ROUTLEDGE

# PLAY THERAPY TREATMENT PLANNING WITH CHILDREN AND FAMILIES

## A Guide for Mental Health Professionals

Edited by Lynn Louise Wonders and Mary L. Affee

"This book on treatment planning stands out for its holistic approach. The co-editors selected some of the best scholars and practitioners in the play therapy field. I love the emphasis on the wide array of contributing factors and wider systems."

**David A. Crenshaw,** *PhD, ABPP,*
*author and board-certified clinical psychologist*

"*Play Therapy Treatment Planning with Children and Families* delivers just what the title describes and much more. The editors provide a thoughtful rationale for the importance of treatment planning, one that extends the plan to be a dynamic process, encompassing relevant contextual factors in the child's life. The editors have assembled seasoned practitioners to offer guidance and practical applications for treatment planning, ensuring that the book is useful across various presenting issues and theoretical orientations. The book will help practitioners craft holistic and high-quality plans to support the well-being of children and families!"

**Anne Stewart, PhD,** *Professor, Department of Graduate Psychology, James Madison University*

"This is a book play therapists will keep handy for many years."

**Richard Gaskill,** *EdD, LPC, RPT-S*

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

# PLAY THERAPY TREATMENT PLANNING WITH CHILDREN AND FAMILIES

*Play Therapy Treatment Planning with Children and Families* is a comprehensive guide that provides an integrative and prescriptive approach to creating customized treatment plans. It's an excellent textbook for graduate programs in social work, counseling, and family therapy and an invaluable guide for practicing clinicians in all settings.

After exploring and explaining the many modalities for treating children and adolescents, this book provides sample treatment plans using a variety of case vignettes. Chapters also take readers through a road map for case conceptualization, meeting with caregivers, problem identification, goal development, diagnosis determination, determination of interventions and termination, and much more.

**Lynn Louise Wonders** is a licensed professional counselor (LPC), certified professional counselor (CPCS), and registered play therapist-supervisor (RPT-S). She has provided clinical supervision, consultation, and training since 2010.

**Mary L. Affee** is a licensed clinical social worker (LCSW), a registered play therapist-supervisor (RPT-S), and holds a doctorate in education. She is the founder and clinical director of Horizon Integrated Wellness Group, a private practice in North Carolina.

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

# PLAY THERAPY TREATMENT PLANNING WITH CHILDREN AND FAMILIES

## A Guide for Mental Health Professionals

**Edited by Lynn Louise Wonders and Mary L. Affee**

Routledge
Taylor & Francis Group
NEW YORK AND LONDON

Designed cover image: Weekend Images Inc. © Getty Images

First published 2024
by Routledge
605 Third Avenue, New York, NY 10158

and by Routledge
4 Park Square, Milton Park, Abingdon, Oxon, OX14 4RN

*Routledge is an imprint of the Taylor & Francis Group, an informa business*

© 2024 selection and editorial matter Lynn Louise Wonders and Mary L. Affee; individual chapters, the contributors

The right of Lynn Louise Wonders and Mary L. Affee to be identified as authors of the editorial material, and of the authors for their individual chapters, has been asserted in accordance with sections 77 and 78 of the Copyright, Designs and Patents Act 1988.

All rights reserved. No part of this book may be reprinted or reproduced or utilised in any form or by any electronic, mechanical, or other means, now known or hereafter invented, including photocopying and recording, or in any information storage or retrieval system, without permission in writing from the publishers.

*Trademark notice*: Product or corporate names may be trademarks or registered trademarks, and are used only for identification and explanation without intent to infringe.

*Library of Congress Cataloging-in-Publication Data*
Names: Wonders, Lynn Louise, author. | Affee, Mary L., author.
Title: Play therapy treatment planning with children and families : a guide for mental health professionals / Lynn Louise Wonders and Mary L. Affee.
Description: New York, NY : Routledge, 2024. | Includes bibliographical references and index.
Identifiers: LCCN 2023044040 (print) | LCCN 2023044041 (ebook) | ISBN 9781032363646 (hbk) | ISBN 9781032363622 (pbk) | ISBN 9781003334231 (ebk)
Subjects: LCSH: Play therapy. | Play therapy—Methodology. | Medical protocols. | Patient-centered health care.
Classification: LCC RJ505.P6 W66 2024 (print) | LCC RJ505.P6 (ebook) | DDC 618.92/891653—dc23/eng/20231229
LC record available at https://lccn.loc.gov/2023044040
LC ebook record available at https://lccn.loc.gov/2023044041

ISBN: 9781032363646 (hbk)
ISBN: 9781032363622 (pbk)
ISBN: 9781003334231 (ebk)

DOI: 10.4324/9781003334231

Typeset in Baskerville
by Apex CoVantage, LLC

This book is dedicated to all the mental health professionals who provide therapy services for children and families now and for years to come. May this book provide you with valuable resources for case conceptualization and therapy planning.

