
The Power of Play Therapy

An Interview with Eliana Gil

Eliana Gil is founding partner of Gil Institute for Trauma Recovery and Education, LLC, a private practice in Fairfax, Virginia. As a registered play therapist; a registered art therapist; and a licensed marriage, family, and child counselor, her research and her clinical practice have focused on working with traumatized children, play therapy, posttraumatic play, and family play therapy. She is the author, coauthor, or coeditor of many publications, including *Cultural Issues in Play Therapy* (2nd ed., 2021), *Post-Traumatic Play in Children: What Clinicians Should Know* (2016), *Play in Family Therapy* (2nd ed., 2015), *Working with Children to Heal Interpersonal Trauma: The Power of Play* (2010), and *The Healing Power of Play: Working with Abused Children* (1991). She has been recognized for her work in child-abuse prevention by the American Family Therapy Association and the California Governor's Award, and the Association for Play Therapy awarded her its lifetime achievement award.

American Journal of Play: Much of your research, scholarship, and clinical work has focused on art and play therapy as a way to help traumatized children. For those who do not know your work, what exactly is play therapy?

Eliana Gil: As the name implies, trained play therapists believe that play has curative factors that can help children communicate, manage stressful situations, manifest their perceptions, and provide a way to resolve social difficulties. Play has been shown to have many change agents that can be helpful including opportunities for catharsis, gradual exposure, and relational connection with others. In Charles E. Schaefer and Athena A. Drewes's *The Therapeutic Powers of Play*, they identified four main dimensions of play that are helpful—it facilitates communication, fosters emotional wellness, enhances social relationships, and increases personal strengths.

AJP: What roles do art and creativity play in this approach to therapy?

Gil: Art is a desirable and pleasurable activity for most children. When trained

play and art therapists provide children with a range of art materials and the comfort of drawing or creating whatever they want without external validation or rejection, children can develop a sense of creative expression and release. In a safe setting, one in which the therapist does not make demands for representational art and provides witnessing, children can tap into their creative imagination and develop a sense of being valued because their art images are accepted. There is a grave misunderstanding about creativity—mainly, that people either have or don't have creativity. My sense is that children start out with creativity (watch toddlers play and show curiosity), but it can be encouraged or discouraged. The environment can support or limit exploration. Comments from others can make creative children feel accepted or rejected. Unfortunately, schools can play a central role in causing people to feel they are not good at art or creative expression and in promoting the notion of evaluating whether something is good or bad based on someone else's opinion. Art and play therapists encourage people to focus on what they see and experience while engaged in creative expression and to pause long enough to look at their creations, valuing them and assessing how they feel as they touch, see, move, or otherwise interact with their images. This interaction between client and image can elicit introspection and insight, as well as offer a connection to their own inner wisdom.

AJP: Charles Schaefer and Kevin O'Connor founded the Association for Play Therapy in 1982, but clinicians used play in therapy before that. Can you tell us about how the field developed?

Gil: Most professionals who work with families find it challenging to engage young children in therapy. Family therapists were keen to invite children into family sessions, and yet they often wanted to ask them questions. Over time, it became clear that young children are not necessarily comfortable with verbal communication, and family therapists developed a preference about working with teens who could respond verbally. Many mental health professionals stocked their offices with paper and crayons, toy cars, board games, and fidgets, to be welcoming and give children something distracting until they could get them to talk.

Play and other expressive therapists differ in that they value the play or art process itself, not necessarily the verbal explanations of the play. Play therapists are trained to identify play themes, typical outcomes, the roles of gender and age, family or historical narratives, and outcomes. Most

expressive therapists don't need verbal dialogue to strengthen the process. They believe that the process of playing or making art is the therapy, not something you do to facilitate talk therapy. A few years back, I remember a six-year-old pouring over a sand tray, taking her time to be as selective as she could, creating a magnificent sand tray with obvious pride after completion. After waiting a little while to see if she had something spontaneous to offer, I said, "You can say as much or as little as you want about the sand tray." She looked up at me and, without missing a beat, she said with confidence, "I just said everything I wanted to say right here," pointing to the sand tray. She then turned around and said she was ready to go. I remember smiling at her assertion and agreeing wholeheartedly. She had spoken symbolically, and my job was to work receptively to understand what she was communicating at that moment in time.

