Directive Play Therapy

Theories and Techniques

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Editors
Directive Play Therapy
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To the young who play and the young in heart who still play
To our own young ones: Elliott, Annamarie, and Daniel
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Preface

Play therapy has been recognized in the counseling profession as a developmentally appropriate model for working with children and adolescents. Directive Play Therapy: Theories and Techniques provides a comprehensive introduction to structured, prescriptive approaches to play therapy to those desiring to gain more information and knowledge about the use of different directive play therapy modalities. Through the years of teaching and presenting on this approach, it became clear that there was a gap in understanding directive play therapy and its potential for addressing specific needs and diversity of children and adolescents. Therefore, the primary intended audience for this book is those becoming trained as play therapists. This includes students enrolled in play therapy courses seeking to explore and understand a directive approach to play therapy. It is also written for clinicians and practitioners who would like to learn more about play therapy and gain a greater understanding of these directive approaches.

A notable strength of Directive Play Therapy: Theories and Techniques is the diversity of the theoretical approaches presented. Chapter 1 delivers the rich history of this approach, introducing the unique integration of play therapy and different theoretical models. It also encompasses the essential concepts and practices of directive play therapy. Most importantly, it shares some guidelines for planning and selecting toys and materials for a directive approach. The chapter also incorporates settings and skills necessary for effective implementation and addresses common questions asked about the use of these.

The following chapters provide the exploration and detailed description of various theoretical approaches to directive play therapy: “Post-Jungian
Directive Sandtray in Play Therapy,” “Solution-Focused Play Therapy,” “Eye Movement Desensitization and Reprocessing and Play Therapy,” “Directive Play Therapy Techniques in Trauma-Focused Cognitive Behavioral Therapy,” “Child Parent Relationship Therapy,” “Creativity in Play Therapy Using Technology,” “Directive Filial Therapy Models With Very Young Children,” “Humanistic Sandtray Therapy With Children and Adults,” and “Directive Approaches to Working With Parents.” Each of these chapters includes a strong overview and introduction to each theory as well as empirical evidence and research. The distinctive techniques and processes of each of these approaches are explained. Finally, case examples are given to demonstrate their application and implementation.

Directive Play Therapy: Theories and Techniques is written by leading experts on each specific theoretical model. We believe that this book will help play therapists learn how to integrate various theoretical approaches with play therapy. Counselors, family therapists, social workers, psychologists, and psychiatrists will find Directive Play Therapy: Theories and Techniques informative and enlightening as well as clinically useful.

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In September 2000, the U.S. Surgeon General’s Office held the *Surgeon General’s Conference on Children’s Mental Health: Developing a National Action Agenda*. At this conference the Surgeon General explained to children and families, practitioners, educational institutions, educators, physicians, and members of the mental health, scientific, and health care professions of the need to develop specific treatment recommendations for the well-being of children (Department of Health and Human Services, 2000). At this conference, several researchers noted that the prevalence of mental health disorders in children ranged from 16% to 22% (Costello et al., 1996; Roberts, Attkisson, & Rosenblatt, 1998). Later in life, Costello et al. (1996) and Roberts et al. (1998) noted that 74% of children who experience mental health disorders go on to have ongoing mental health needs into adulthood. At the Conference on Children’s Mental Health, the Surgeon General’s Office decided on four guiding principles to address the mental health needs of children in the United States. These were:

(a) promoting the recognition of mental health as an essential part of child health, (b) integrating the family, child, and youth-centered mental health services into all systems that serve children and youth, (c) engaging families and incorporating the perspectives of children and youth in the development of all mental health care planning, and (d) developing and enhancing public-private health infrastructure to support these efforts to the fullest extent possible. (Department of Health and Human Services, 2000, p. 3)

The counseling profession has long recognized play therapy as a developmentally appropriate model for working with children presenting in
counseling with a variety of mental health concerns. The beginnings of play therapy can be traced back to Sigmund Freud. Freud worked with the father of a young child, Little Hans. Through their interactions with the father, Freud made recommendations to the father about ways he could help his son improve. This is considered the first documented case of filial therapy. Freud was followed in his work by Hermine Hug-Hellmuth, Melanie Klein, and Anna Freud. Each of these practitioners used play with children in various ways as a means to either build a relationship with the child or assist in analyzing the strength of the child’s ego. Later, relationship play therapy emerged with a focus on the child’s present environment and emotional state. Developers of relationship play therapy (e.g., Jessie Taft, Frederick Allen, and Clark Moustakas) allowed the child permission to engage in any type of play the child was interested in and would play with the child, if invited.

