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Regular Article

Developing a program theory for play therapy intervention in co-creation with the professional field

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A R T I C L E I N F O

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A B S T R A C T

This study describes the development of a program theory for play therapy as an intervention for children and young people with mild intellectual disabilities and difficulties with aggression regulation. The program theory was developed in collaboration with registered play therapists through focus groups and individual interviews. The aim was to gain insight into explicit and implicit knowledge regarding therapeutic practice with this target group.

Data collection took place in three phases: first, a focus group with experienced play therapists; second, interviews with therapists working specifically with the target group; and finally, a comparative round with therapists working with a general client population. The interviews were analyzed thematically, with additional attention to the type of knowledge expressed, including explicit, implicit, or unique knowledge specific to the target group.

The results show that play therapists work from a client-centered attitude, strongly focusing on building a therapeutic relationship and providing a safe environment. Collaboration with the child's support system and the use of micro-interventions during play were identified as key elements. This study represents the first step toward establishing a theoretical foundation for play therapy as a complex intervention for this specific target group.

1. Introduction

Play therapy has been used for decades to address social and emotional problems (Cochran et al., 2023; Schaefer & Drewes, 2014). It is an effective treatment for young people with such issues in everyday practice. Play therapy is increasingly used for young people with mild intellectual disabilities due to the observed successful results (Mora et al., 2018, pp. 178–191). Play therapy is a form of psychotherapy that utilizes play as a form of communication. Thoughts, feelings, and experiences can be expressed through play, especially when verbal expression is too complicated. In this context, play is a safe and natural means of communication. As such, this development is still primarily based on experiences shared within the field. However, a scientific evaluation and underpinning of the positive results of this therapy is still lacking.

Therefore, the government, the professional field, education providers, and health insurers demand a scientific basis for such therapeutic interventions (Banks et al., 2017).

This research aims to develop a program theory for play therapy with young people who have a mild intellectual disability. A program theory includes all the ingredients of an intervention (Rossi et al., 2019). Program theory establishes the interrelated connection between a target group, goals, approach, context, and outcomes. A program theory clarifies how and why an intervention works for a specific target group (Yperen et al., 2017). The figure below illustrates this Fig. 1.

The work described in this paper represents the first fieldwork aimed at collecting further details on the operation of this program theory for young people with mild intellectual disabilities and identifying the elements of tacit knowledge that contribute to its effectiveness. The results of this work will be translated into a more detailed program theory for this type of intervention. Before describing this work, a brief outline of play therapy is presented, explaining how it is applied as an intervention for young people with mild intellectual disabilities.

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2. Background

2.1. Play therapy

As mentioned in the introduction, play therapy is a form of psychotherapy for children up to the age of twelve and individuals of all ages with intellectual disabilities (Cochran et al., 2023; Groothoff et al., 2009).

Play therapy is regarded as a means of facilitating communication. It is not concerned with a general exploration of play behavior but with the specific meaning of the individual's play (Landreth, 2012). Play therapy aims not to teach the child how to play, but to address and resolve the client's emotional difficulties. Due to its imaginative component, play can serve both a processing and a wish-fulfilling function (Landreth, 2012). Play is seen as a highly individual and personal way of engaging with the world within the therapeutic context. Play therapy is conducted by a trained therapist in a specially designed room for this purpose.

Each play session follows a general structure, although no fixed protocol is used. Below is a description to provide an impression of what such a session looks like (Axline, 1971).

The therapist picks up the child from the waiting area, and the session begins by having a drink together. During this time, the child is invited to share the past week. Afterwards, the child chooses what to play with. The therapist and child then engage in play using the materials the child has selected. As the session nears the 45-min mark, the therapist signals that it is time to wrap up. They say goodbye, the child returns home, and the therapist tidies up the Playroom.

The definition provided by the Association for Play Therapy (2014) is used to clarify what is meant by play therapy as a treatment intervention. It describes play therapy as:

> "*The systematic use of a theoretical model to establish an interpersonal process in which therapy is used to help prevent or resolve psychosocial problems and achieve optimal growth and development.*" (Jensen, 2017, p. 390).

2.2. Population characteristics

The target group of this article consists of children and adolescents with a mild intellectual disability who are undergoing treatment through play therapy. All of them present with challenges related to aggression regulation. The participants include boys and girls, ranging in age from four to fifteen years. They have been diagnosed with either an intellectual disability or a developmental delay. These young individuals receive play therapy at a facility specializing in the treatment of people with intellectual disabilities. Some participants live at home while others reside in foster care, family homes, or other settings.

A widely used international definition of intellectual disability is that of the American Association on Intellectual and Developmental Disabilities (AAIDD), as cited in Buntinx and Schalock (2010). The AAIDD indicates that there is a disability if you cannot perform one or more necessary life activities. Five key domains contribute to intellectual functioning.