AJP: What inspired your early interest in the field of play therapy?

Gil: When I was in a doctorate program in family therapy, I was fascinated to see seasoned (famous) family therapists struggle to know what to do with young children. More often than not, they gave children something to do while they engaged the adults in conversation. I found myself watching the kids, and, if it was possible, I would go retrieve any artwork they did while their parents or family members participated in family therapy. I was shocked to see that the art images were more often than not related to the topics being discussed by the adults on the other side of the room. On one occasion, a child put a note in a bubble over the head of the adult that the child had drawn. "I've got them all fooled," stated the male figure in the picture, and I truly believe that he was referring to his father, who was particularly charismatic with the family therapist while others alleged inappropriate behaviors behind closed doors.

I found consistently that children had unique ways to express family dynamics and issues and, in fact, unfortunately were being gravely neglected. This lack of attention to children (or discomfort with young children) sparked my interest. I wanted to understand not only what the struggle was about—to engage children but also to find novel ways of inviting children to participate fully in family therapy.

AJP: Who are the scholars and clinicians who helped shape your development as a researcher and therapist?

Gil: I have been influenced by many people, mentors who saw something in me, who recognized that I had something to offer. The first one was Tom Stern,

who guided me through my master's program and cheered me on while challenging me. Tom talked to me about a doctorate program on the night that I got my master's degree and, without him, I'm not sure I would have pursued more education. I was raised in South America (Ecuador), and women were usually expected to go to high school, marry, and have children. The thought of higher education was not commonplace or expected. Tom believed I could go farther and inspired me to do so. The other major influence was Robert Jay Green, who was my internship supervisor. He is a creative and brilliant family therapist, and he really gave me wings by his interest, curiosity, and support. In the field of play therapy, I have been inspired by many, most notably Garry Landreth and Louise Guerney. What they have in common is an acute interest in how to be of service to others, humility, and a great love for helping family members feel emotionally connected to each other.

AJP: What were some of your own earliest play experiences?

Gil: I grew up in South America and experienced a lot of earthquakes. In addition, my parents divorced and my mother relocated to the United States when I was thirteen. After earthquakes, which terrified me and my grandmother, I found myself coping through play. Specifically, I made up a dance in which my entire body shook, then I froze, then I shook again. In addition, I took playing cards and set them up structurally, then threw them down. I also wrote stories about faraway places where the villages were built on water and floated, so that the earth could not shake and break apart and where street lamps did not fall down and burn.

When it came to my parents' divorce, that was more difficult to understand and process, especially since it prompted my mother immigrating to the United States without my father. I remember taking small male and female figures and locking them up somewhere so they could "talk and figure it out." I also had a police officer in the dollhouse who would arrive at the first sign of yelling. Finally, when we were in the United States, I kept writing stories about a father who found his children even though they were living far away, on top of a mountain, and the father didn't know how to find them. I remember drawing a very elaborate map, and I sent the story to my father.

During this period of intense change, loss, and relocation, I devised many expressive arts activities in my room. We went from living in a large house in Ecuador with extended family and family helpers, to living in a

small apartment in Washington, D.C., and spending a lot of time alone. My mother went from being a stay-at-home mom to working full time. Thus, my brother and I spent a lot of time alone. Play truly helped me cope with my loneliness, my brother's negative attention, and my missing my father. I did a lot of playing with a small dollhouse, bringing my father into the play and generally managing many difficulties through play. And I distinctly remember that, in this play, I used my voice fully and in my native Spanish. While at school I coped with peers and teachers calling me Elaine, Eileen, Ellen, and a host of other names, unable or unwilling to learn to pronounce Eliana. In my play, I would often stop people, correct them, patiently teach them my name, and not allow them to say any variations.