From relationship play, the field moved to nondirective play. This model was created by Virginia Axline (1947) as she adapted the work of Carl Rogers to her work with children. Axline’s focus was on building a relationship with the child as a means to create a safe environment in which change could be explored at his or her own pace. Axline, like Rogers, believed that individuals (including children) have an innate ability for self-growth and healing and that all play is a reflection of this ability for or drive toward growth. Due to this belief, Axline allowed children the freedom to play with all of the items and toys in the playroom as she focused on reflecting the child’s feelings, thoughts, and behaviors. By doing so, the child would then be able to recognize and deal with those feelings. In 2002, Garry Landreth defined this approach as child-centered play therapy. Since the early 1900s, practitioners and researchers from a wide variety of theoretical orientations (psychoanalysis, cognitive behavior therapy [CBT], gestalt, Adlerian, family therapy, etc.) have begun to explore the use of play therapy. Many of these more directive approaches, including common techniques and case applications, are discussed later in this book.

OVERVIEW OF DIRECTIVE PLAY THERAPY

Directive play therapy is an integrative approach that combines different theoretical models in a manner that responds to and addresses the needs of children (Kenney-Noziska, Schaefer, & Homeyer, 2012). Other names for this integrative approach include: structured, prescriptive, focused, and non-humanistic. Counselors use directive play therapy to focus attention, stimulate further activity, gain information, interpret, or set limits (Jones, Casado, & Robinson, 2003). Purposeful activities, such as games or make-believe, are structured by the counselor to elicit imaginative responses
from the client. The counselor assumes the responsibility for the guidance and interpretation of the play interactions (Rasmussen & Cunningham, 1995). Therefore, the work of Anna Freud and Melanie Klein continued within the form of structured play therapy. David Levy (1939) developed release therapy in the 1930s using toys to help children relive traumatic events and thereby release negative emotions. Levy would review the child’s case history to understand the struggle and then control the play by providing selected toys to allow the child to work out the problem (Frost, Wortham, & Reifel, 2001; Jones et al., 2003). Gove Hambidge (1955) disapproved of the idea of flooding or pushing the child to release strong negative feelings. As a result, he developed a structured play therapy which was implemented only after a relationship had already been established through nondirective play therapy. His method promoted a slow start, using less threatening toys and materials to recreate events, and then using the play to recover from the events (Hambidge, 1955). Consequently, much thought and deliberation was required in the selection of an activity with the client’s need and goal in mind. Activities used in directive play therapy cannot be randomly selected but must have a rationale for being chosen (Hambidge, 1955; Jones et al., 2003).

Jones et al. (2003) provide some guidelines for planning and selecting toys and materials that are based on the model of structured play therapy. This group of authors combined their understanding of Sloves and Peterlin’s (1994) work with time-limited play therapy and Knell’s (1997) cognitive-behavioral play therapy to create the three stages of structured play therapy model: opening, working-through, and termination. These stages begin with a low intensity before increasing that intensity to its highest point during the working-through stage and then decreasing it as the termination stage approaches. The directive or structured activities and techniques are selected to create the desired level of intensity for each session. These levels are defined as (a) evoke anxiety, (b) challenge to self-disclose, (c) increase awareness, (d) focus on feelings, (e) focus on the here and now, and (f) focus on the threatening issues (Jones et al., 2003). Therefore, as the counselor plans for each session, he or she determines the level of self-exploration or intensity needed and then assesses the direction of the session, activities, and materials (Jones et al., 2003).

**TOYS AND MATERIALS**

Children use toys and materials to express their thoughts and feelings symbolically through the language of play. These are used to (a) express emotions, (b) learn new coping skills, (c) increase self-esteem, (d) recognize
and develop responsibility, (e) improve decision-making skills, and (e) increase self-control (Ray et al., 2013). There are differing perspectives about which toys and materials are required to supply children with the opportunity to express their thoughts and feelings. Nash and Schaefer (2011) point out that the selection of toys and materials will vary depending on a number of issues, including the counselor’s theoretical orientation, personal ideas and values, space, and budget.

