# PLAY THERAPY DOCUMENTATION ESSENTIALS

A Child-Centered Approach
to Case Conceptualization
and Treatment Planning

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# Introduction

I have never loved documentation. In fact, I resented it, avoided it, drudged through it. I checked the boxes and wrote what I needed to write in order to move on to the more important work: the relationship with my clients. Historically, this viewpoint—that documentation is done "after the important tasks are complete"—is one shared across health care disciplines: social work (Gelman, 1992, p. 73), marriage and family therapy (Chenail et al., 2009), and counseling fields. If you are anything like me, documentation has always felt like a necessary evil, not something vital to your therapeutic work. An administrative task that is clinically meaningless but required to get paid.

Documentation generally includes a written intake assessment, a treatment plan, progress notes, and a termination summary. And in the era of managed care, for clinicians to be reimbursed for clinical services, treatment plans must include a set of measurable goals that meet medical necessity for treatment for a particular diagnosis. This is particularly challenging for humanistic or depth-oriented clinicians like myself, who view goal-focused treatment planning as antithetical to how change occurs: through the unconditional positive regard, congruence, and empathic understanding found within the therapeutic relationship, not by directing the client to focus on the problem. Goal-focused treatment planning, with its focus on evaluating and directing, runs counter to the theoretical foundation of child-centered play therapy (CCPT), the *person-centered theory of change*. This theory holds that providing the client with core conditions for change, such as nondirective understanding and listening, will increase their internal resilience, which will, in turn, change or decrease their maladaptive behaviors (Rogers, 1980).

In addition, for us as child therapists, it's even more difficult to develop a treatment plan and assess progress toward goals because the child rarely mentions their problem, symptoms, or challenges. Instead, the child is brought to therapy to address the caregiver's concerns. If we were to focus on the problem in session with the child, this would inherently conflict with CCPT's theory of change. But what if there were a method of treatment planning and documentation that aligned with this theory of change *and* met the needs of insurance companies, caregivers, and clients alike?

Over time, I have developed such an approach, which I've outlined in this manual. Through stories and examples from my experiences as a play therapist, I will share with you how to translate the beauty of your work with children in the playroom into understandable deliverables to caregivers and managed care companies while staying true to the CCPT theory of change.

This framework has been incredibly helpful to me and those who have attended my child-centered documentation (CCD) trainings, and I am delighted to be able to put it on paper for others to try. But before delving into it, I'd like to share with you how I got to this point.

## My Relationship with Documentation

My journey as a therapist began in a Medicaid-funded community mental health clinic. There, I worked with children and families oppressed by the very systems that were supposed to support them. To me, the required documentation was just another form of oppression. I had to document and pathologize my clients' *completely understandable* responses to stress and trauma using medically necessary language to receive funding for therapy.

In addition, there was just too much paperwork. I spent so much time just trying to get through the required paperwork that my clients got the last of my energy. I wanted and needed it to be the opposite, but I was bogged down by the administrative expectations. Between an enormous caseload to serve, endless and meaningless paperwork requirements, and ultimately, a dwindling passion for clinical work, I was burning out.

So I took the leap to private practice. With different funding sources and fewer observable and specific requirements, I relished being my own boss. I wrote the bare minimum in progress notes and the simplest treatment plans. But what was liberating initially didn't give me the tools I needed to succeed. Not having a clear treatment plan and meaningful documentation was getting in the way of optimal clinical work.

It was when I met a child client—who we'll call Daisy—that this became clear. Daisy's parents brought her to me for play therapy because of her behavior difficulties. I saw her between the ages of seven and ten, and during that time, Daisy's play transformed. The stories she played out in the playroom grew in complexity and seemed to have a transcendent feeling. I observed her—literally, through play and the relationship—building a safe place to be herself. She was creating the internal organization and structure she needed to thrive in the outside world.

Daisy's caregivers, however, needed "data points." They could not understand how "just playing" with Daisy was going to decrease her problematic behaviors. They needed answers—and I didn't have them. I couldn't explain to them how play was helping her reduce her symptoms in the outside world. I had been trained in play therapy, I knew it was powerful, and I knew it was helping her to be stronger on the inside, but I didn't know how to explain to Daisy's caregivers *how,* through play, we were working on her symptoms and behaviors they were concerned about. This work, and the progress Daisy was making, was in a language only I understood. I could not convey to them, or anyone else, how these meaningful moments in her play were powerful examples of change.