AJP: How have these play experiences informed the way you have approached working with children?

Gil: I recognized early on how play could help manage stressful situations, especially at times when others did not appear to be able or willing to communicate clearly or when others had emotional responses that they were trying to curtail to put on a brave face. I learned that children can sense that something is wrong, can feel protective of parents who are struggling with their own emotions, and might end up isolated with their thoughts and feelings. Pretend play, in particular, can provide children an opportunity to sort out feelings, feel a sense of mastery, and soothe themselves.

AJP: In your 1991 book, *The Healing Power of Play*, you note how much you learned from the growing body of literature about adult survivors of abuse and how that and other case studies drove home the importance of choosing the right types of play therapy and treatment case by case. What have we learned about abuse and trauma since then that has informed approaches to play therapy?

Gil: The more information becomes available about the impact of trauma on children, the more credible ideas about expressive therapy become, especially as it becomes clear that traumatic experiences are embedded in the right hemisphere of the brain and that they are not always available through traditional talk therapy. Bruce Perry, coauthor of *The Boy Who Was Raised as a Dog: And Other Stories from a Child Psychiatrist's Notebook: What Traumatized Children Can Teach Us About Loss, Love, and Healing* and developer of the neurosequential model of therapy, talks about the brain as a hierarchical system with the cognitive abilities at the top of the brain as the most advanced. Thus, traumatic memories might best be processed

sequentially with cognitive discussion provided later in therapy (bottom up) while first working on behavioral and emotional regulation, feeling states, and coping responses. This is likely most relevant when working with children who tend to become dysregulated if asked to provide verbal narratives of their traumatic experiences. It may be advisable to address behaviors and feelings associated with lower parts of the brain first. When children are dysregulated, their nervous system gets very active, and they may be unable to formulate thoughts, identify feelings, or interact with others because they are outside their window of tolerance. Thus children can become hyper- or hypoaroused when overstimulated. We must first coregulate children to allow them to calm their nervous system for therapy receptivity.

AJP: You have written extensively about posttraumatic play in children. What is posttraumatic play, and how does it differ from other kinds of play by abused and traumatized children?

Gil: Posttraumatic play is a unique form of play used by traumatized children who—by playing out what’s on their mind—find ways to externalize their difficult experiences and make them manageable. Traumatized children can often self-initiate gradual exposure, which means they expose themselves symbolically and incrementally to the events that worry, frighten, or concern them. Through posttraumatic play, children can regain personal control and mastery. This type of play is usually different from generic play in that it has a literal quality, it can be repetitive, and children may do solitary play. As clinicians observe the play initially, they may notice an intense quality to the play as well as a lot of duplication from session to session. After a period of time, children begin to find resources to add, and they begin to visualize new outcomes in which they detach themselves from rigid repetitions of the play. In other words, they begin to disconfirm cognitive distortions, organize their narrative, and discharge whatever thoughts or feelings they might have been carrying. The memory, thus, is deactivated in intensity, and the child learns how to manage feelings when they arise or are triggered by external factors.

AJP: What are the differences between dynamic posttraumatic play and toxic posttraumatic play?

Gil: Likely the most curious and sometimes expected aspect of posttraumatic play is that it can become stuck. Dynamic posttraumatic play seems to meet most or some of the positive intent of the play, allowing children to

see the big picture, freeing themselves from challenging thoughts and feelings, and eventually processing and then leaving behind difficult or feared aspects of their traumas. By contrast, toxic posttrauma play does not allow enough movement or satiation, enough relief or cognitive reevaluation. Instead, the child can feel retraumatized by playing out a story in repetitive fashion, without emotional release. When clinicians assess that the play is stuck, they will need to attempt direct interventions to enable the movement and growth associated with the potential benefits of posttrauma play. Lenore Terr, a San Francisco psychiatrist and author of *Too Scared to Cry: Psychic Trauma in Childhood*, was the first to place a spotlight on the plight of traumatized children by interviewing them and then chronicling her work with the elementary school children kidnapped and buried in a bus in Chowchilla, California. She coined the term “posttraumatic play.”