Landreth (2012) provides broad guidelines within three categories of toys and materials used for both directive and nondirective play therapy: real-life toys, acting-out/aggressive-release toys, and creative expression and emotional release toys. Real-life toys allow direct expression of feelings and include toys and materials such as dolls, dollhouses, puppets, cash registers, cars, trucks, and boats. The acting-out/aggressive-release toys and materials offer a means to convey intense pent-up emotions, such as anger, hostility, and frustration. These include a Bobo or bop bag, an alligator puppet, soldiers, wild animals, and rubber or play weapons. Other useful items are egg cartons, Popsicle sticks, and Play-Doh (useful for both aggressive and creative categories).

Finally, the creative expression and emotional release toys and materials make available the opportunity for clients to be spontaneous, expressive, and constructive or destructive. These may include sand, water, paints, and blocks (Landreth, 2012). For Kottman (2011), there are five specific categories of therapeutic values applicable across theoretical orientations. The toys are selected to represent each of the categories. These categories are: (a) family/nurturing toys, (b) scary toys, (c) aggressive toys, (d) expressive toys, and (e) pretend/fantasy toys (see Table 1.1).

Nash and Schaefer (2011) point out that a selection of basic items should be consistently useful.

...animal families, baby doll (with bottle), dishes/plastic silverware, doll families, doll house or box with furniture, puppets, toy soldiers, blocks and other building materials, clay, art supplies (markers, crayons, large paper, tape, blunt scissors), small pounding hammer, two telephones or cell phones, doctor’s kit, small soft ball, playing cards, small box with lid, and transportation toys (cars, airplane, ambulance, etc.). In addition to these items, such items as masks, mirrors, rope, dinosaurs, plastic tools, cardboard bricks, Lincoln Logs, books, board games, a magic wand, dress-up clothes, and a sandtray and miniatures can also be beneficial. (p. 17)

Furthermore, Nash and Schaefer recommend predictability and consistency in these as the most important features for children. They
point out that this allows the clients to know that the toys and materials they need are available and how to locate them. Without consistency and familiarity, clients will spend time exploring the things rather than playing with them (Kottman, 2001 as cited in Nash & Schaefer, 2011).

<table>
<thead>
<tr>
<th>Family/Nurturing</th>
<th>Scary</th>
<th>Aggressive</th>
<th>Expressive</th>
<th>Pretend/Fantasy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baby doll</td>
<td>Plastic snakes</td>
<td>Bobo or bop bag</td>
<td>Easel and paints</td>
<td>Doctor kit</td>
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<tr>
<td>Dollhouse</td>
<td>Toy rats</td>
<td>Small pillows</td>
<td>Watercolor paints</td>
<td>Human figure puppets</td>
</tr>
<tr>
<td>Baby clothes</td>
<td>Plastic monsters</td>
<td></td>
<td>Crayons</td>
<td>Animal puppets</td>
</tr>
<tr>
<td>Baby bottles</td>
<td></td>
<td></td>
<td>Markers</td>
<td>Blocks</td>
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<tr>
<td>Cradle</td>
<td></td>
<td></td>
<td>Colored pencils</td>
<td>Magic wand</td>
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<tr>
<td>People</td>
<td></td>
<td></td>
<td>Newsprint</td>
<td>Pieces of fabric</td>
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<tr>
<td>puppets</td>
<td></td>
<td></td>
<td>Sequins</td>
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<tr>
<td>Animal families</td>
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<th>Family/Nurturing</th>
<th>Scary</th>
<th>Aggressive</th>
<th>Expressive</th>
<th>Pretend/Fantasy</th>
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</thead>
<tbody>
<tr>
<td>Small rocking chair</td>
<td>Dinosaurs</td>
<td>Soldiers</td>
<td>Play dough</td>
<td>Big pillows</td>
</tr>
<tr>
<td>Soft blanket</td>
<td>Dragons</td>
<td>Military vehicles</td>
<td>Pencils</td>
<td>Iron and board</td>
</tr>
<tr>
<td>Families of dolls</td>
<td>Sharks</td>
<td>Foam rubber bats</td>
<td>Glue</td>
<td>Two telephones</td>
</tr>
<tr>
<td>Stuffed toys</td>
<td>Insects</td>
<td></td>
<td>Scissors</td>
<td>Animals, zoo and farm</td>
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<tr>
<td>Pots, pans</td>
<td></td>
<td></td>
<td>Tape</td>
<td>Puppet theater</td>
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<tr>
<td>Dishes, silverware</td>
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<td>Stickers</td>
<td>Knights &amp; castles</td>
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</table>