I realized that my first problem was not having a clear treatment plan. My aha moment was recognizing that a clear treatment plan was important, not just for the agency, billing, or administrative requirement, but to illuminate to Daisy's caregivers, and even myself, what we were working on in CCPT. Those data points of change were essential for more than just the agency; they were also a road map for me, the caregivers, and other stakeholders.

Motivated to more deeply understand how change was occurring so that I could "prove" to Daisy's caregivers that she needed to continue therapy, I went home that weekend and laid out the pictures I had taken of her sand trays, artwork, and play creations (i.e., her visual chart). Then, I created a timeline of her teacher and caregiver reports to understand how her behavioral symptoms were changing (i.e., the clinical record).

This process made me realize that something crucial was missing from traditional treatment plans and documentation. The clinical documentation required for managed care didn't adequately reflect what was happening in the therapy room. Through play and the relationship, Daisy was becoming stronger on the inside, which, in turn, was giving her more flexibility and resilience to respond to everyday challenges. I needed to find a way to communicate how the nuanced changes in Daisy's play were ultimately going to lead to behavioral change. This was the beginning of the CCD framework: a way to meaningfully connect what is happening in the playroom to the caregivers' concerns, to insurance requirements, and to the medical model of change.

As a therapist, you've likely had times when you felt pressure from caregivers and other stakeholders (e.g., teachers, school personnel) to "fix" the child's symptoms, while at the same time experiencing meaningful moments in the playroom that you knew were signs of progress. As you read my story, I imagine that you connected to those contrasting feelings of truly believing in the healing power of play and the relationship and struggling with the pressure to "do more" to "fix" the symptoms faster. That tension can often lead you to engage in incongruent encounters in the play therapy. This means that despite knowing in your heart that the child needs presence and care, you direct the play or verbal interaction to address the concerns because you feel anxious about pressure from caregivers or others who are frustrated by the child's behaviors. I recall a vivid example of this.

Early in my play therapy career, I was working with a six-year-old client, whom I'll call Jaya, throughout her father's terminal cancer diagnosis, subsequent decline to hospice care, and eventual death. We hadn't "talked about" her father's death. In fact, we hadn't talked about much at all. Jaya would come into the playroom each week and sort through the foam stickers by color and shape, choosing a few to add to a small card that she would take home. The surviving parent was putting pressure on her to "process the grief" faster and kept asking if she was talking about the death. I felt concerned that I wasn't doing enough, and I asked Jaya a direct question about her feelings about her father's death. For the first time, her energy shifted, her face turned red, and her drawing became harder and faster. She drew on her paper a very large stop sign, pushing her crayon on the page so hard that it shed chunks of red crayon.

I felt awful that I had pushed Jaya further than she was willing to go at the moment. She didn’t have control over her father dying or even people bringing it up in her life—her whole world had been surrounded by her father’s cancer diagnosis, treatment, and eventual death for over a year. She relished in the silence in the playroom, where she could sort and organize her world, creating a small image to take with her each week. Each session, Jaya would collect pirate foam stickers and hearts of various colors and sizes. The pirate image was always in the center, sometimes with a cloud or a rainbow.

Only upon reflection did I realize that at the end of her father’s life, he had a patch over his left eye, similar to the pirate foam stickers. Something meaningful was happening in therapy, and it was happening at Jaya’s own pace. What a gift to have the silence to process and express that which was inside of her, in her own medium and without pressure to talk or do it “faster.” But I fell into the trap of pushing her because I felt pressure. It was incongruent with what I know and appreciate is the power of CCPT.

As CCPT therapists, we need support for staying true to the healing properties of CCPT while working in a society and field that (1) emphasizes verbal expression, (2) requires diagnosing a problematic behavior that meets medical necessity, and (3) inherently pressures us to move away from the very theory of change in CCPT. It is my aim to provide this support for you through this manual.

## The Child-Centered Documentation Framework

In these pages, I’ll present a new model for conceptualizing clinical work and treatment planning called the child-centered documentation (CCD) framework. The CCD framework weaves the theoretical underpinnings of CCPT—the person-centered theory of change—into a clear road map that will be the backbone of this manual. This road map will serve as a guide for treatment planning and will help both you and your clients’ caregivers understand how change occurs in CCPT, and how to view progress accordingly.

The CCD framework is based on a dual process of measuring progress—both quantitative (i.e., behavioral symptoms) and qualitative (i.e., internal growth in play therapy)—and demonstrates how this leads to your clients’ achieving long-term treatment goals. This manual will provide you with numerous tools and templates to increase your own understanding of case conceptualization; enable you to better explain the process of change to others, including caregivers; and guide you to implement the CCD framework in your practice. Finally, by reading this manual, you’ll improve your understanding of *why* treatment planning and documentation are important as well as *how* to complete the paperwork.