1) Intelligence: learning ability compared to peers and applying knowledge. This is measured in terms of an intelligence quotient (IQ), which is the ratio of measured knowledge to age. 2) Adaptive behavior: the behavior through which we can deal with change. People with intellectual disabilities are often limited by their lack of adaptive capacity. 3) Social roles, interaction, and participation. Deficiency in the field of social capacity is common among people with an intellectual disability. They are often less able to engage in family relationships and social interaction. 4) Health: Physical complaints are more burdensome in combination with reduced intelligence and less capacity for adaptive behavior. 5) Context or environment: This is the total environment in which someone functions. In addition to the immediate environment, such as family, school, and work, this also includes the environments in which the family participates.

The five domains cannot be separated because they mutually influence one another Fig. 2.

Since the target group of young people with a mild intellectual disability often cannot function entirely independently in society, the social system in which the young person is embedded can be characterized as an intermediate target group (Didden et al., 2016).

This includes the parents/educators and, in the case of a residential setting, the young person's supervisors. Depending on what is necessary for the success of the play therapy and the client's needs and environment, the intermediate target group is involved to a greater or lesser extent in the play therapy. The intermediate target group is always involved, as these young people cannot function independently (Bruijn, Buntinx, & Twint, 2014).

2.3. Professional field

The professional field that contributed to developing and describing the program theory consists of certified Dutch play therapists. All of them are registered play therapists. In the Dutch context, they have completed a Master's program in play therapy. This Master's program is a postgraduate specialization for those with a degree in educational sciences (Orthopedagogy), psychology, or teaching. With the Master's diploma in play therapy, they can register in the national quality register, thereby obtaining the title of Registered Play Therapist. In the Netherlands, a registered play therapist is a recognized healthcare

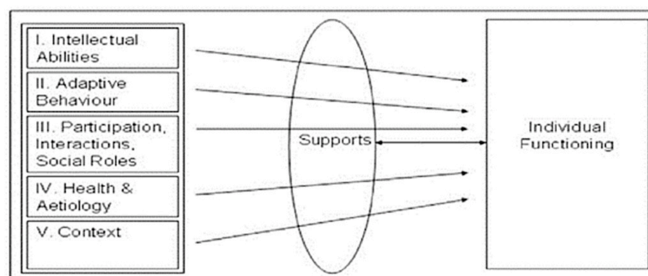

Fig. 2. Conceptual model of human functioning (AAIDD, 2010).

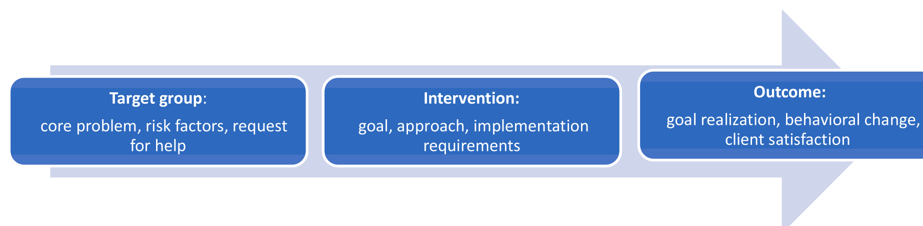

Fig. 1. Elements of a program theory. (Yperen et al., 2017).

professional. The play therapists who work with individuals with intellectual disabilities are employed in specialized institutions that provide care for people with such disabilities. These play therapists work in collaboration with family practitioners and behavioral scientists. Following the interviews with these play therapists, several other therapists who work with children up to 12 years old with normal intelligence were also interviewed. These therapists have the same education and registration as those working in disability care but are employed in youth care institutions, social support services, or private practices. The decision to interview this second group was made because the program theory description also contains some general elements that should be applicable to play therapists working with a different target group.

3. Method

Ethical approval

This study was reviewed and approved by the Ethics Review Board of the School of Social and Behavioral Sciences, Tilburg University (approval number: RP181, dated June 20, 2020). Data collection was limited to interviews with professional practitioners; no data were obtained directly from children, adolescents, or their parents. All participating therapists provided written informed consent prior to their involvement in the study. The informed consent procedure, including its content and implementation, was reviewed and approved by the Ethics Review Board as part of the overall research protocol.

3.1. Program theory

When developing a program theory in collaboration with these practitioners, their knowledge and experience are leveraged. This is of great value in generating acceptance and support for the newly developed program theory (Boer et al., 2023; Kwakman & Schilder, 2005). Banks (2017) also describes the added value of involving individuals with an active interest in the implementation of the research results. She cites the impact that this approach has on individuals and organizations. She uses the concept of co-impact in research to describe this effect. Leung (2007, 2014) also promotes the sharing of knowledge through the development of communities of practice. This vision of knowledge sharing aligns with the co-creation of a program theory, in conjunction with the professional field.