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

# CONTENTS

*Foreword by Athena A. Drewes* *xiii*

*Preface by Lynn Louise Wonders and Mary Affee* *xv*

*An Overview of the Text* *xvi*

*Acknowledgments* *xvii*

*About the Editors* *xix*

*List of Contributors* *xx*

**PART 1 FOUNDATIONS OF TREATMENT PLANNING 1**

**1 PURPOSEFUL AND EFFECTIVE TREATMENT PLANNING FOR CHILDREN AND FAMILIES 3**

*Lynn Louise Wonders*

**2 UNDERSTANDING THE CONTEXT OF HUMAN DEVELOPMENT IN TREATMENT PLANNING 16**

*Cary McAdams Hamilton*

**3 CULTURAL IMPLICATIONS TO TREATMENT PLANNING FOR CHILDREN AND FAMILIES 26**

*Rebeca Chow*

**4 APPROACHES FOR CASE CONCEPTUALIZATION AND TREATMENT PLANNING 33**

*Lynn Louise Wonders*

**PART 2 TREATMENT PLANNING FROM A VARIETY OF THEORETICAL ORIENTATIONS, MODELS, AND APPROACHES 41**

**5 AN ADLERIAN PLAY THERAPY APPROACH TO TREATMENT PLANNING 43**

*Susan Becker Kerley and Erica Wassenaar*

**6 TREATMENT PLANNING FOR ANIMAL ASSISTED PLAY THERAPY™ 52**

*Risë VanFleet*

7 **AN AUTPLAY® APPROACH TO THERAPY PLANNING** **61**
*Robert Jason Grant*

8 **A CHILD-CENTERED PLAY THERAPY APPROACH TO TREATMENT PLANNING** **67**
*Rosie Newman*

9 **TREATMENT PLANNING FROM A COGNITIVE BEHAVIORAL PLAY THERAPY PERSPECTIVE** **75**
*Sueann Kenney-Noziska*

10 **A DIGITAL PLAY THERAPY™ APPROACH TO TREATMENT PLANNING** **82**
*Rachel A. Altvater*

11 **USING A FAMILY SYSTEMS APPROACH TO ASSESSMENT AND TREATMENT** **90**
*Eliana Gil and Timothy Baima*

12 **A FILIAL THERAPY APPROACH TO TREATMENT PLANNING** **97**
*Risë VanFleet*

13 **A DEVELOPMENTAL APPROACH TO TREATMENT PLANNING FOR INFANTS WITH FIRSTPLAY® THERAPY** **105**
*Janet A. Courtney*

14 **A GESTALT APPROACH TO TREATMENT PLANNING** **113**
*Felicia Carroll*

15 **A JUNGIAN APPROACH TO TREATMENT PLANNING** **121**
*Eric J. Green and Kim Powell Street*

16 **KALFFIAN SANDPLAY IN ASSESSMENT AND TREATMENT PLANNING** **130**
*Rosalind L. Heiko*

17 **A PSYCHODYNAMIC APPROACH TO TREATMENT PLANNING** **141**
*Geoff Goodman*

18 A NEUROBIOLOGICAL RELATIONAL APPROACH TO THERAPY PLANNING 150
*Rita Grayson*

19 A SYNERGETIC PLAY THERAPY® APPROACH TO TREATMENT PLANNING 161
*Lisa Dion and Judith Norman*

20 TREATMENT PLANNING IN TRAUMAPLAY™: STORY KEEPING FOR THE FAMILY SYSTEM 169
*Paris Goodyear-Brown*

PART 3 SPECIAL POPULATIONS AND CONSIDERATIONS WITH TREATMENT PLANNING 181

21 THERAPY PLANNING FOR SEXUALLY ABUSED CHILDREN AND ADOLESCENTS 183
*Sueann Kenney-Noziska*

22 THERAPY PLANNING WITH EMDR® AND PLAY THERAPY 187
*Ann Beckley-Forest and Rhonda Johnson*

23 PSYCHOTHERAPY TREATMENT PLANNING WITH CHILDREN IN CRISIS 191
*Claudio Mochi and Isabella Cassina*

24 A NEURODIVERSITY AFFIRMING APPROACH TO THERAPY PLANNING 194
*Robert Jason Grant*

25 TREATMENT PLANNING WITH CHILDREN DURING HIGH-CONFLICT DIVORCE 198
*Lynn Louise Wonders*

26 TREATMENT PLANNING WITH LGBTQ+ (SOGIE) YOUTH AND FAMILIES 203
*Kurt W. Oster*

27 RACE-BASED ASSESSMENT, DIAGNOSIS, AND TREATMENT PLANNING WITH BLACK CHILDREN AND FAMILIES 209
*April Duncan*

**28 MINDFULNESS IN TREATMENT PLANNING** **217**

*Lynn Louise Wonders*

**29 FAMILIES, CHILDREN, AND TECHNOLOGY IN TREATMENT PLANNING** **222**

*Mary Affee, Lynn Louise Wonders, Courteney Matteson, and Julia Krebs*

**30 TREATMENT PLANNING IN CLINICAL SUPERVISION** **230**

*Eleah Hyatt*

*Appendix A: Sample Assessment and Intake Forms* *233*

*Appendix B: Sample Treatment Plans* *237*

*Appendix C: Sample Session Notes* *248*

*Appendix D: Other Documentation Samples* *254*

*Index* *256*

# FOREWORD

How do we know whether or not we have arrived somewhere if we don't know where we are going or what the end point is, or even have a road map to help get us there? We wouldn't think of getting into our car and just heading out in any direction for that long-desired and hoped-for transformative trip without taking along our GPS system (be it on our phone or through another means). This is very true for working with children and families in therapy.