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<th>Family/Nurturing</th>
<th>Scary</th>
<th>Aggressive</th>
<th>Expressive</th>
<th>Pretend/Fantasy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sand in sandbox/tray</td>
<td>Alligator</td>
<td>Weapons (rubber)</td>
<td>Needles and thread</td>
<td>Hats and purses</td>
</tr>
<tr>
<td>Kitchen appliances</td>
<td>Puppets of dangerous animals</td>
<td>Handcuffs</td>
<td>Beads</td>
<td>Dress up clothes</td>
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<tr>
<td>(wooden or plastic)</td>
<td></td>
<td>Plastic shield</td>
<td>Construction paper</td>
<td>Costumes</td>
</tr>
<tr>
<td>Empty food containers</td>
<td></td>
<td></td>
<td>Poster board</td>
<td>Fantasy puppets</td>
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<td>Family miniatures</td>
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<td>Butcher paper</td>
<td>Toy vehicles &amp; cars</td>
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<td>Magazines</td>
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<td>Paper bags</td>
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<td></td>
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<td>Sock puppets</td>
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Adapted from Kottman (2003); Ray (2015).
Jones et al. (2003) support those ideas shared by Nash and Schaefer, stating that a variety of resources and theoretical orientations contribute to directive activities, toys, and materials. Therefore, in addition to those already listed, other materials could also include: (a) books and stories; (b) collages; (c) role-play; (d) checklists and worksheets; (e) games; and (f) self-composed songs, poems, and stories. For counselors working out of play bags, play kits, and/or rolling boxes, additional considerations must be given to portability. Limiting the number of toys and materials does not stifle the range of messages and feelings that children can communicate (Landreth, 2012). The limited play materials recommended are: crayons, newsprint, blunt scissors, clay, Popsicle sticks, tape, baby bottle, doll, plastic dishes and cups, doll family, dollhouse and furniture, face mask, rubber knife, dart gun, handcuffs, toy soldiers, car, airplane, puppets, two telephones, rope, and costume jewelry (Landreth, 2002).

The key to the selection and use of toys and materials in directive play therapy is the need of the client. Thought and deliberation on what the focus of the therapy is and what each session should provide the client should dictate these choices. If the focus is for the client to identify an object in the playroom that represents his or her problem, then toys and materials from varied categories must be available. “Look around at the things here, can you find something that looks like the _____ you have been talking about?” This process of externalizing the problem allows the client to select from an assortment of items. Likewise, when the focus is on a single event or time in the client’s life, a sole specific toy, activity, game, or object may be used. If a client is struggling with anxiety in anticipation of riding a bus to school or an extended stay in a hospital, the use of a toy school bus or miniature hospital dollhouse would be items specifically required. Ray (2011) encourages counselors to ask these three questions about the selection of toys and materials: (a) What therapeutic purpose will this serve for the child? (b) How will this help the child express his- or herself? and (3) How will this help me build a relationship with the child? As a result, although these lists of toys and materials are notable, they are only a starting point. The needs and issues of the client make the final decision.

**Settings for Directive Play Therapy**

The general setting for play therapy is in an office with intentional playrooms or play areas specifically designed for the use of toys in therapy. Bratton, Ray, Rhine, and Jones (2005) shared the findings that
play therapy is effective in a number of settings. These findings support the notion that toys can be taken anywhere the child is. Peterson and Boswell (2015) explain the ways creative counselors use to find settings where play therapy can take place. Creative settings for play therapy develop as counselors begin using play bags, play kits, and rolling boxes to carry a collection of toys to locations outside the traditional playrooms. Unique locations for such counseling sessions include schools, homes, hospitals, prisons, and shelters (Bratton et al., 2005; Peterson & Boswell, 2015). Peterson and Boswell go further, listing converted old school buses, portions of or empty rooms, sections of cafeterias or stages, and even outdoor natural settings (Landreth, 2002; Peterson & Boswell, 2015).

Attention and thought must be given to each setting selected for play therapy. Confidentiality is always important and should be secured with our clients. However, use of a nontraditional setting may compromise confidentiality; therefore, additional consent or confirmation of consent may be required. The comfort of the client should also be addressed as necessary. Certainly, the selection of toys and materials must also be mindfully considered. The availability to travel allows counselors to bring toys, materials, and service to a client in a multitude of settings (Peterson & Boswell, 2015).