A scientific study requires the development of a program theory to measure the common factors that operate. This involves extracting the tacit knowledge from the play therapists and converting it into explicit and shared knowledge. Exploring the intervention is necessary to understand and explain the active mechanisms involved. We employ the concept of program theory to examine the common factors of an intervention, despite limited knowledge about it.

This is a demanding approach, justified by the significant knowledge gap regarding the effectiveness of play therapy in general, on the one hand, and by the pressure from health insurers and the government to demonstrate the effectiveness of this intervention in order to ensure continued funding for clients, on the other hand.

Play therapy is a complex intervention that encompasses a broad spectrum of behaviors, expertise, and skills necessary to shape the intervention. Examples include communication and relationship-building. In addition to therapeutic skills and attitude, the therapist must also be trained in working with play as a language.The interventions during the sessions occur through play and within the play itself (Goodyear-Brown & Yasenik, 2024).

A scientific evaluation of this intervention, with the development of the program theory as the first step, will provide greater insight into the practical components of this intervention. Without the development of the program theory, we would not be able to open the “black box” of play therapy. We would only be able to evaluate the outcomes, but not how these outcomes came about (Funnell & Rogers, 2011). Skivington et al. (2021) argue that a better understanding of how interventions contribute to change, as well as their relationship to their context and systems, can make a significant contribution to optimizing population health.

This concept of program theory generates the set of structured questions to be addressed in the interviews. These cover a set of seven topics (Yperen et al., 2017). namely:

1. The context within which the intervention takes place
2. The problem that this intervention aims to address
3. The target group for which the intervention is intended.
4. The objectives of this intervention
5. The architecture of the intervention
6. The theoretical outline and the play therapeutic treatment vision.
7. The preconditions of the intervention

4. Data collection

Three fieldwork studies have been carried out. First, a focus group interview was conducted to establish the topics of the program theory. This was followed by 12 individual interviews with play therapists applying the intervention within the target group. Finally, four interviews were conducted with general play therapists as a control group. More details of the different types of interviews are elaborated below.

4.1. Focus group

In developing the program theory, the professional field was involved in several rounds of consultation. The first round presented the framework of general and specific active factors (Bent et al., 2022) and described the target group and their support needs to practitioners. The aim was twofold: (1) to establish a shared language for describing the target group and their needs, and (2) to assess the extent to which the model of active factors was recognized.

At this early stage of the program theory development, a focus group was chosen for the following reasons: (1) the development of the program theory was still in its exploratory phase, and it was unclear which factors would prove crucial, and (2) a well-rounded understanding requires discussion between multiple perspectives to allow for careful consideration and deliberation (Baarda & Bakker,2021).

For this first round, a small focus group was formed, consisting of four play therapists, all of whom work at an institution for people with intellectual disabilities and have substantial experience working with this target group and their specific needs. This focus group session occurred in August 2020 at the institution where the therapists were employed. Based on the outcomes of this focus group, the program theory was adjusted and subsequently presented to the focus group again.

This was followed by rounds two and three. In the second round, the revised program theory was presented to play therapists working with people with intellectual disabilities. In the third round, the program theory was presented to play therapists working with typically developing children, addressing the exact support needs. In both the second and third rounds, data were collected through interviews. The interviews and the focus group results were analyzed using ATLAS. Ti: The Qualitative Data Analysis & Research Software. The interviews were transcribed verbatim, and the transcripts were imported into ATLAS.ti. The texts were then segmented into fragments, to which codes were assigned. Semantic codes (in vivo codes) were used to remain as close as possible to the original wording and to provide a concise summary of each fragment (Verhoeven, 2020).

4.2. Interviews

The second round, involving the professional field in the development of the program theory, consisted of interviews with play therapists

who work with individuals with intellectual disabilities and who have support needs related to aggression regulation. Following the interviews with these play therapists, several other therapists who work with children up to 12 years old with normal intelligence were also interviewed. These therapists have the same education and registration as those working in disability care but are employed in youth care institutions, social support services, or private practices. The decision to interview this second group was made because the program theory description also contains some general elements that should be applicable to play therapists working with a different target group. These interviews took place between July and October 2020.

The third round involved play therapists who work with children of average intellectual ability but with similar aggression regulation support needs. This round took place between January and March 2021.

All interviews lasted 1 h and were conducted by the first author of this article. The interview rounds were concluded once data saturation was reached. In-depth interviews were chosen because the study had an exploratory character. This approach was also selected to elicit as much personal knowledge as possible from the participants. Topics were used instead of fixed questions, as the subjects to be covered were predetermined, having emerged from the focus group interview. For some topics, additional probing was done using a few key prompts (Baarda et al., 2021). See the visual representation in the figure below Fig. 3.