Our clients generally want exactly the same things in life as ALL people: they want to be able to thrive and not just survive. A high-quality treatment plan is an essential tool that can help in this process. And it is important that individuals have the ability to design their own road maps and yet have the knowledge of and feeling that there is a supportive and invested therapist who is walking beside them while they are on their journey and helping them to develop, facilitate, and keep track of their individualized road map.

In order for treatment to be successful, there needs to be the creation of an allied stance with families, and most importantly, to move beyond emphasizing problems to emphasizing competence; moving out of the role of expert and into the role of accountable ally; moving off of our professional "land" and onto the family's "turf," and out of the stance of teaching and into that of learning *with*. If we ever hope to help our clients change, in a meaningful way, we need to think about what works in therapy with regard to the working relationship. In *The Heart and Soul of Change. What Works in Therapy*, editors Hubble, Duncan, and Miller (1999) report four common factors for positive behavior change: Client Factors: 40% which included resources and influences such as persistence, faith, or a supportive relative; Hope and Expectancy: 15% which includes expecting to get better and do better; Model and Technique: 15% which included staff procedures, techniques, and beliefs; and most importantly, Relationship Factors: 30%, which was the strength of the alliance. To make therapy effective, we need to join with families in treatment planning and partner with them, giving the family a voice and choice and opportunities for involvement.

By bringing in the family and client into becoming involved in the treatment planning, it demonstrates a culture of respect, being listened to, and having their input valued and considered in treatment planning. Planning needs also to consider the family's readiness for involvement and their ability to assume tasks on behalf of their child. We must also include the child/teen client as an expert resource, respecting their voice and treating them as equal partners in creating a system of change. They need to be included in all meetings concerning them, and no idea is a "bad" idea, should they offer it, along with helping the child/teen become educated about all their choices, and most importantly, having transparent conversations with them. It becomes a "partnership," making decisions together, which leads to investment in the treatment process and in initiating their own treatment through their goals, objectives, and interventions.

Treatment plans need not only have a goal, an endpoint, but also the strengths related to the goal and the barriers to the goal, along with measurable objectives, interventions, services, and supports. The goals are the broader endpoint and help to express the hopes and dreams of the individual expressed in the child/teen's or parent/guardian's own words. The goals identify the hoped-for-destination to be arrived at through the services being offered. Goal development becomes a critical component in engagement and in creating a collaborative working relationship.

A lot goes into thinking about the goal and the more specific objectives of how to get there. For example, strengths, abilities, competencies, values and traditions, interests, hopes, dreams, motivation, resources, and assets, unique individual attributes, things that have worked well in the past, "natural supports" (e.g., family members, relatives, friends, community resources), and cultural influences are all woven into the tapestry of the treatment plan. But it is not complete if there is no consideration of what factors keep the person from their goals. Barriers such as skill development, environmental and familial factors, lack of resources, self-defeating strategies, threats to health and safety, and cultural factors need also to be spotlighted and addressed for a successful outcome.

And lastly, but far from the least, objectives must be stated in behaviorally measurable language, be time-limited, and clear for when we know the client has achieved the established objectives and the end has been reached. Objectives should capture the positive alternative to the current needs and challenges and work to remove barriers, build on strengths and address cultural issues. Objectives are like stepping stones along the path, bringing the client closer to attaining the broad goal. Objectives can be changed and updated as the plan is reviewed, and when all the necessary objectives have been achieved, then we have arrived at our destination, and the goal has been successfully met.

Writing treatment plans and conceptualizing them from a theoretical framework is not an easy task, and it requires nuance and takes practice, support, and guidance. How fortunate we are that there is now a volume exclusively devoted to the broad topic of treatment planning, illuminating the topic from a myriad of angles and lenses. Edited by Lynn Louise Wonders and Mary Affee, *Treatment Planning with Children and Families: A Guide for Mental Health Professionals* is the one resource all clinicians should have at their side and in their professional library. It is comprehensive, offering a rich variety that succeeds in meeting the need for an inclusive how-to book on writing detailed and relevant treatment plans with measurable objectives that will lead to effective outcomes. The book is divided into three sections: Foundations of Treatment Planning; Treatment Plans from Theoretical Models and Approaches; and Special Topics, Samples, and Resources. The editors have gathered an impressive array of chapter authors, experts on their topics and fields of interest, who openly share their wisdom and time-honored approaches to treatment planning with us.

Readers, you will delight in reading this well-crafted, comprehensive and contemporary volume. It will help guide you toward a richer treatment practice with more effective outcomes.

—Athena A. Drewes

## REFERENCE

Hubble, M. A., Duncan, B. L., & Miller, S. D. (1999). *The heart and soul of change: What works in therapy*. American Psychological Association.