**PLAY THERAPY SKILLS**

There are various therapeutic mechanisms within play that help clients. Some therapists and counselors are primarily interested in the use of their preferred theory, whereas others seek to understand and apply multiple agents in play therapy (Drewes & Schaefer, 2014). The following chapters introduce, describe, and illustrate the application and nature of play within various therapeutic approaches and illustrate their application. Yet the personal qualities of play therapists facilitate the therapeutic relationship. These key qualities include empathy, genuineness, and unconditional acceptance of the client. Axline (1947) suggests that successful counseling begins with the counselor. The use of consistency, courage, confidence, and relaxation are essential to this therapeutic relationship (Axline, 1947).

The basic skills shared in counseling with all populations include nonverbal and verbal skills. The nonverbal core skills include leaning forward to demonstrate openness; appearing interested, relaxed, and comfortable; and showing expression and tone congruent with the
client. The verbal skills used for counseling with children require a different cognitive level and more limited vocabularies than those used with adults (VanVelsor, 2004). Ray (2004) describes the basic verbal skills as: (a) verbal responses, (b) tracking behavior, (c) reflecting content, (d) reflecting feeling, (e) facilitation of decision making and creativity, and (f) esteem building. Although these are expected in most play therapy sessions, the extent would depend on the theoretical orientation of the counselor (Ray, 2004). Along these lines, there are additional and varied skills to consider that may be specific to directive play; therapy to consider; clarity of a goal; open and closed questions; using metaphor; and the directive or prompt given to the client to move him or her toward the identified goal.

**Nonverbal Skills**

**Leaning Forward.** Leaning forward with an open body posture helps the counselor create a warm and accepting environment for the client. This small mindful action can impact the client’s perception of the counselor and counseling. Therefore, as the client moves about, the counselor should be squarely facing the client. This also applies to the positions of the counselor’s arms and legs (Giordano, Landreth, & Jones, 2005; Ray, 2004). This may require the counselor to shift or swing around in his or her seat to maintain a position that faces the client throughout the session while providing the space needed for the client to move about.

**Appearing Interested, Relaxed, Comfortable.** Interest in the client ought to be communicated throughout the session. The counselor should not be preoccupied with other matters. This can be demonstrated with the counselor’s body postures, facial expression, and accurate responses (Giordano et al., 2005; Ray, 2004). The counselor’s level of comfort will bring a sense of calmness and establish emotional availability. This can also increase the ability of the client to remain relaxed throughout the session (Giordano et al., 2005; Ray, 2004).

**Expression and Tone Congruency.** The counselor strives to be congruent with the client’s expression. Matching the affect of the client should appear genuine and be reflected in the counselor’s tone. Although the tone ought to reflect the affect, it should not end on a high note. This might communicate a question to the client where there is not one (Ray, 2004).
Verbal Skills

A counselor communicates with a client to convey an understanding of the material explicitly expressed. When working with adults, this communication translates into reflecting the verbal messages shared. Children share these messages through play and action. Therefore, a counselor must consider his or her verbal skills when working with young clients (VanVelsor, 2004).

Verbal Responses. Within verbal responses, there are two skills to consider: succinct interactive responses and rate of response (Ray, 2004). Children do not remember lengthy responses and may not internalize the meaning of the response. A lengthy response can be disruptive to a client’s focus and interfere with the progress of the play or activity. With this in mind, the length of responses should be short, succinct, and focus on the client. Succinct, interactive responses reduce client confusion and communicate the counselor’s understanding (Landreth, 2012). Rate of responses is the frequency of the verbal response, and the rate of the counselor’s interactions or responses should match those of the client. Therefore, the counselor should be slow in his or her responses if the client is quiet. Likewise, the responses and interactions should increase if the client is highly active (Ray, 2004). It should be understood that silence is an added ingredient to the rate and succinct nature and rate of responses. Silence can often be overlooked and underutilized in the desire to provide clear and focused responses.

Tracking Behavior. When tracking behavior, the counselor is simply reflecting what the client is doing at any particular time: “You’re drawing something.” “You decided to pick that one.” Behavioral tracking expresses the counselor’s attentiveness to the client as he or she is engaged in play or activities instead of the traditional conversation (VanVelsor, 2004). When clients first experience a counselor’s verbal tracking of their behavior, they may be confused because they are more accustomed to answering a question. A client could feel threatened if he or she does not feel safe around the adult (VanVelsor, 2004).