4.2.1. *Interviews with play therapists working with the target group*

The topics of the draft program theory formed the guiding principles for the interviews. These seven topics comprised the entire therapeutic play process, from requests for help and intake to goals, treatment, collaboration with the intermediary target group, and completion. In-depth interviews were conducted with eight play therapists, and adjustments were made to the program theory description after each interview. The interviews were conducted online via Microsoft Teams. The reason for this was that face-to-face contact was impossible because of COVID-19.

After these interviews, saturation was achieved, and no further additions or improvements were made.

4.2.2. *Interviews with general play therapists*

Four in-depth interviews were selected for the last round with other play therapists who do not work with young people with mild intellectual disabilities. These interviews were conducted in the same way as the interviews with the play therapist who works with young people with mild intellectual disabilities. The seven topics of the draft program theory were also used as a guideline in these interviews.

These therapists are familiar with the demand for help with aggression regulation. Due to COVID-19 restrictions, a decision was made to conduct an additional round of interviews to collect further feedback on the implementation of the treatment and therapeutic play interventions. In these last four interviews, saturation was also achieved. These interviews likewise took place online through Microsoft Teams.

5. Data analysis

The data underwent a three-phase analytical process. The initial phase focused on categorizing knowledge types, as outlined by Nonaka and Takeuchi (1995). The second phase comprised a thematic analysis (Braun et al., 2016). The final phase focused on the examination of specialized knowledge about the target population, specifically adolescents with mild intellectual disabilities, and the corresponding adaptations implemented within the context of play therapy to address their distinct therapeutic needs.

5.1. *Preliminary analysis of knowledge types*

A knowledge creation model was employed to accurately analyze and describe the play therapists' tacit and explicit knowledge. The four phases of the SECI model (Nonaka & Takeuchi, 1995) served as the guiding framework for the classification used in this analysis.

In the field of management sciences, Nonaka and Takeuchi (1995) developed a model to explain the knowledge-sharing process. The model has four different ways of moving between tacit knowledge and explicit knowledge, expressed as 'socialization', 'externalization', 'combination, and 'internalization' (hence the abbreviation SECI). This model remains current and is still used as a basic knowledge-sharing model (Gibbons & Prusak, 2020). Knowledge is viewed as a process of sharing and creating knowledge, involving several transitions between implicit and explicit knowledge.

Codes were chosen to analyze the types of knowledge: explicit knowledge, tacit knowledge, and unique knowledge.

Explicit knowledge is generally known and can be found in the literature and in the study programs of training courses for play therapists.

Tacit knowledge refers to the knowledge that a practitioner has developed through experience but has not shared with others.

Unique knowledge is the knowledge that concerns the target group explicitly, and the adaptations in play therapy for young people with mild intellectual disabilities.

5.2. *Second analysis: the thematic analysis*

The following codes have been used for the thematic selection: interventions, therapeutic skills, therapeutic attitude, adjustments for the target group, and intermediate environment. These are also semantic codes that summarize the fragments. These codes are grouped into the following themes(Lin & Bratton, 2015):

1. Collaboration with the child's environment,
2. Play interventions,
3. The therapeutic attitude and skills.

5.2.1. *Third analysis: Unique knowledge, adaptations for the target group*

In addition to tacit and explicit knowledge, a third category emerges: the specialized knowledge concerning adolescents with mild intellectual

Topic	Key Prompts
Presenting Issue / Target Group	Type of aggression; clinical indication; referral procedure
Foundational Attitude	How do you implement this? How important is it? Are there other knowledge or attitudes you employ that haven't been mentioned? Where did you learn these?
Micro-Interventions	Do you recognize these? How do you deploy them? Do you adapt them, and if so, how? Are there additional interventions you use?
Adaptations for the Target Group	Which adaptations do you make, and why?

Fig. 3. Interview topics and key prompts.

disabilities. This knowledge is essential for effective therapeutic engagement with this population and typically encompasses both tacit and explicit components. It is distinguished by its focus on the unique needs and characteristics of the target group. Such knowledge is used to adapt play therapy practices, making the intervention suitable for these adolescents.

6. Results

This section presents the results of the focus group, interviews, and the target group, followed by the analysis results and an interpretation of what these results imply for the program theory.

6.1. Focus group

The outcome of the focus group was the development of a shared language for the core components of the program theory. The discussion centered on the model of active therapeutic factors in play therapy, from which the following foundational elements were identified: a basic therapeutic attitude comprising congruence, empathy, and unconditional acceptance. Additionally, components related to therapeutic practice were formulated, specifically the so-called micro-interventions: following the child, facilitating play, implementing play interventions, and verbalizing actions, feelings, and emotions. These elements were subsequently used as guiding topics for the interviews. An example of the therapist's verbalization:

"*I try to put feelings into words, difficult feelings, no matter how difficult or scary for me, but sometimes it is just impossible*" (interview D1 1:21).