# PREFACE

This is a contemporary treatment planning book that provides perspectives on how clinicians may conceptualize and develop plans for therapy through various lenses and with attunement to various special considerations. The book provides essential resources for mental health clinicians working with children and their families. After the editors' encountered repeated challenges of having to access multiple books for treatment planning resources, encountering gaps in treatment planning, training opportunities, and through years of providing clinical services, teaching master's level students, and training clinicians through continuing education about treatment planning, this book was conceived. The editors observed that many practicing clinicians did not receive thorough training on the topic of treatment planning specific to child clients and families in graduate school or in continuing education. This book is designed to represent a diversity of perspectives on the topic of planning for therapy by including contributing chapter authors who are experts on theories, models, and important points of view. The vision for this book was to provide a comprehensive text for clinicians in training as well as practicing therapists in the field of child and play therapy on the process of case conceptualization with an evolving road map for the course of therapy. The editors have sought to straddle the medical model and the growing need for more sensitivity, inclusivity, cultural humility, and avoidance of over-pathologizing children's mental health challenges. The book will help clinicians organize and formulate information collected and observed with clients to develop effective and measurable treatment goals and objectives that lead to effective outcomes. For all theoretical orientations from which clinicians provide services, this guide provides a golden thread of goal-directed treatment planning that is substantive and purposeful so that clinicians can be accountable to the efficacy and quality of the psychotherapy services being provided.

—Lynn Louise Wonders and Mary Affee

# AN OVERVIEW OF THE TEXT

This book is organized into three parts.

Part 1 takes the reader through a thorough overview of contemporary, purposeful goal-directed treatment planning, including reasons for having a plan, a case for goals and objectives regardless of theoretical orientation, phases of therapy, the process of case conceptualization, human development, systemic and cultural considerations, and an introduction to the use of an integrative and prescriptive model for treatment planning.

Part 2 includes chapters authored by expert and revered therapists and trainers in the field of child and play therapy. The theories, models, and approaches were intentionally chosen as most closely representing the canon of theoretically based approaches to providing play therapy services for children and their families but also have gone beyond theories alone, considering that theories are not the only lens through which we approach therapy. Some particular models and approaches offer their own unique and important filter through which clinicians can shape the way therapy is delivered that may or may not be based upon a particular theoretical orientation. Each author's perspective and voice were honored and preserved while keeping this book section aligned with a sense of continuity. There are 17 chapters, each providing an overview of the theory, model, or approach and a fictional case study demonstrating the treatment planning process through the lens of the chapter's orientation.

Part 3 provides chapters that address special considerations during the treatment planning process, including special populations and circumstances. There are sample forms, documents, and resources included in this section of the book as well.

## VOICES AND TONES

It's important to note that many voices contribute to this book, and each author's voice is their own. Some contributing authors have chosen to use the first person and some the third person when providing a narrative of their case studies. Some voices are more formal, and some more casual. The editors hope this lends to the spirit of representing variety and diversity of perspectives without removing the intention of flow and easy structure of the book. Due to variations in terminology and methods in the theory and method chapters, it was necessary to shift some of the original wording and organization to facilitate synthesis.

## A WORD OF CARE AND CAUTION

It is always advisable to seek formal training, supervision, and consultation as the process of treatment planning can be complex, given every client and their presenting challenges and their biopsychosocial factors are unique. This book is not intended to be a stand-alone source but rather one that compliments further training, supervision, and consultation.

# ACKNOWLEDGMENTS


## FROM LYNN LOUISE WONDERS

The synergy Dr. Mary Affee and I experienced in formulating this book was remarkable. After I had been teaching about the importance of treatment planning in the field of play therapy when often there seemed to be a gap in this part of our field's education, Mary approached me, having realized the same need I had realized. She suggested we write a book and I jumped at the opportunity to join forces. I am grateful for Mary's gift of visioning and creativity! We've laughed and we've cried through this project and I'm grateful for every moment because we have both grown so much professionally through this project.

I want to acknowledge my husband Dennis Wonders whose support and patience through the process of writing and editing for this book has been invaluable.

I want to acknowledge one of my many beloved mentors Dr. Janet Courtney whose wisdom and experience with editing and writing books was a tremendous support from the very beginning of this process all the way through.

I also want to thank Judith Norman, my consultant in Synergetic Play Therapy® training and Lisa Dion, creator and teacher of Synergetic Play Therapy® who both inspired and supported me in being true and staying connected to my essential self throughout this process.

I most certainly stand on the shoulders of many giants. I am so grateful for my many mindfulness-based practice teachers over the past 30 years. My mindfulness practice personally and professionally carries me through all big and important projects such as this book. I have learned so much from many of the great contributors to this book, humble and grateful to now have them offering their expertise and wisdom to this book and to my revered colleagues who were gracious enough to lend their expertise to this book as well. I am so thankful for each and every one of you.

Lastly, I want to acknowledge all of the child and family therapists providing therapy services for your clients and leaning in to learn and grow as professionals. To all my many consultees, supervisees, and students over the years, I offer a deep bow of respect and gratitude for all you have done and continue to do to be the best therapists you can be.

## FROM MARY AFFEE

With humility and gratitude, I want to thank our universe and the divine for the mystery, misery, and the magnificence of life.