In short, implementing the CCD framework for case conceptualization and treatment planning will allow you to:

- Integrate managed care requirements with symptom-focused goals while staying true to the person-centered approach of change
- Translate the meaningful moments observed in play therapy sessions into a broader context that will support the client's reduction in behavioral symptoms
- Track and assess the client's internal progress toward growth in each CCPT session
- Find language to communicate growth and change to caregivers and other providers
- View documentation as a *meaningful opportunity* rather than *just a requirement* (and therefore be less likely to avoid or resent it)
- Be more congruent in your work with clients, trust the process, and feel confident in your approach

The term *congruence* has major significance throughout the book, so it may be helpful to define the term here. Rogers (1980) described congruence as both an internal, or *intra*personal, process and an external, or *inter*personal, process. Internally, it refers to the degree to which one is aware of and in connection with their authentic internal experience. The external aspect refers to the degree to which one communicates one's internal experience to another, such that the other experiences the communicator as a whole and integrated person. The internal aspect of congruence has been simplified to be synonymous with authenticity, while the outer layer of congruence could be seen as genuineness or transparency (Kaimaxi & Lakioti, 2021; Kolden et al., 2018; Rogers, 1980). Throughout this manual, I primarily use the term congruence to refer to the intrapersonal aspect, which enables the external aspect of congruence.

Also with regard to language use throughout this book, you will notice that I use the words *caregivers* and *parents* interchangeably—though I lean toward the former. Both terms refer to the adults involved in a child's treatment who are able to notice and assess measurable changes in the child's progress.

## How This Book Is Organized

This manual is divided into five parts. Part I covers the foundational considerations of the CCD framework. In chapters 1 and 2, we will discuss the medical model's influence on documentation as well as the ethical, legal, and billing considerations pertinent to documentation. We'll also explore the theoretical underpinnings of CCPT and the inherent conflict between CCPT theory and treatment planning.

Part II focuses on conceptualizing play therapy cases and developing treatment plans based on the CCD framework. Note that you won't get the details on how to *do* CCPT, but rather, you will learn how to conceptualize change as it relates to overall case conceptualization and treatment planning. First, chapter 3 will explain the CCD framework using graphic elements and examples. In chapter 4, we'll discuss the importance of setting the therapeutic frame, and you'll learn how to gather information using a five-session assessment format. Following that, you'll learn how to conceptualize cases using the CCD framework, and you'll meet Ophelia, a child whose case we will follow throughout the book. Chapter 5 will walk you through the sections of the CCD treatment plan and will address the importance of taking into account cultural considerations with regard to the language you use. Finally, chapter 6 will present Ophelia's treatment plan.

Part III is all about assessing progress. Chapter 7 looks at different models used to assess progress in play therapy: formal instruments, themes, continua of progress, developmental stages, and stages of play. In chapter 8, you'll learn how to blend parts of these methods together in the CCD multimethod assessment approach, which assesses a child's progress toward both symptoms and internal growth. In chapter 9, you'll have the opportunity to see how Ophelia's therapist assessed her progress throughout her therapy using the multimethod approach.

Part IV takes a deep dive into the task of writing progress notes. In chapter 10, I'll present a template for writing play therapy progress notes, and, again, we'll address cultural and language considerations. We'll return to Ophelia's case to look at some examples. Chapter 11 covers considerations for writing caregiver session progress notes and other special concerns for progress notes.

And, speaking of caregivers, part V focuses on the important issue of working with caregivers and systems in play therapy. Chapter 12 discusses several aspects related to communication with caregivers, and chapter 13 offers some solutions to common challenges that therapists face when working with caregivers and systems.

Part VI pulls everything together. Chapter 14 offers step-by-step guidance for implementing the CCD framework throughout the course of treatment, whether you are starting with a new client inquiry or an existing client. Finally, in chapter 15, I offer a brief review of what you've learned in the book, along with some words of encouragement as you put the CCD framework into practice.

In the appendix, you'll find numerous handouts and worksheets containing the tools presented throughout the manual, as well as additional useful resources. The appendix is organized into three parts: (1) Appendix A: Therapist and Caregiver Resources, (2) Appendix B: Templates and Worksheets, and (3) Appendix C: Quick Reference. My hope is that you will use these resources in your practice and that they will become familiar reference guides.