The focus group also sought to establish a shared understanding of the issues presented by this specific population of children. In particular, the group explored what " aggression " means and how this understanding informs the goals of play therapy. The discussion primarily addressed verbal and physical aggression as expressions of underlying trauma, attachment issues, loss experiences related to cognitive limitations, and disrupted communication with the environment. It also emerged that play therapists do not focus directly on the observable behavior but rather on the underlying causes. Behavioral changes observed during therapy are viewed as indicators of effective treatment. This understanding of the presenting issues was also incorporated into the interview topics.

6.2. Interviews

All interviewed therapists demonstrated substantial explicit knowledge regarding the basic attitude of client-centered practice.Axline, 1971 Working from this paradigm was consistently described as highly valuable and essential. What is noteworthy, however, is that the characteristics of Rogers' (2022) client-centered approach are not initially mentioned. It is only upon further questioning that concepts such as empathy, congruence, and unconditional acceptance are brought up. Initially, therapists refer to concepts such as the therapeutic relationship and the importance of safety. At the same time, therapists noted that client-centered approaches are increasingly under pressure due to funding structures. Financial frameworks often demand more solution-focused and directive forms of therapy. However, the play therapists emphasized that client-centered work is especially beneficial for this target group, allowing them to follow the child's pace and facilitating deeper integration of therapeutic outcomes.

This tension has also contributed to the development of tacit knowledge. The interviews revealed that many play therapists pursue additional training in methods related to but outside of traditional play therapy. The knowledge acquired through such training is often adapted and integrated into their therapeutic work. Although this knowledge is considered highly valuable, it is rarely shared with the broader professional field. Play therapists discussed body-oriented work that is done in response to a request for help with anger in children.

Examples are:

"*Because I have doubts, it is as though I see a big child who tries to crawl under the table, but the table is too small, but he thinks that he can get through anyway, and I see what is happening, and I think that he will not fit, but the child manages it anyway*" (interview: D1 1:28).

They help young people develop a more accurate understanding of their bodies, recognize emotions, and learn to manage them effectively.

Another aspect of attitude and explicit knowledge is witnessing the youngster's story. The therapist's important message is to show clearly that their story matters.

"*That may be the first time they experience that another person is really listening*" (Interview: D6 6: 5).

Another central theme that emerged from the interviews was the use of micro-interventions. These were widely recognized and actively applied in practice. There is a substantial body of explicit knowledge regarding micro-interventions within the field of play therapy. Similar to the theme of therapeutic attitude, tacit knowledge also develops through continuing education in adjacent therapeutic approaches, which are then applied in play therapy practice. An illustrative example of this is the following quotes:

"*So I did the course on grievances that they talk about. They talk about pleasant or unpleasant feelings. You do not really have to put your emotions into words; you feel them in your body* "(interview: D9 9:40).

"*If you are very tense, you inflate the ball, with those breathing exercises, or just dance or stomp - just get back into your body and release the anger; these may be behavioral alternatives you can use.*"(interview: D9 9:27).

Additional active therapeutic factors identified in the interviews included the importance of collaboration with parents. Co-creating therapeutic goals and jointly formulating the child's help request were considered essential and meaningful components of the process. An example of this is how a play therapist indicates during the interview how she works with the parents when they ask for help with the child's anger.

"*You want to remove that burden. I realize that when I have a parent consultation, you want to remove the burden that comes on that child.* "(interview: D4 4: 7).

Another quote is:

"*Yes, I try to explain that and seek hypotheses with parents about where the anger might come from. I suggest that it is okay and that the outbursts will naturally decrease when we start working on this*".(interview: D1 1:17)

"*I believe that play therapy is not something you do alone. It is always a matter of interplay with the intermediate target group* "(D10 10:19).

In cases involving aggression regulation, therapists employed specific interventions, which were classified as forms of tacit knowledge. One of the play therapists put it this way:

"*But you really cannot treat the aggression properly if you do not treat the underlying trauma*" (interview: D4 4:37).

6.3. Target group

When working with somewhat older young people, non-play therapeutic interventions are also used. The reason is that older children often no longer want to engage in fantasy play. Examples of such non-play interventions include portraying your family, life course assignment, working with photo cards, and using a mood meter. These are forms of

visual communication and have a strong non-linguistic character. The therapist must connect to the interests of the young people, as a play therapist puts it:

"*So I look for something that interests him, to talk about. There was a boy who was crazy about tractors, and at first, I went to look at pictures of tractors. Just to try to connect. Then he is happy to talk, but only briefly, and then it is back to the tractors* "(interview: D4 4:27).

