PLAY THERAPY QUESTION
How Does a Client-Centered Play Therapist Handle Revelations of Abuse and Similar Issues?

by Sandra Frick-Helms

This is the third in a series of columns based on questions, sent to me by graduate students taking a play therapy (PT) course taught via telecommunications. In these columns, I've made no secret of my (research supported) belief that PT should always involve correctly adhering to the play therapist's choice of theoretical framework(s) for practice. The questions, upon which this column is based, address whether or not a client-centered (CC) approach should be "abandoned," when a child reveals abuse (or something equally serious) during a CCPT session. Let's look at one of the original questions that inspired this column.

Question 1: The CCPT approach states it never teaches. If, during a PT session, a child reveals she or he is in an abusive situation, isn't it more ethical to change approaches and become more directive? Sometimes individuals, who are learning about CCPT, "hear" the instructions about CC "core conditions," as if they are being made about therapy in general. They react to this (mistaken) belief by resisting the idea that tools, *they have already found valuable, cannot be used.* This belief may extend to an idea that, if they use CCPT, they can't *ever* address a situation directively. Teaching only "*violates*" the theoretical formulations of CCPT, not the principles of therapy as a whole. While, teaching (or praising, or explaining, or questioning) are not CC; they can be *used as tools in non-CC portions of therapy* sessions, or in an educational format outside the therapy session. This does not mean that the CC play therapist would treat the incident in a CC manner and never address it directly. As will be seen below, ethical responsibilities can and must be met, regardless of the theoretical approaches used.

This leads to some of the more specific questions that were asked, regarding how the CC play therapist handles situations, such as a child who reveals abuse during a session:

Question 2: How would a CC play therapist handle a situation in which a child reveals evidence that (s)he is abusing or seriously aggressing against another (smaller) child? (3) In situations, where the play therapist decides that a situation needs to be dealt with directly, how would the therapist transition out of CCPT?

Why It's Important to Adhere to the CC Theoretical Framework

In addition to answering the "how," of this question, it will be important to look at the "why." One of the major strengths of CCPT is that it facilitates establishing and maintaining a secure, trusting child-therapist relationship. Theoretically, this is because, when the play therapist adheres to the CC "core conditions" empathy, unconditional positive regard (UPR), and genuineness or congruence, the child learns that (s)he will be: heard when (s)he is ready and without judgement. In a previous column, I discussed how criticism, praise, and questions could give the child a message that there were conditions for receiving positive regard. If a child has come to trust that (s)he can say anything to the therapist without receiving judgement or disapproval; suddenly ending the CC portion of a session, to teach her/him about the situation raised, might give the impression that this is not an *acceptable* area. This does NOT mean that the therapist will not deal with the situation directly. When, such a situation occurs, the CC therapist would respond empathically. For example, when a play therapist responds to a child's revelation of abuse ("My *daddy hurt me like this," during socio-dramatic* play); with a CC response ("You want me to know that your daddy hurt you like that") while maintaining the same level of UPR, the child receives the message, "you can continue to feel safe and to trust me, even when you talk about your abuse."

How is the Immediate Situation Handled?

Obviously, play therapists have an ethical responsibility to address (and report) allegations of abuse and suspicions that a child may be offending against other children. The ethical responsibility to report extends to informing the child that a report will be made. The play therapist would end the CC portion of the PT session early enough to take care of these ethical issues. The session would be ended in the same manner and with the same (structuring) communications as used in all other CCPT sessions (two time warnings and an ending statement). Some CC play therapists might prefer a more specific time warning and/or structuring statement, such as, "(Child's name), it's time to stop the "special play" part of our time together; so we can talk about something important." After using an appropriate structuring statement to end the CC portion of the PT session; the therapist