I want to thank the clients who graciously and painfully shared their hardest moments and memories in life with me, for they have all made me a better human. I want to thank the children who taught me resilience and how to play in their deepest pain. I am thankful for the wisdom and the incredible insights I have gained in the service of helping others and teaching others.

I owe an extraordinary debt of gratitude to all the authors, for this book would not have been possible without all of you. Anna Moore, at Routledge, thank you for your patience and support. It was a pleasure and honor to work with you.

I want to thank Lynn Louise Wonders, for sharing in this incredible writing project, and for the journey of learning how to edit a book. Thank you for putting your heart and time into this entire project, and for putting up with me! I could not have done this without you.

Taylor Auslander, my newly hired administrative assistant. Taylor, the last few weeks of completing this book often felt insurmountable. I know the completion of many editing tasks would not have been possible without you. You are one of the most intelligent, tenacious, and incredible humans I am honored to know and work with. Thank you for showing up in my life! Courteney Matteson, my executive assistant, thank you for all your hard work and all the laughs during the last few weeks in the editing process around the long table. Cindy Yewdall, Office Manager at Horizon Integrated Wellness Group, PLLC. Thank you for caring so much and taking the initiative when I couldn't.

I want to thank my granddaughter Adalina Eve Torrey-Lerose, for teaching me patience and when to walk away from the computer, for our play is my respite from difficult days. My mother, Mary Buttafuoco-Aguilar, who taught me to never give-up. I am so proud of all you have accomplished. My daughter Mary Torrey, you have always been the reason I am where I am. You gave me purpose and inspiration to be better and do better from the day you were born-I love you. J. C. Moeller for challenging me, encouraging me, and spending time with Adalina so I could write and research.

I want to thank my mentors, Dr. John Demartini, Founder of the Demartini Institute®. I could write pages about how impactful your teaching is and how it has changed and continues to change my life for the better. You are an incredible human and I am thankful. Lisa Dion, Founder of Synergetic Play Therapy® Institute, for boldly doing life; you are an inspiration! Thank you for the brilliance of Synergetic Play Therapy®. Carmen Marzella, Founder of Marzella Law Group, PLLC. Thank you for your time, patience, support, and demonstrating that lawyers can operate with so much compassion.

# ABOUT THE EDITORS

**Lynn Louise Wonders** has been licensed and certified as a professional counselor and supervisor in Georgia since 2007. She is a registered play therapist-supervisor, and since 2010 she has provided play therapy training, supervision, and consultation. She is the author *of When Parents Are at War: A Child Therapist's Guide to Navigating High Conflict Divorce & Custody Cases*, the therapeutic children's book series Miss Piper's Playroom, author of *Jule Moved to a New House and a New School*, *Jolie Wants to Go Swimming: A Lesson in Patience*, *Breathe: A Coloring & Activity Book*, co-author of *Spark and His Screenagains*, *Sammy Saw Something on the Screen*, and co-editor of *Nature-based Play & Expressive Play Therapies for Children & Families*. She is the co-editor and author of *Treatment Planning for Children and Families: A Guide for Mental Health Professionals*. Ms. Wonders has been a certified teacher of mindfulness meditation, Tai Chi, Qi Gong, and Yoga since 1995. She is a certified AutPlay® Therapist, a certified Pure Presence Practitioner, on track to be a Board Certified Coach providing Life Design Coaching, and a trained divorce and parenting coach. She is currently a psychology Ph.D. student at Saybrook University. Ms. Wonders is known for her efforts to curate mental health support resources for child and family therapists worldwide, for her international, engaging speaking and training, as well as her creative support by way of groups and individual clinical consultation. Ms. Wonders is the owner and director of Wonders Counseling Services, LLC and the founder and director of The Mindfulness-based Therapy Training Institute ™ and the Mindfulness-based Play Therapy™ transtheoretical approach to play therapy services.

**Dr. Mary Affee** is a licensed clinical social worker and a registered play therapist-supervisor. She has worked in the mental health field for more than 12 years and is the founder and clinical director of Horizon Integrated Wellness Group, PLLC, a practice that provides mental health services for children, adolescents, and families. Dr. Affee specializes in play therapy, and she is the President of the North Carolina Association for Play Therapy. Dr. Affee received the 2023 NASW-NC Social Worker of the Year award. In 2022, she was awarded the Emerging Leader National Award of Excellence from the Association for Play Therapy. In 2014, she received an Award of Excellence from the National Institute for Trauma and Loss in Children. Dr. Affee is the author of *Adalina's Mask*, co-author of *Adalina and Eli Play Together*, co-author of *Spark and His Screenagains* and *Sammy Saw Something on the Screen*. In April 2020, Dr. Affee volunteered her time and expertise to provide psychological first-aid to New York's first responders during the COVID-19 pandemic. She was interviewed several times by news outlets highlighting her efforts in promoting mental health interventions during the pandemic lockdown and her leadership in spearheading a statewide action for fair reimbursement for practitioners from United Healthcare. She has presented numerous workshops, training, and presentations to parents, teachers, professionals, and students. Dr. Affee teaches a summer creative and expressive play therapy course at Molloy University, and she is a field supervisor for the University of Mount Olive's Counseling Department and North Carolina State University's MSW program. She is also an advisory board member for Hope Connection International, where she facilitates free children's mental health groups, and for Carol's Hope, and serves on NASW-NC's Private Practice Work Group.