In directive play therapy, there may be some variations not generally found in nondirective therapy. Also, new counselors can find tracking a client’s behavior awkward. Common questions about tracking might be: (a) How often do I track? (b) Can I ask questions about what the client is doing? and (c) Can I talk about other things while the client is playing or
doing something? It can be hard when first starting out to determine how often to track a client’s behavior. Landreth (2012) shares some ideas that are helpful for understanding this skill. He states that if the counselor sits quietly during the client’s play or focus on an activity, the client may feel the counselor is not interested and could experience anxiety. However, if tracking is overdone, it can make the client feel self-conscious. Tracking should not follow the client’s activity too closely (Landreth, 2012). When tracking with an older child or adolescent, it may be helpful to track less. Oftentimes, a client may initially feel scrutinized or judged by this skill until he or she is more comfortable and understands the counselor’s intent. Keep in mind that tracking responses should not label items, objects, or colors. It should be putting into words what the counselor sees and observes the client doing. It is important to begin these responses with “You’re” or “You are” rather than “I see…. This keeps the focus on the client, provides validation, and empowerment (Landreth, 2012).

With directive play therapy, questions often fill the session. The nature of this approach, following its theoretical orientation, includes the use of open and closed questions. For some new counselors there can be confusion about when to track and when to ask questions. It might seem that while a client is playing, creating, or engaging in an activity (such as drawing or completing a task) it is an opportunity for the counselor to ask questions rather than track actions. However, this could cause the client to lose focus on what he or she is experiencing in the play or creation. An example of this would be for a counselor to direct a client to draw a picture and then begin to ask questions about the drawing while the client is still focused on drawing. The young client may be confused about what should be taking place at this time and wonder if he or she should be drawing or answering questions. In order to respond to the questions about the drawing, the client must stop synthesizing his or her thoughts about what should be included in the picture to answer the questions. This can slow the counseling process and effectiveness of the session. Therefore, when a counselor gives the client a directive or prompt it should be followed by time, space, and tracking of behaviors.

**Reflecting Content.** Reflecting content in directive play therapy is similar to counseling with adults. The counselor paraphrases the verbal utterances of the client. Landreth (2012) describes these reflections as: (a) short; (b) succinct; (c) interactive with the client’s activity; (d) verbally descriptive; (e) reflective of content; (f) demonstrating of the counselor’s understanding and acceptance; and (e) providing an opportunity for the client to unfold his or her story from his or her perspective.
Reflecting Feelings. Reflecting the client’s affect serves to make the feelings explicit to the client. A child, much like an adult, may avoid the verbal expression of feelings. Many times it is difficult for a child to confront these feelings, but more specifically he or she lacks the vocabulary to express these feelings or affects (VanVelsor, 2004). Furthermore, Kottman (1995) maintains that it is unproductive to ask a child how he or she feels because he or she often lacks the self-awareness or language to answer the question. Landreth (2012) points out that reflecting a client’s feelings leads to: (a) demonstration of the counselor’s understanding and acceptance, (b) trust and acceptance of his or her feelings, (c) validation, and (d) creation of empathy.

A child may express his or her feelings in a variety of ways. These expressions are not limited to verbal communications. A young client may not have the words or self-awareness to communicate his or her feelings; however, he or she may share these with the use of play, or role-playing, or puppets. It is the counselor’s role to reflect the feeling. This can also deepen the client’s experience. Consideration should be given to how cultural, gender, and development levels affect the way a young client expresses feelings. In addition, the counselor should demonstrate patience with a child who may be experiencing an open communication and affirmation about feelings that the family may have been hiding (VanVelsor, 2004).

Both the reflection of content and feelings should be done with statements beginning with you. “You got to spend the weekend with your dad.” “You just drew on there.” “You look frustrated because you can’t get that to stay.” “You’re angry your mom didn’t stay with us.”

