Ethical Issues in Play Therapy

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The Association for Play Therapy (APT) defines play therapy as the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development (www.a4pt.org). Although the idea of play as a modality was introduced over 80 years ago, this therapeutic orientation is still considered new (Carmichael, 2006b), and has really only experienced major growth and development in the last 20 years (Bratton, Ray, Rhine, & Jones, 2005). This is apparent when one looks at the play therapy literature. Most research and writing in this area still focuses on efficacy, with very little available that addresses daily clinical issues such as ethics. In fact, while conducting an outcome study in 2001, researchers Jackson, Puddy and Lazicki-Puddy were unable to find any published research that addressed the ethical practices of play therapists. Even training in clinical issues is lacking. Seymour and Rubin (2006) state that less than half of current graduate level play therapy courses mention ethics in their syllabi. Of the texts used most often for these courses, only one has a chapter specifically focused on ethics. This problem extends beyond graduate programs. The APT's online training includes nothing on ethics, and this year's annual conference brochure shows just three of the sixty-two workshops devoted directly to ethical issues (www.a4pt.org).

Although the APT has developed voluntary practice guidelines, they are general in nature and are relevant, but not specific, to daily clinical work. At the same time, ethical codes from licensing boards and professional organizations may not address the "unique, multi-layered ethical dilemmas" (Seymour & Rubin, 2006, p. 104) experienced by play therapists. With 1 in 10 children needing mental health services, and the wide use of play therapy as a therapeutic

modality (Bratton et al., 2005), it is important that these ethical issues be understood, and that therapists have a plan for addressing them.

Ethical Considerations for Play Therapists

A play therapist encounters many of the same general ethical dilemmas as other practitioners. However, there are also many issues related directly to working with children, and specifically to the mode of play therapy. This writer recently had the privilege of spending 30 minutes of uninterrupted time with Dr. Garry Landreth, distinguished contributor to the field of play therapy. During this time I was able to get his viewpoint on the ethical issues of most concern in the field of play therapy.

Competence

Landreth's opinion seems to agree with most of the literature; therapist competence is one of the chief ethical issues facing play therapists. All the Codes of Ethics pertaining to this writer (American Association of Marriage and Family Therapy, 2001; Oregon Board of Licensed Professional Counselors and Therapists, 2008), as well as the APT's Voluntary Play Therapy Practice guidelines, address the importance of practicing within the scope of training and competence. Unfortunately, many therapists practicing play therapy do not have the specialized training needed. According to Landreth, less than half of the therapists currently practicing play therapy have taken a graduate course in the same (personal communication, October 29, 2007). Even workshops, which can be helpful in continuing training, should not be considered a replacement for a graduate course (Sweeney, 2001). These courses are important because they allow for specialized instruction in the history, theories, and techniques of play therapy (Carmichael, 2006a). Children are a special client population, and simply having a degree in

counseling or another similar field does not qualify a person to provide therapy for them (Corey, Corey, & Callanan, 2007; Jackson, 1998).

Confidentiality

The issue of confidentiality can become difficult for therapists working with children. As minors, children are unable to consent for treatment, leading many play therapists to consider the parent or legal guardian to be the actual client. In addition, children do not have a legal right to confidentiality for information given during treatment (Carmichael, 2006a; Jackson, 1998). Despite this, it is important for play therapists to explain confidentiality issues to both the parent and the child, at a developmentally appropriate level for the child (Sweeney, 2001). While children may not have a right to confidentiality, play therapists can ask the parents to respect the child's need for privacy regarding their treatment (Carmichael, 2006a; Sweeney, 2001).

The issue of breaking confidentiality can be especially problematic for play therapists. As play therapy focuses on play as the child's language, evidence needed to ethically break confidentiality may not be conclusive. The therapist may be limited to using only the themes he sees in the play as a reason for breaking confidentiality. Furthermore, most play therapists believe that trying to use verbal communication to discuss these concerns could affect the therapeutic relationship (Jackson, 1998).

Finally, because of the special nature of play therapy, the therapist must be especially considerate of client records. These include any drawings or paintings created by a client during a play therapy session. As Landreth (personal communication, June 18, 2008) noted to this writer, "you wouldn't ever hang a client's case notes on the wall for everyone to see, so why would you hang up a child's painting made during a play session?" Whereas it may seem

innocuous to do so, displaying a child's artwork is unethical and a breach of confidentiality (Sweeney, 2001).

Boundaries

Managing boundary issues is an important skill for all therapists (Corey et al., 2007). Boundary issues can be especially confusing for play therapists working with children. Because of the potential for boundary crossings, it is crucial that the therapist discuss the purpose of boundaries and potential boundary issues with the parent before therapy begins. Two issues that come up most often in regards to boundaries are gift-giving and hugging or physical contact.

It seems clear that accepting a gift from a client is inappropriate; however, the issue becomes muddy when a child gives the gift. Turning down a gift from a child client could be detrimental to the child's development, as well as to the therapeutic relationship (McGuire & McGuire, 2001). Accepting small, handmade gifts, baked items, or paintings made in the playroom may be reasonable. This should not extend to accepting a child's allowance, valuable or sentimental items belonging to the child, or expensive gifts from a child's parents (McGuire & McGuire, 2001; Sweeney, 2001).