AJP: In your latest book, a completely revised second edition of the edited collection *Cultural Issues in Play Therapy*, you and your coeditor discuss the impact of the COVID-19 pandemic and antiracism on play therapy. How have these developments shifted the way many clinicians approach play therapy?

Gil: The presence and highly contagious nature of COVID-19 quickly became a significant factor in our daily lives, affecting clients and therapists alike. Initially, there was a climate of confusion with mixed messages from our country’s leadership regarding this urgent health crisis. The health crisis quickly became intertwined with political issues and divides. Eventually, some citizens believed the pandemic to be a hoax, refused to get vaccinated, and did not want to adhere to rules and curfews designed to protect people from being contaminated. It’s almost impossible to believe that as of April 26, 2023, the number of both confirmed and presumptive positive cases of the COVID-19 disease reported in the United States had reached over 104 million with over 1.1 million deaths reported among these cases.

The impact on families was intense and massive, with people unable to work onsite, business owners losing their businesses, and people finding it difficult to negotiate all the stressors during this time. Many families felt the claustrophobic aspects of being shut down in their homes, without outside social contact. Suddenly parents had to work from home while their children were underfoot, some doing their own zoom school attendance. Children apparently suffered in both the learning and social opportunities afforded by attending school daily.

And in some families that had conflictual adult relationships, incidences of domestic violence and child abuse rose, because family members had high stress and a lack of coping resources and were in the unfamiliar situation of imposed isolation. The rates of depression, anxiety, and drug use also rose. Overall, the country is still recovering from the stagnating health crisis and there is still concern over what comes next.

The COVID-19 pandemic also had racial overtones because our former president kept referring to it as a “China pandemic,” hinting that it might have been a retaliatory, purposeful release of a virus by the Chinese government. The crime rate against Asians has increased. American citizens began to feel frightened of traveling to other countries and looked askance at those coming to the United States from other countries. Thus, immigration issues became more central to Americans in the United States, and the climate of anxiety toward immigrants has continued, creating pronounced racial divides in our country. During COVID-19, there was a great deal of information generated about racism, and clinicians were encouraged to build antiracist policies into their work settings. During this time, we also had the very public murder of George Floyd in May 2020, and everyone became focused on this prime-time example of racism. Floyd’s murder also highlighted the implications of those in power harboring resentments about and inflicting cruel behaviors on those from other races. This has led to continued assertions about civil rights, antiracism, and forging bridges among different cultures. It certainly feels like a long-standing, urgent issue, which continues to challenge political leaders as they focus on immigration reform and the crisis at the borders, to say nothing of domestic terrorists. There is consensus on how complex all these issues are, and the social climate around welcoming immigrants might become permanently changed.

Children and families sustained ongoing stress for a long period of time, and we are just recognizing all the ways we were impacted by this global pandemic. Children have had incredibly high rates of anxiety and depression, violence (at home and school), and exposure to two global wars that contribute to a general feeling of anxiety, lack of safety, helplessness, and despair.

AJP: When you look back on all your work, what are you most proud of?

Gil: I am most proud of my ability to integrate approaches, keep an open mind, and stay curious about multiple ways to help children and families. My flexibility reflects a clear commitment to being of service to diverse families

and making invitations designed to elicit their personal investment in their therapy process. I believe that as clinicians our greatest gift is showing up in full force: Being present, interested, and flexible while recognizing that no one approach will work for everyone, and traditional, verbal psychotherapy is likely overrated.

AJP: One last question: What is your favorite way to play?

Gil: I have always enjoyed playing sports such as tennis and pickleball, so my inclination is to say physical sports. However, I also love drawing, dancing, music, acting, writing poetry and prose, as well as making art, and having a daily or weekly practice of sand therapy and mandala drawing. In addition, I like to invite children to play with me in my garage, and I like playing hide-and-seek with them, storytelling, puppet making, and so on.