Facilitating Decision Making and Creativity. When the client asks questions or asks for help from the counselor, it is an opportunity to return the responsibility back to the client. The counselor’s role is to encourage the client to make his or her own decision and to take responsibility for the current concern. Another opportunity to facilitate decision making is recognizing when a client takes charge of a situation in the counseling session and makes a decision about what he or she wants to do or how he or she wants to do it. These occurrences help the client learn to be more autonomous, independent, and more comfortable with his or her own initial ideas (Giodano et al., 2005). Facilitating creativity and spontaneity helps a client experience a sense of uniqueness. This can be encouraged by responses that allow the client to develop flexibility in thought.
DIRECTIVE PLAY THERAPY

and action (Ray, 2004). “You can create the sand tray however you want.” “You changed your mind about the color.”

Facilitating decision making and creativity in directive play therapy can be a thin line because many times a directive or prompt is given to the client. The decision regarding how to respond to the directive would be for the client to make, thus providing him or her with the responsibility. If the counselor asks the client to “Draw a picture of a time when you had a good day in Ms. Smith’s class,” it should be the client’s decision to choose the tools to use, colors, size of the drawing, and so on. The counselor responses that facilitate the decision making or return the responsibility to the client might be: “You decided to use the paint.” “You know just what you want to draw.” “You can spell that name any way you want.” Additional caution is needed here for counselors to stay away from giving the client suggestions or comments that include rigid instructions. A counselor should refrain from proposing how the client might draw the picture: “You can use the pencils there.” “Remember to include your friend in the picture.” “I can tell you how to spell his name.” These comments direct the client to create the drawing from the counselor’s perspective rather than the client’s. Allowing the client to facilitate decision making and to create spontaneously provides the opportunity for him or her to learn how to make a decision, take responsibility, become self-directed and self-motivated, and have a sense of control in his or her life (Giordano et al., 2005).

Esteem Building and Encouragement. Using esteem-building statements and responses helps a client experience and recognize his or her capabilities. These statements recognize when a client achieves something he or she may have struggled with, such as getting the top off of a container: “You didn’t give up, you got it!” At times, counselors can struggle between encouraging a client and praising the client. A praise statement encourages the client to perform for the counselor. This reinforces an external locus of control (Ray, 2004): “I like the way you built that.” “Your drawing is pretty.” An esteem-building statement encourages the client to develop an internal locus of control: “You are proud of the way you built that.” “You drew that picture just the way you wanted.” When a client is encouraged to value the effort and work he or she put toward a task, he or she develops an internal source of evaluation. Then, instead of seeking approval from others, the client is able to applaud his or her own effort and accomplishment (Giordano et al., 2005).
CULTURAL SENSITIVITY

The Association for Multicultural Counseling and Development (AMCD) has established a framework for training mental health professionals. These guidelines include: (a) counselor awareness of his or her own cultural values and biases, (b) counselor knowledge of a client’s world view, and (c) counselor implementation of culturally appropriate intervention strategies (Arredondo et al., 1996). In addition, the Association for Play Therapy (APT, 2000) requires that play therapists provide interventions that demonstrate an understanding of the diverse background of their clients, as well as be aware of how their own cultural/ethnic/racial identity may influence their work with their clients. These standards suggest that counselors can provide effective intervention strategies when they have self-awareness, cultural knowledge, and a commitment to play therapy (Chang, Ritter, & Hays, 2005). The therapeutic relationship is especially important and effective in contributing to positive outcomes in counseling. It is also a critical component in multicultural counseling (Swan, Schottelkorb, & Lancaster, 2015). Roaten (2011) advocates that counselors cannot treat young clients like mini adults, but rather must implement strategies that meet their developmental level. Furthermore, she maintains that young clients need to have control in sessions and feel valued and respected. The use of strategies such as sandtray, art therapy, and play therapy have been deemed best practices for working with young clients (Roaten, 2011).

However, challenges still remain and call for self-evaluation and awareness as the clients served by play therapy grow in diversity. In 2008, Homeyer and Morrison’s review of practices, issues, and trends in play therapy shared Kao and Landreth’s words of concern. These authors described the challenges between some of the common play therapy goals that come into conflict with particular cultural beliefs (Kao and Landreth, as cited in Homeyer & Morrison, 2008).

An example of this might occur when a play therapist offers a response to return the responsibility to the client: “You can decide how to do that” is often used to facilitate decision making. Yet it demonstrates an individualistic perspective common in Western values. Therefore, when working with a client with a collectivist viewpoint, the approach or wording should be different. An example of a different approach might be: “You’re wondering if it is okay for you to decide how to do that. In here it is okay for you to decide.” Play therapists must be responsive to their clients’ culture (Homeyer & Morrison, 2008).
REFERENCES