# CONTRIBUTORS

Rachel Altvater Psy.D, RPT-S

Mary Affee Ed.D, LCSW, RPT-S

Timothy Baima Ph.D, LMFT

Ann Beckley-Forest LCSW-R, RPT-S

Felicia Carroll LMFT, RTP-S

Isabella Cassina TPS, CAGS, PhD Candidate in Expressive Arts Therapy

Rebecca Chow Ph.D, LPC, LCPC, RPT-S,

Janet Courtney Ph.D, LCSW, RPT-S

Lisa Dion LPC, RPT-S

April Duncan DSW, LCSW, RPT-S

Eliana Gil Ph.D, LMFT, RPT-S, ATR

Geoff Goodman Ph.D, ABPP, CST, CSAT-S, RPT-S

Paris Goodyear-Brown LCSW, RPT-S

Robert Jason Grant Ed.D LPC, RPT-S

Rita Grayson LCSW, RPT-S

Eric J. Green Ph.D, RSP, RPT-S, LPC-S

Cary Hamilton LMHC, RPT-S, CDWF

Rosalind L. Heiko Ph.D, RPT-S

Julia Krebs LCMHC

Eleah Hyatt LMFT, RPT

Rhonda Johnson LPC-S, LMFT-S, RPT-S

Susan Becker Kerley LPC, CPCS

Courteney Matteson LCMHC -A

Claudio Mochi RP, RPT-S

Sueann Kenney-Noziska LCSW, LISW, RPTS

Rosie Newman LMHC, RPT-S

Judith Norman LPC, LSC, RPT-S

Kurt Oster LCSW, ACSW, BCD

Kim Street LPC

Risë VanFleet Ph.D, RPT-S, CDBC, CAEBI

Lynn Louise Wonders LPC, RPT-S, CPCS

# PART 1

# FOUNDATIONS OF TREATMENT PLANNING

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

# CHAPTER 1

# PURPOSEFUL AND EFFECTIVE TREATMENT PLANNING FOR CHILDREN AND FAMILIES

*Lynn Louise Wonders*

## INTRODUCTION

The process of planning for therapy begins the moment therapists meet a child's caregivers and continues throughout the child's and family's time in therapy. The treatment plan is not only a step in the required clinical record documentation; it is a multifaceted, ongoing process. To gain a complete understanding of a client's presenting circumstances, concerns, and challenges, a thorough intake is needed. As all the data is gathered, the therapist pieces the information together, formulating and conceptualizing the presenting case. Collaborating with the child and caregivers, the therapist develops an itinerary for the journey of therapy to include identification of the destination (goals), milestones to track progress toward the destination (objectives), and selection of vehicles and routes (interventions). Therapists learn these skills conceptually in graduate school, but it is not until working directly with clients that they can apply that knowledge meaningfully (Fairburn, 2011; Sperry & Sperry, 2020). Even with the most client-centered theoretical approach, the therapist needs to conceptualize what the client is experiencing, expressing, and needing for the most appropriate course of therapy (Sperry & Sperry, 2020).

Effective psychotherapy with children and their caregivers is built on a foundation of a therapeutic alliance rooted in the therapist's warm, welcoming, attentive, and reflective presence (Axline,1981; Halbur, 2011; Landreth, 2012; Ray, 2021). The therapeutic alliance is a trans-theoretical construct (Koole & Tschacher, 2016) and, therefore, the relationship between therapist and client(s) is believed to be essential and necessary for effective psychotherapy outcomes regardless of theoretical orientation or approach (Tschacher et al., 2015). While randomized controlled trials about the therapeutic alliance have yet to show that the relationship is the basis for effective therapy, research has demonstrated that the therapeutic alliance is strongly correlated with positive outcomes (Koole & Tschacher, 2016). This foundation of rapport, trust, and connection is optimal for working collaboratively with the child and caregivers (Treichler et al., 2021) to develop a therapy plan based on what the child and family are presenting (Stewart et al., 2022). Treatment planning is, ideally, a dynamic and fluid process that allows for collaborative adjustments as progress is tracked and as new information and needs may arise.

## PHASES OF THERAPY

While various therapy models may differ, there are typically three phases of psychotherapy.

### Phase 1: Connect, Gather, and Develop

In the first phase, caregivers and the therapist come together to begin forming the therapeutic alliance through authentic connection during the intake session and the first several

DOI: 10.4324/9781003334231-2

sessions to follow. Clinicians build rapport with the child and caregivers, gather information, assess, develop a case conceptualization, establish goals and objectives collaboratively, determine the approach to use, and choose interventions with the initial therapy plan.

### Phase 2: Maintaining, Observing, and Adjusting

Here, the therapist's role is to maintain the therapeutic alliance and assess for progress, regression, and new needs that may arise as indicated by the nature of the child's play or by the client or caregiver report. In addition, the therapist consults closely with caregivers and may adjust the therapy plan to offer new interventions to meet the presenting needs of the child and the family system as needed. This phase continues until all needs have been addressed, objectives achieved, and goals are met.

