FEATURE ARTICLE: PLAY THERAPY QUESTION

How Does a Play Therapist Combine Directive Non-Directive Play Therapy Approaches?

by Sandra Frick-Helms

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This is the next in a series of columns based on questions sent to me by graduate students taking a play therapy (PT) course taught via telecommunications. In each edition of the newsletter, I address at least one question received during that course. I hope that individuals, who have additional questions, will send them to me or to their branch newsletter editor. I will do my best *to answer as many as I can or find someone else* who can. I also invite any individual(s), who so desire, to be guest author(s) and answer a question.

The first columns have dealt with client-centered play therapy (CCPT), a non-directive approach. This column will address the use of *directive as well as non-directive PT approaches.* (Note: In my practice, I use CCPT as my non-directive approach and cognitive-behavioral play therapy (CBPT) as my directive approach.)

Question 1: When a play therapist is using both directive and non-directive PT in the same session, which one should be used first? Why?

Answer: The answer to this question would be determined by the play therapist's reason for the way in which two PT approaches are sequenced. (In my practice, the reason for using an intervention and the goal I have for the child are synonymous. *The goal is the reason* for addressing a problem and the way it is addressed.) Directive PT interventions are under the play therapist's control or direction. They are usually done to meet a specific goal, such as helping the child to express feelings, modeling a new behavior for a child, giving a child new ways to cope, etc. In CBPT, the reason for or goal of interventions is to modify or change an existing behavior or cognition, or to bring about a new behavior or cognition. In non-directive (CC) PT, interventions are, by definition, under the child's control or direction. If the play therapist were to decide, ahead of time, what her/his goal for the child would be in a particular session and use a directive intervention to meet that goal, control would be taken away from the child.

Reasons for Beginning a Session with Non-Directive (Client-Centered) PT

1. To develop the child-therapist relationship. It is generally agreed, by therapists and researchers who focus on factors influencing therapy outcomes, that the relationship between client and therapist is a critical factor for success. CCPT is an ideal way to establish a positive child-therapist relationship right from the beginning of therapy. The therapist informs the child that (s)he will be in charge of what happens in PT child and assures the child, through empathic responses, the child quickly learns that (s)he can trust the play therapist to do exactly what (s)he tells her/him (s)he will do. Additionally, because being responded to with empathy and unconditional positive regard is affirming to children, the therapy experience begins in a reassuring and pleasant way.

2. To facilitate assessment. Another advantage of CCPT is that it provides assessment *data about the child and her/his relationships.* After as few as two or three CCPT sessions, the play therapist can have a good indication of: (a) the child's developmental level and capabilities, (b) how the child separates from and rejoins the caretaker; (c) what play materials the child prefers, and (d) how (s)he uses play materials. With some children, the first few sessions reveal their perceptions of events that have happened to them and how they reacted to and feel about these events. If a play therapist is planning to use directive interventions at some point in the course of therapy, this assessment data becomes useful in prioritizing treatment goals and "tailoring" interventions to "fit" the child's preferences. For example, while playing with a family of toy rabbits, a child may reveal a misperception about something that is important to a favorable treatment outcome. Among other treatment goals, the play therapist has a goal to change (correct) the child's misperception. If correcting the misperception might influence the play therapist's ability to successfully meet other important treatment goals, (s)he knows that this goal has a higher priority than some of the other goals. When (s)he designs her directive intervention, (s)he chooses the family of toy rabbits. Without the early CCPT sessions, the play therapist might not have had this important assessment data. As PT progresses, CC sessions (or CC portions of sessions) will continue to yield assessment data at a time that is more likely to be optimal for the child.

A play therapist may want the child to begin a session by bringing up (in her/his play) whatever (s)he seems to need to address most at that point in the therapy process. It is possible that whatever directly precedes CC portions of PT sessions may influence the content of those non-directive portions. If, in the example above, the play *therapist begins with CBPT, not knowing about the* child's misperception and toy preferences, (s)he may start with a directive intervention that requires a clear understanding of what is misperceived. (S)he may also use a play modality or equipment, with which the child is not comfortable.

3. When it is necessary that PT content and process have not been influenced by the therapist. There are situations in which the play therapist wants to avoid influencing a child's play process and content, or even the *appearance* of influence. One such situation might exist when the play therapist finds her/himself in the (unenviable) position of needing or wanting to verify or bolster abuse allegations. In this situation, the play therapist can use CCPT, knowing that it yields favorable treatment outcomes unaffected by therapist actions, except using the (non-directive) core conditions of CCPT. Any material that is yielded by CCPT sessions was as a result of the child's actions.

4. To re-establish the child-therapist relationship. When clients, child or adult, have been processing difficult material, through directive interventions, for a while; they experience times when they feel unable or unwilling to continue doing so. Adult clients communicate such feelings verbally. Children's language skills are not as sophisticated as adults and most of them have not had as many successful past experiences, as have adults, in communicating their own wishes and desires. The child refuses to participate, as before, in directive interventions. If the play therapist persists and tries to coax, force, or otherwise coerce the child to continue participating in directive interventions, much, if not all, of the trust that the child has in the therapist may be lost. When the play therapist recognizes signs of resistance, (s)he can resume non-directive (CC) methods and re-establish the necessary trust of the child in the therapist. When the child shows signs of ability to resume the difficult material, the play therapist begins using directive (CB) methods again. Kelly (1995) described a model that rotates non-directive and directive interventions with sexually abused children.

Reasons for Beginning a Session with Directive (Cognitive-Behavioral) PT

1. CBPT is used to change or modify an existing behavior or cognition or bring about a new behavior or cognition. In this reason, I am answering from my CBPT perspective. CBPT, by definition, is specifically used to change or modify an existing behavior or cognition or bring about a new behavior or cognition. This change, modification, or occurrence of a behavior or cognition as a result of CCPT; but the behavior or cognition change, modification, or occurrence is not a specific goal or expected outcome of CCPT.

2. To prevent stalling by the child. When sessions are begun with non-directive PT, the child may try to prolong the non-directive portion of the session by stalling when time is announced. The play therapist can avoid this by beginning sessions with directive (CBPT) interventions and ending with non-directive (CC) PT.

3. To continue an intervention that was begun in the previous session. If the play therapist wants to continue a directive intervention, that was begun in the previous session, without having other themes or activities intervening; (s)he may decide to begin the PT session with directive (CBPT) interventions. This is especially true if the child tends to forget aspects of the directive intervention or find portions difficult to achieve.

4. When the goal is to emphasize the message of directive (CB) PT. If the goal of directive PT interventions is to drastically modify a behavior or cognition or bring about a completely new behavior or cognition, the play therapist may decide to begin sessions with the directive intervention; so that they are fresh in the child's mind during the non-directive (CC) portion of the PT session. This decision is based upon the assumption that whatever directly precedes the non-directive portion of a PT session may influence the content of those non-directive portions.

References:

Kelly, M.M. (1995). Play therapy with sexually traumatized children: Factors that promote healing. *Journal of Child Sexual Abuse*, *4*(3), 1-11.

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