A great deal of tacit knowledge is also present when recognizing the problem. Sometimes, the theme of anger is not immediately apparent in therapy, but it manifests itself differently through various behaviors that are indirectly related to it. An example of this is:

" But it does emerge as a theme of deep down wanting to be a sweet child and enjoying compliments" (D10 10: 6). Another example of this tacit knowledge is: "*The young person keeps building castles in the sand and then he hits it and breaks it, and then I say 'oh, it is broken now'. 'We can build it again anyway, ' he says. He now begins to embellish it with decorative stones. I say, 'Ah, you are going to make it prettier. ' He says, 'Yes, and now I think it would be worse to knock it. ' And I say 'What happens if you break it?' 'Then I get sad, ' I say, 'oh, and does that feel different from angry?' 'Yes, that feels different from angry. ' I say, 'and do you want to break it?' 'Well, actually, I do not'* " (D8 8: 5).

Play therapists deviate from this because they have experienced that following only one approach results in insufficient depth. They see this as encouraging play.

An example is:

" *With our target group, I will not get anywhere with just free play. Then they get nowhere. You have to be more direct; more focused, making suggestions, but still using your toolkit*." (Interview: D4:21).

6.4. Results of the analysis

6.4.1. Preliminary analysis of knowledge types

A summary of the four distinct types of knowledge can be articulated as follows.

1. Socialization: From Tacit Knowledge to Tacit Knowledge

In this phase, knowledge is shared through social interaction or the exchange of experiences while remaining tacit. It is not articulated in written or verbal form but is instead embedded in personal routines and professional intuition. Findings from the interviews indicate that this form of knowledge exchange predominantly occurs among professional peers, for instance, during peer consultation meetings or supervision sessions.

2. Externalization: From Tacit Knowledge to Explicit Knowledge

This phase involves articulating tacit knowledge, transforming it into explicit knowledge that can be communicated and disseminated. Such externalized knowledge becomes accessible to others and may serve as a foundation for developing new knowledge and theoretical concepts. Within play therapy, an example of this process is the widely accepted perspective on collaboration with the client's broader support network, which refers to all adults involved in the child's upbringing and care. All interviewed play therapists emphasized the importance of working collaboratively with the youth's system of care.

3. Combination: From Explicit Knowledge to Explicit Knowledge

This phase involves integrating existing explicit knowledge with other explicit knowledge sources, resulting in new insights. This often involves adapting techniques and models from other therapeutic disciplines to fit the context of play therapy. A recurring theme in the interviews was the role of continuing education, in which play therapists acquire new knowledge through training and subsequently translate this knowledge into the practice of play therapy. This newly developed knowledge is frequently shared within the professional community, for example, through publications in professional journals.

4. Internalization: From Explicit Knowledge to Tacit Knowledge

In this phase, explicit knowledge becomes internalized through experimentation, synthesis, and critical reflection. This leads to new, personalized tacit knowledge, characterized by intuitive understanding and pattern recognition that may not be explicitly articulated. Although this also involves knowledge acquired through continuing education in related therapeutic approaches, the knowledge remains personally applied and is not typically disseminated within the broader professional field.

6.4.2. Thematic analysis

6.4.2.1. Collaboration with the environment. The explicit knowledge within this theme pertains to setting therapeutic goals and aligning these goals with the child's environment. Another component of this knowledge involves using play therapy techniques, such as verbalizing the child's actions, feelings, emotions, and thoughts. Therapeutic skills such as providing safety, establishing a relationship, attuning to the child, and following the child's lead were also crucial in the interviews.

When setting and aligning goals with the environment, play therapists emphasize the importance of communicating that play therapy focuses on the underlying causes of behavior, as it is often the behavior that prompts the referral for help. When setting and aligning goals with the environment, play therapists emphasize the importance of communicating that play therapy focuses on the underlying causes of behavior, as it is often the behavior that prompts the referral for help.

6.4.2.2. Play interventions. A play therapist is proficient in various play intervention techniques. These techniques aim to support the child during sessions, assist them, and influence the play process. Several types of play intervention techniques were mentioned, referred to as micro-interventions. Examples include verbalizing actions and feelings, setting boundaries, facilitating play, and following the child in their play.

An example of implicit knowledge is that therapists sometimes deviate from a strictly client-centered approach. They do so because they experience that adhering to a single therapeutic approach does not always provide sufficient depth. They refer to this as "stimulating play."

6.4.2.3. Therapeutic attitude and skills. Each interview highlights that the therapeutic skills of the play therapist are characterized by a fundamentally client-centered attitude (Rogers, 2022). In everyday practice, the play therapist seeks a connection with the child and follows the child's lead in play. The role of the play therapist is to be actively engaged and to show genuine interest in all the emotions, actions, and choices expressed by the child. The therapeutic relationship within which the child feels safe and can work on their themes is vital to the therapy process. The opportunity to share one's story within the secure environment of the Playroom is seen as essential. To establish this foundational sense of safety, a structure is provided that is tailored to the child's preferences and interests.