### Phase 3: Closure of Therapy

As objectives and goals are reached, the clinician, caregivers, and the child together bring the therapy to a close. In this phase, the therapist ensures ethical and appropriate termination so that the child and caregivers feel a sense of satisfactory completion, healthy goodbyes, and an easeful transition from therapy.

## THE INTERSECTION OF RELATIONAL PSYCHOTHERAPY AND THE MEDICAL MODEL

The belief in the therapeutic alliance as essential and foundational for desired treatment outcomes in psychotherapy seems to conflict with the standard medical model (Koole & Tschacher, 2016). All theoretical orientations in the field of child mental health are ideally rooted in a strong therapeutic relationship (Landreth, 2012; Ray, 2021). This relational emphasis creates distinct differences between psychotherapy and medical services. In child and family counseling, those coming for therapy are referred to as *clients,* whereas in the medical field, the term is *patient*. In the medical field, a patient receives a treatment believed to cure the patient's problem with no need for a relationship between the patient and the medical practitioner (Koole & Tschacher, 2016). Contrarily, therapists providing mental health services rely upon the therapeutic alliance to create the necessary connection, rapport, and trust for the therapy to be most effective.

The standard medical model does not fit the broader case conceptualization process unique to psychotherapy (Gehart, 2015). A mental health professional needs to conduct a full intake that considers the context of the child client's multiple systems and lived experience for case conceptualization, but there is no need for a medical doctor to have a complete biopsychosocial understanding of the patient's life to treat the patient's medical problem.

Many mental health professionals find it challenging to operate from the medical model while honoring the therapeutic alliance. And yet assigning a diagnosis and maintaining a clinical record is a necessary reality for most therapists (Ray, 2021). Mental health professionals are required by third-party payers to establish *medical necessity* for the client's participation in psychotherapy (Stockton & Sharma, 2019). Medical necessity must be documented with particular language in the clinical record. To meet the requirement of medical necessity, services

must be evidence-based and appropriate for diagnosing and treating a disorder (Wiger, 2020). While some clinicians have the privilege of providing services outside of the medical model and can, therefore, avoid diagnosis and goal setting, most families in the United States need to use their health insurance to participate in psychotherapy. As a result, mental health professionals paneled as providers with insurance companies and Medicaid must have one foot in the medical model and the other in their chosen theoretical orientation(s).

The concept of treatment planning was born out of the medical model, not from the original psychotherapy theorists (Gehart, 2015). According to Luepker (2022), the medical model has advantages:

1. The medical model provides a clear structure and legitimizes mental health services in the eyes of the managed healthcare system.
2. Competent recordkeeping can be a framework for supporting the therapeutic alliance from the start of therapy.
3. Recordkeeping can ensure continuity of care if the client is referred for other services.
4. Recordkeeping protects clinicians from accusations of poor quality of care or lack of professionalism.

## PLAY THERAPY AND THE MEDICAL MODEL

Play therapy is considered the most appropriate modality for supporting children with mental and emotional health challenges (Ray, 2021; Wonders, 2021a). Just as in the greater field of psychotherapy, play therapy includes a variety of seminal and historical theoretical orientations (Wonders, 2021a). Establishing the medical necessity of play therapy during treatment planning and documentation may initially seem daunting, given the relational emphasis of all play therapy seminal theories and models. But play therapy can be supported as medically necessary because *one* of the many benefits of play therapy is that it supports children's acquisition of developmental milestones. According to the American Academy of Pediatrics, this meets the requirement of medical necessity (Giardino et al., 2022). Play is the natural way children access and explore their inner and outer worlds, make meaning of experiences, process perceptions and emotions, meeting physical, cognitive, and emotional milestones (Hancock, 2021; Rathnakumar, 2020). Play therapy provides children with a designated space and time to playfully explore, express thoughts and feelings, and gain a sense of empowerment through play (Landreth, 2012; Ray, 2011; Schaefer, 1993). Given the literature about the powers of play as children's natural means of growth, healing, and change (Bratton et al., 2005; Hughes, 2021; Schaefer & Drewes, 2013), therapists providing play therapy can feel confident that with proper documentation the use of play therapy can both satisfy theoretical orientation guidelines and medical model requirements.

While child therapists working within the required parameters of third-party-payers need to have one foot in the medical model, it is important, at the same time, to avoid pathologizing or stigmatizing children (Kohrt et al., 2020; Suhr & Johnson, 2022). When a child receives a potentially stigmatizing diagnosis, it may negatively color the child's self-view or influence negative perceptions of the child by those aware of the diagnosis in the family, school, or community. It is important to utilize the medical model's necessary aspects while discerning when assigning diagnoses. Additionally, therapists need to be aware of

the pathologizing risks of using certain medical model terminology. Being sensitive and informed about various populations can inspire therapists to seek more inclusive terminology. One example of using inclusive terminology is to refer to the adults bringing the child to therapy as *caregivers* rather than *parents* because not all caregivers are parents. Often children are in foster care or raised by an aunt, uncle, grandparents, adult cousin, or older sibling. Additional inclusive terminology can help to avoid unnecessary pathologizing of the presenting challenges that many children face resulting from traumatic events, neurodivergence, or systemic barriers such as racism, antisemitism, and ableism. Traditional terminology is often used, such as *parent, treatment plan,* and *presenting problem* in this book but also may use more inclusive terms, such as *caregivers*, *therapy plan*, and *presenting challenges*. While the spirit of this book seeks to provide a broad and inclusive process of conceptualizing and planning for therapy with children and families, the terminology and perspectives contained herein are purposefully varied to harmonize requirements of managed healthcare documentation with efforts to avoid pathologizing children.