In any therapeutic relationship, it is important for the client to realize that the therapist cares. Therapists accomplish this in adult therapy by attentive listening, reflecting, and empathy; little to no touch is involved. This can be quite different when working with children in a play setting. Children can be naturally very spontaneous, and may hug the therapist in response to a positive or negative feeling. It is important for the therapist to be aware that hugging and touch are used in many different types of relationships and have a variety of meaning. An ethical response to this issue is to abstain from hugging all clients, especially child clients (McGuire &

McGuire, 2001). On the other hand, if a therapist is hugged by a child, remaining stiff may send a negative message to the client (Landreth, as cited in McGuire & McGuire, 2001).

There are many other ethical issues such as choice of modality, informed consent, client records, and custody issues which, when considered in the context of play therapy, can be quite confusing. While there is not room within the confines of this paper to discuss each of these in depth, therapists should have an understanding of the complex nature of these issues as they relate to play therapy.

A Model for Ethics Problem Solving

Much of the literature cites a need for an ethical model specific to play therapy (Jackson, 1998; Jackson et al., 2001; Seymour & Rubin, 2006; Sweeney, 2001). Until recently, no cohesive model for ethical problem solving in the field of play therapy existed. Although the APT published practice guidelines for play therapists in 2001, the disciplinary diversity of clinicians (Carmichael, 2006a; Jackson et al., 2001) and the complexity of the issues beg for a specific model for addressing ethical dilemmas.

Seymour and Rubin (2006) proposed a model for "applying historical ethical principles to clinical situations" (p. 101). The Principles, Principals, and Process (P^3) Model is an integrative and play therapy-relevant model which allows play therapists from diverse backgrounds to apply their historical ethical guidelines to specific challenges they face in their practice (Seymour & Rubin, 2006). This model was developed in response to the suggestion that "since the ethical decision is made in the context of a therapeutic relationship, then relational, as well as rational factors, should be considered..." (Seymour & Rubin, 2006, p. 105). The author's model addresses the contextual factors of ethical decision making, as well as the *a priori* principles. The three parts of the model and how they are applied are explained in further detail.

Principles

The historic ethical principles of autonomy, beneficence, nonmalfeasance, fidelity, justice, and veracity serve to help therapists remain objective and balance their moral intuition when making ethical decisions. When using the P^3 model, the therapist considers the historic ethical principles that will guide him and determines which ethical concern is primary in the particular case. Additionally, the clinician considers the specific guidelines from the ethical codes of his therapeutic discipline. Finally, the therapist considers any other guidelines such as employer policies that may be applied to the case (Seymour & Rubin, 2006).

Principals

To balance the effect of a purely rational decision making process, “some writers have suggested balancing the therapist’s voice with the voices and experiences of the other people involved in the therapeutic relationship” (Seymour & Rubin, 2006, p. 108). This is accomplished by inviting input on the case from the principals of the relationship: the client, the counselor, the collaterals, and the community. In this step, the therapist “reviews those principles from the perspective of each of the principals, directly involving the principals where possible” (Seymour & Rubin, 2006, p. 110).

The client’s voice is vital in working through ethical decisions, as it serves to remind the therapist of the power differential between child and therapist. The therapist’s self awareness (or lack thereof) can have a bearing on ethical decision making within the therapeutic relationship. Collateral voices including family members, teachers, and medical professionals should be considered. These add clues to the social context of the problem which help the therapist to better understand how to apply his ethical principles to the situation at hand. Collateral voices may also include clinical colleagues and supervisors. Finally, the community voice adds to the

therapist's understanding of the gender, race, ethnicity, and cultural influences that impact the therapeutic relationship (Seymour & Rubin, 2006).

Process

The engagement of the principles and principals in dialogue defines the final step in this model. This step becomes a natural integration of identifying all the principles guiding the ethical situation, as well as the principals whose voices are informing the final decisions. Once dialogues have taken place, and the information has been synthesized, the therapist begins to develop a therapeutic response (the process). This can include anything from clarifying information with family members, to making plans for future treatment. The authors state it succinctly, "the therapist facilitates a recursive dialogue concerning the principles, with the principals to develop a shared understanding that will inform an ethical decision" (Seymour & Rubin, 2006, p. 110).

Seymour and Rubin (2006) have developed a model for ethical problem solving which gives play therapists from all disciplinary backgrounds a clear process for making ethical decisions regarding their clinical cases and day-to-day work. The Principles, Principals, and Process (P^3) model could address all of the ethical issues discussed in the earlier section of this paper. The magic of this model is that it takes into consideration the differences in educational background of the counselor, as well as the unique contributing factors to each therapist's ethical dilemmas.

Therapist Reflections

Although play therapy has been in existence of some form for over 100 years, it was not until 1982 that a national organization was founded. The APT created their Voluntary Play Therapy Practice Guidelines a mere seven years ago in a field which, by its own admission, has

been booming for over 20 years (Bratton et al., 2005). Although I found the literature on ethical issues in play therapy to be lacking, the information I did find was illuminating. It certainly caused me to spend more time thinking about the many ethical situations that are specific to working with children and to play therapy. This means being aware of potential ethical issues before they arise and planning to handle those situations. I was encouraged by the direction the literature appears to be heading, which is providing play therapists with models for ethical problem solving. Seymour and Rubin's (2006) article on the P^3 model of ethical problem solving by will be one that holds an important place on my desk for some time to come.

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