Another aspect of attitude and explicit knowledge discussed in the interviews is the therapist's capacity to witness the child's story. The therapist conveys a key message by demonstrating that the child's story matters.

6.4.3. Unique knowledge, adaptations for the target group

Unique knowledge includes, for instance, knowledge related to

communication strategies, the use of visual aids, and a general understanding of relevant syndromes, all of which are necessary to ensure appropriate therapeutic support.

One element of unique knowledge pertains to expertise related to the target group, specifically adolescents with mild intellectual disabilities. This type of knowledge and experience is scarce within play therapy, as it builds upon the foundational knowledge and skills that play therapists are already expected to possess, such as knowledge of play therapy (explicit knowledge) and extensive practical experience (tacit knowledge). A central question this article seeks to address is: what specific knowledge and expertise do play therapists working with this target group possess? For instance, have they adapted the play therapy approach to meet the needs of this population? What new knowledge are they contributing to the field of play therapy?

Play therapists working with this group frequently utilize supportive communication strategies. One example is using visual aids or drawings to explain the therapy process and clarify the child's request for help. This is necessary because these young people often experience challenges with language and language comprehension.

Another example of unique knowledge is the use of a more directive therapeutic style, which deviates from the standard client-centered orientation typically associated with play therapy. These adolescents often struggle with decision-making and engaging in play. As a result, therapists reduce the number of choices presented and actively offer materials and play activities to support the child's development. They must also provide greater play stimulation, as imaginative play can be difficult or inaccessible for this group. Furthermore, the exploratory phase tends to take longer in therapy with young people who have intellectual disabilities compared to the general play therapy population. This extended phase also slows the development of the therapeutic relationship.

6.5. Program theory

The focus group and the interviews indicated that client-centered practice is considered essential and valuable. The foundational elements of this attitude only emerged during the interviews after further probing; they were not mentioned spontaneously, yet were widely recognized and acknowledged as the basis of the therapeutic attitude in play therapy. Micro-interventions were implemented based on this foundation.

The underlying active mechanisms supporting these foundational elements are the therapeutic relationship, the sense of safety, and strong parental involvement. These mechanisms align with what play therapists identified as essential and effective within play therapy.

These three components, therapeutic attitude, micro-interventions, and underlying mechanisms, are seen as contributing to the positive outcomes of the play therapy intervention. Reported positive outcomes include behavioral change, improved parent–child interaction, enhanced emotional regulation, and increased systemic resilience.

The program theory is presented as a model in the following section Fig. 4.

7. Discussion

This study demonstrated that the key active mechanisms, therapist-client relationship, care for a safe and facilitating environment, and high parental involvement, form the foundation of the program theory. These mechanisms were broadly recognized and endorsed in the focus group and the interviews, and there is a substantial amount of shared and explicit knowledge about them. The other two building blocks, therapist attitude and micro-interventions, were also acknowledged and applied. It became clear that the therapeutic attitude is essential for effectively using micro-interventions. These findings are consistent with the work of previous scholars (Bent et al., 2022; Landreth, 2023).

Another outcome of the study was the importance of high parental

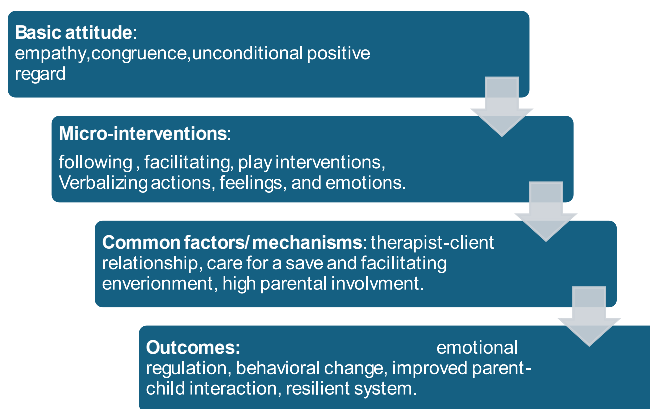

Fig. 4. Model of the program theory.

involvement in treatment, which enhances the effectiveness of play therapy. This is consistent with existing literature (Jensen et al., 2017; Porter et al., 2009). When setting and aligning therapeutic goals with the environment, play therapists emphasized the importance of communicating that play therapy addresses the root cause of the child's behavior, as this behavior is usually the reason for the help request (Goodyear-Brown & Yasenik, 2024). Based on their experience, all interviewed therapists stated that play therapy yields more positive outcomes when there is strong cooperation in the environment. This belief is not supported by the literature, but rather by clinical experience.