While some clinicians can work outside of the medical model to avoid diagnosing children altogether, it is more common that mental health providers participate as paneled insurance providers. Knowing how to use DSM-5-TR criteria to direct therapy without stigmatizing or unnecessarily pathologizing children is essential (Kohrt et al., 2020; Suhr & Johnson, 2022). While children's behaviors may seem to align with items on the symptom lists for various disorders in the DSM-5-TR, therapists might first consider the underlying reasons for the behavior and the context for an individual child through a non-pathological perspective (Probst, 2006).

## DIAGNOSTIC IMPRESSION AS A GUIDE

At the beginning of therapy services, there is a presenting concern or challenge, often referred to, in traditional medical terminology, as the *presenting problem*. Rather than seeing it as a problem to be solved, however, a more inclusive way to frame this concept is to see it as a challenge through which the client can learn and grow in therapy. The presenting challenge most often motivates caregivers to seek therapy for the child. Identifying the presenting challenge will be one stepping stone on the path to determining a diagnostic impression, which provides a launch toward case conceptualization and the therapy planning processes (Schwitzer & Rubin, 2012; Wonders, 2021b). The root of *diagnosis* is the Greek word *diagignōskein,* which means *to distinguish* or *discern*. While the term *diagnosis* has since become associated with the scientific determination of pathology, it may be worth revisiting the root meaning to use the diagnostic process as a directional sign for the therapeutic journey toward the most optimal route to take rather than a fixed determinant. Doing so will aid in the effort to avoid pathologizing children and instead lead to seeking to understand underlying causes for behaviors and develop a plan to support the resolution of those underlying causes.

While listening for concerns and challenges, the clinician identifies symptomatic patterns that align with the diagnostic criteria outlined in the DSM-5-TR. While there has been discussion about perceived problems with the DSM-5 (Clark et al., 2017; Michelini et al., 2020; Wakefield, 2016; Yager, 2017; Ross & Margolis, 2019), we can mindfully employ symptomology and the diagnostic criteria as a starting point for conceptualization and therapy planning (Jongsma et al., 2014; Wonders, 2021b). The initial working diagnosis can be established early during therapy, pointing the clinician toward a path to gain a greater understanding of what

the client is experiencing and needing through case conceptualization (Schwitzer & Rubin, 2012). Ideally, the child, caregiver(s), and therapist will work together to determine the presenting challenge on which the therapy will first focus (Hawley & Weisz, 2003; Zubernis et al., 2017). As the case conceptualization process unfolds, fluidity is important as often the presenting challenge can be merely a directional sign pointing to a bigger or deeper challenge (Wonders, 2021b). The initial diagnosis will sometimes change during case conceptualization and through treatment based on new information gained. The diagnosis, therefore, need not limit the course of therapy to one direction but rather serve as an initial cue guiding the therapist to begin shaping the course of therapy and the plan for best supporting a child's challenges while remaining flexible as needed if new information is presented.

## CASE CONCEPTUALIZATION

Sperry and Sperry (2020) assert that case conceptualization is the one competency counselors most need subsequent to forming the therapeutic alliance. The authors define conceptualization as a process for developing a map that guides counselors in understanding and addressing the reasons for a client's presenting concerns. Case conceptualizations provide the landscape from which interventions can be chosen and applied to achieve therapy goals. According to Sperry & Sperry (2020), there are eight elements they call "the eight P's" that illustrate the elements of case conceptualization:

**Presentation:** symptoms, expressed concerns, therapist's observations

**Predisposition:** biological, psychological, and social factors

**Precipitants:** causative or coinciding stressors such as pain and trauma

**Protective Factors and Strengths:** secure attachment, coping skills, positive support systems

**Pattern:** predictable and persistent personality tendencies

**Perpetuates:** processes through which patterns are processed and perpetuated

**Plan:** goals, objectives, clinical decision-making, and ethical considerations

**Prognosis:** forecast for client's expected response to therapy

The case conceptualization or formulation process begins when caregivers first initiate therapy, and this process continues throughout the phases of therapy. The initial step occurs in the first phase of therapy and, more specifically, in the intake session. From there, the lion's share of the work happens in the intake process. The intake provides the opportunity for the therapist to gather multifaceted information that will evolve into a holistic framework of understanding what the child is experiencing currently, what has contributed to these experiences in the past, and how therapy can best support growth, development, relief, and healing (Thomassin & Hunsely, 2019).

## THE INTAKE

As the therapist is meeting with caregivers, there are three processes practiced simultaneously: (1) building trust and rapport between the therapist and caregivers, (2) collecting information