teacher had indicated Lucy's difficulty following class rules and maintaining friendships at school over the past 3 months. Both parents and the teacher completed the children's behavioral instruments, and the results of all subscales fell within a normal range; however, the anxiety subscale from the teacher's report fell between the borderline and clinical range. I also conducted individual play therapy sessions with both children separately to screen their appropriateness for group play. Based on these data and observation, I began seeing Maya and Lucy in child-centered group play therapy (CCGPT), the theoretical approach I identify with. Usually, play therapists conduct consultations with the caregivers of the potential group play candidates separately to ensure they are appropriate for the group approach prior to working with the children.

In the first few sessions, they focused on their own play without involving each other. When I reflected on what they were doing individually or bridged their shared feelings or behaviors, they would look at each other, showing their curiosity and awareness. During this time, they focused their interactions with me only. One day, around the sixth or seventh session, Lucy repeatedly tried and failed to open a container of play-dough. Maya saw this and immediately tried to help, yet she also struggled. Lucy and Maya started talking to each other and trying to figure out a way to open the container together through the entire session. When the session ended, they had not succeeded. However, this moment seemed to build a feeling of connection between them and thus facilitated increasing numbers of interactions between them in subsequent sessions.

In those sessions, I also observed the relationship dynamic between them; Lucy tended to lead and to tell Maya what to do, whereas Maya followed. At first, Maya showed neither verbal nor nonverbal expressions when Lucy tried to control their play. Once, however, when Lucy took a shovel away from Maya, saying, "I need to use this; you use something else to make the sandcastle," I observed that Maya just stood there with a frown on her face and reflected this interaction by saying, "Lucy, it is important for you to have what you need, so you took that away from Maya. Maya, you seem frustrated when Lucy did that, but you are not sure how to let her know." They both looked

at me. A moment later, Lucy gave the shovel back to Maya and said, "Sorry. I can just use the rake." After this session, I noticed that both Lucy and Maya were gradually progressing in their social development in their own ways; Lucy would sometimes pause to look at Maya's reactions when she wanted to do something, and Maya would be more able to verbally share her thoughts and feelings with Lucy.

When I was contemplating the idea of terminating the CCGPT with both of them due to the growth I saw in the playroom and the positive feedback from their parents, I got an opportunity to spend time with Lucy individually; Maya had to cancel the session, but Lucy expressed her desire to come to therapy even without Maya's presence. In that session, Lucy verbally shared with me how exhausting it had been for her to visit two homes every week and how much she missed her both parents living together. She tried desperately to stop crying, but I knew she was not able to hold back her sadness, loneliness, and feelings of hurt and being out of control any longer. I left the session feeling somewhat surprised. After consulting with my supervisor and meeting with Maya's and Lucy's parents, it seemed appropriate to terminate group play after several additional sessions and continue individual play therapy with Lucy to help her process the experiences around her parents' divorce.

This case study highlights that each child heals at their own pace and is unique in their own way of developing and growing. The therapist must continuously incorporate various methods to assess each child in the group to ensure that group play therapy is still the appropriate modality for them. It is imperative for the therapist to have the sensitivity, clinical judgment, and flexibility to develop an appropriate plan for all children when it becomes evident that one of the children needs individual play therapy more than group play. Afterall, both individual and group play therapy could be therapeutic for children, but sometimes in different ways. Maya and Lucy shared a few similar background (e.g., age, gender, race, and parental divorce) and were perceived as having social struggles when they showed up for group play services, and they both demonstrated enhanced social skills as a result of group play. However, as sessions progressed, Lucy's pressing needs changed, or emerged. Or perhaps she was ready to process the experiences related to the divorce, but not during the group play time. The various anxious behaviors Lucy displayed at school were perhaps related to her reactions to the divorce, and her need to control Maya in the group may have been her way to regain a sense of control and security in her life. Without the additional individual session with Lucy, I could have missed the opportunity to support her in a different way. If I solely focused on group cohesion between Lucy and Maya, Lucy probably would not have felt comfortable enough to share her internal struggles with me.

Conclusion

Social–emotional well-being serves as a critical foundation for not only childhood development but also development throughout life. Group play therapy enables children to grow inter- and intrapersonal awareness and social skills as they experience a consistent and accepting environment fostered by the therapist. However, group play may be a challenging approach for many play therapists to implement, given the complex nature of the therapeutic process, including the presence of multiple children, multilateral relationship dynamics, and various cultural interactions. As such, to better

prepare for composing helpful groups and facilitating therapeutic group play therapy sessions, play therapists are encouraged to reflect on the personal beliefs of group members, explore the personal needs that could be met or unmet in group play, strengthen verbal and nonverbal responses that facilitate group process, and engage in continuous self-exploration regarding how diversity and multiculturalism are embedded in each group member and the group as a whole.

CONSIDERATIONS FOR PRACTICE

- Group play therapy is a rewarding and powerful play therapy approach, but it is not an easy one to implement. Play therapists are encouraged to ponder what group play therapy looks like in their guiding theory and accordingly engage in learning opportunities to ensure a solid foundation for such practice.
- Things sometimes happen quickly in group play, and children may be reactive to each other's behaviors, which requires the therapist's prompt response. This is especially crucial when a child displays physically impulsive or aggressive behavior toward another child. When necessary, the therapist may need to stand between the children to ensure the safety of everyone involved while using verbal responses to set limits and to convey understanding (e.g., "Kevin, I know you want to hit Joy, but Joy is not for hitting. I am standing between you two to make sure everyone is safe").
- As discussed throughout this chapter, group play therapy may easily test play therapists' limits and genuine way of being with children. To prepare ourselves, play therapists are encouraged to engage in self-exploration, such as imagining a situation or a child's behavior in individual play therapy that you struggle with the most and then double or even triple the intensity of the behavior or situation. Then we reflect on this as a way to explore our vulnerability, our strengths, and how our personal needs may be met or unmet in group play therapy.

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