Another example of implicit knowledge about collaboration concerns the importance of a stable environment. A lack of continuity may pose a risk of premature therapy termination.

An analysis of the interviews reveals several areas that warrant further research. First, there is a discrepancy between theory and practice. Play therapists report that their training is client-centered. Rogers' (2022) theory of client-centered practice is based on various concepts that influence the therapist's attitude, empathy, unconditional acceptance, congruence, centering the child in therapy, and viewing the therapeutic relationship as the vehicle for change (Cochran et al., 2023). These concepts, however, are not consistently cited in the interviews as the foundation for therapeutic work.

Nevertheless, the therapists refer to concepts closely related to client-centered practice (Gill, 2018; Crenshaw). The literature also outlines the prerequisites and importance of ensuring sufficient safety, which is essential for the child to work on their help request.

The theory describes many more effective mechanisms related to the therapist's attitude and skills. During the interviews, it appeared that the play therapists do not always consciously possess this knowledge.

It is also noteworthy that therapists possess significant knowledge about intervening during play. This knowledge is action-oriented. However, therapists struggle to articulate why a particular micro-intervention is essential. Their knowledge has developed through experience, certain interventions, or specific materials that have proven effective through practice.

For the development of this program theory, both therapists who work with children with mild intellectual disabilities and those who do not were interviewed. The method and structure of therapy appeared broadly similar in both groups. A distinct difference, however, was that therapists working with this target group routinely use supportive communication, as they are accustomed to working with children with lower language comprehension.

Another important consideration was the objectivity of the interviews. The researcher is also a play therapist familiar with this target group. During the interviews, care was taken to avoid influencing the outcomes by asking leading questions. The interview questions were shared with participants in advance to mitigate this risk as much as

possible.

One limitation of this study is the relatively small number of in-depth interviews conducted. Nevertheless, the data collection was concluded only after data saturation had been achieved, ensuring the adequacy of the gathered insights. The typological distinction of knowledge reveals that implicit knowledge is extensively present among play therapists working with this specific population. Once made explicit, this previously unarticulated knowledge constitutes a valuable contribution to the advancement of the professional domain of play therapy.

In summary, the following questions require further investigation:

How do theory and practice relate to one another, and how can the implicit knowledge of play therapists be further substantiated through literature? Additionally, video analysis should be employed to examine whether the theoretically active mechanisms are also visible in the actions of the play therapist. The central hypothesis to be tested is whether play therapists have internalized the knowledge of client-centered practice, according to Rogers' (2022) theory, to such an extent that they are no longer consciously aware of it.

8. Conclusions

By employing qualitative interviews as the primary methodological approach, this study has generated contextually rich insights that offer a preliminary understanding of the implicit dimensions of therapeutic knowledge. The depth and nuance afforded by qualitative inquiry appear to be valuable in exploring experiential and practice-based understandings that may be less accessible through quantitative methods.

The interviews gave us the various elements of a program theory description of play therapy for this target group. Some of these elements were already known (or could have been known), as they are based on explicit knowledge among practitioners or a unique understanding of the target group. The new elements are primarily based on the tacit knowledge among the play therapists working with this target group.

This type of fieldwork appears suitable for revealing and identifying tacit knowledge within the target group, which can then be used to develop the theory of play therapy further.

Working together with the professional field enriches the theory based on existing practice. The program theory can be further refined and described in more detail based on the results of the interviews. Due to the involvement of the professional field, the program theory is also more widely supported, which is essential for the implementation process of the program theory. It is encouraging to observe that play therapists demonstrate a strong sense of professional identity and commitment to their field. They are convinced of the added value of their work and that play therapy contributes to the well-being of young people. This is also reflected in their involvement in cooperating with the substantiation of the program theory. A key finding is that play therapists working with different target groups exhibit similar approaches. This is important because much tacit knowledge is utilized in play therapy, and intuitive actions are taken. Tacit knowledge and intuitive action are more challenging to quantify and must be made explicit before further investigation into play therapy can proceed. This will be the subject of additional research, focusing on how the program theory is implemented and the active mechanisms involved.

Future research should investigate the extent to which this tacit knowledge can be transferred through training or education.

CRediT authorship contribution statement

Dineke Bent-Lenselink: Writing – review & editing, Writing – original draft, Formal analysis, Data curation, Conceptualization. **Martine Noordegraaf:** Writing – review & editing, Supervision, Conceptualization. **Tine Van Regenmortel:** Supervision, Methodology, Conceptualization.

Data availability statement

The data are not publicly available due to privacy or ethical restrictions.

Declaration of the use of AI

During the preparation of this work the authors used Grammarly for proof reading and spell checking. The authors reviewed and edited the content as needed and take full responsibility for the content of the publication.

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