could refer to the preparation the child was given for PT. The play therapist could use a statement such as, "remember I told you that, in our time together I would be like the leader (team captain) and you would be like the follower (team member)? Now I'm being the leader (team captain) so I can tell you what you can do the next time (abusive situation) happens to you" (James, 1989). If there is a need for a report to be made, this should be told to the child also (APT, 2000). If in doubt as to what is reportable, the APT (2000) *Play Therapy Practice Guidelines* indicate that, "play therapists keep information confidential except when disclosure is required to prevent clear and imminent danger to the child client or others." Play therapists also become cognizant of state law related to confidentiality and comply with it. It is important to note that, even in situations where no report is indicated (e.g. report has already been made), it is important to clearly document such incidents. If possible, a colleague and/or supervisor (and, often, the child's caretaker) should be notified regarding the details of the situation, using, as much as possible, the child's exact words and behaviors. In addition to providing protection for the child and the play therapist; according to APT (2000) "play therapists responsibly consult with other health care professionals and child care providers when in doubt."

When Might the Situation Require Directive Intervention?

Sometimes, the child' statement/play reveals a misperception or inaccurate belief. A common instance of this occurs when a child incorporates, *into play, her/his belief that (s)he is responsible* for abuse. Or the child might attribute incorrect motivations to a perpetrator or other individual; such as a belief that: "daddy hit me because he wants to make me be good;" or "the doctor stuck the needle in my back because he likes to hurt kids." Often inaccurate perceptions/beliefs can *be dealt with by continuing to use CC responses.* The child might continue "playing out" the inaccurate perceptions/beliefs, and having them empathically responded to and with UPR, through many sessions, without appearing to gain relief. Many child therapy experts believe there is a point at which some directive intervention becomes necessary (James, 1989; Terr, 1991). The thinking is as follows: If the child persists in playing out a belief that may be psychologically damaging to her/his self-esteem, body image, etc. and the therapist validates the belief by empathically reflecting it, long term psychological harm may result. In addition to theoretical reasons for directive intervention, there is a growing body of research that indicates that directive, abuse-focused interventions should be used with abused children, at least in the case of sexual abuse (Berliner & Elliott; 1996; Cohen & Mannarino, 1993 a-c, 1997, 1998 a-c; Deblinger, Lippman, & Steer, 1996; Deblinger, McLeer, & Henry, 1990; Friedrich, 1996; Mannarino & Cohen, 1996; Mannarino, Cohen, & Smith, 1991).

If the play therapist decides to intervene directively; the CC portion of the PT would be ended in a similar manner to what is described above. Then the pre-planned directive intervention would be delivered. If the therapist believes the child might be distracted from the directive intervention by the toys that were used in the previous CC play or by the atmosphere of the CC playroom; the directive intervention can be carried out in another location. This might be a section of the playroom or therapist's office reserved for such activities. (During the CC portion of the PT session; a limit can be set on carrying the CC play into the reserved area, in the same manner as a limit is set on a computer in an office that serves also as a playroom.) Play therapists who routinely use both CC and more directive interventions, often arrange and stock their playrooms differently than the "typical" CCPT playroom. I like to use a modification of what O'Connor (2000) describes in his discussion of "setting up the playroom." My ideal playroom contains child-size table & chairs, very generic versions of a few of the domestic *props found in a CC playroom (stove, sink).* Everything else is kept in a separate cabinet or closet that is close to or inside the playroom.

Steps Summarized

So, basically, the answer to the original question for this column involves several steps the *play therapist should follow: (1) determine if the* child has revealed something in her/his play that requires a direct response or intervention, and/or documentation/report; (2) give a CCPT response to what the child reveals/shows; (3) when possible, allow enough time in the session to deliver the direct response or directive intervention; (4) end the CC portion of the session in the same manner as other CCPT sessions are ended; (5) carry out the direct response or directive intervention; (6) document what occurred in the CC portion of the session and report, as appropriate, what direct response or directive intervention(s) was/were

used.

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Answers to "PT Questions" are the opinion of the author. Feedback is invited. Additional questions for the column are also requested. "PT Questions" are used with the consent of Sandra Frick-Helms and *SCAPT NewsLetter*, where they are originally published. Dr. Frick-Helms is Professor Emerita, University of South Carolina College Of Nursing and Adjunct Professor, USC School of Medicine, Columbia SC & Converse College, Spartanburg SC and is Clinical Editor of the APT NewsLetter. She can be contacted at sandifh@sc.rr.com.