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PRINCIPLES, PRINCIPALS, AND PROCESS (P^3): A MODEL FOR PLAY THERAPY ETHICS PROBLEM SOLVING

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Abstract: *Little has been written about ethical issues faced by those providing play therapy. Play therapists working in a variety of settings need specific guidance on professional ethical issues relating to privacy, confidentiality, informed consent, therapist competence, multiple relationships, and treatment outcome. Basic ethical principles of child psychotherapy are reviewed for application to play therapy. An ethical decision making model, the Principles, Principals, Process Model (P^3 Model) is proposed for applying historical ethical principles to clinical situations. Specific clinical examples illustrate the application of the P^3 Model for play therapists.*

In order to obtain a graduate degree in the major disciplines of mental health counseling, social work, marriage & family therapy and psychology, prospective clinicians must demonstrate a basic knowledge of, and the ability to apply ethical principles in their work. The primary credentialing bodies of these disciplines require graduate ethics coursework as well as demonstrated ethics proficiency (an exam or CE course) prior to licensure (L. Freeman, Ethics and Professional Standards Office, American Counseling Association, personal communication,

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2006). Further, clinicians are required to include ethics training in their ongoing post-licensure/certification continuing education (L. Freeman, personal communication, 2006). Guidance in the area of ethical decision-making throughout the course of professional development has been critical to the point that major professional counseling organizations regularly revise and update their respective ethics codes. These organizations include the American School Counselor Association (ASCA), the American Psychological Association (APA), the American Association for Marriage and Family Therapy (AAMFT), the National Association of Social Workers (NASW), and the American Counseling Association (ACA).

Each of these organizations have ethical codes for their members, which have implications when providing play therapy (AAMFT, 2001; ACA, 2005; APA, 2002; APT, 2005a; ASCA, 2004; NASW, 1999). Members of these professional organizations have produced articles and textbooks applying these codes to specific ethical dilemmas in practice (Corey, Corey & Callanan, 2006; Cottone, 2001, 2003; Cottone & Tarvydas, 1998; Gladding, Remley & Huber, 2001; Jackson, 1999; Koocher, 1995, 2003; Koocher & Keith-Spiegel, 1990, 1998; Reamer, 1995; Remley, Hermann & Huey, 2003; Welfel, 2002, Woody & Woody, 2001a, 2001b).

In specialty disciplines, ethical guidelines and principles derive from the secondary credentialing body, the Association for Play Therapy (APT) in the case of play therapy. While APT has indeed promulgated its *Voluntary Play Therapy Practice Guidelines* (APT, 2005a), it does not act as an ethics regulatory body per se. Instead, APT encourages its members and requires its credentialees to adhere to those standards and ethics promulgated by the licensing boards or other certifying authorities in their respective states or primary mental health disciplines (APT, 2005b). Having derived largely from the codes of ethics of the major professional organizations noted above, the APT guidelines are relatively generic. Clearly relevant to the practice of play therapy, they are not specific to it. The play therapist is left without ethical clarity in the conduct of day-to-day clinical work.

This lack of clarity is not an insurmountable problem in its own right, as various models of ethical problem solving are available to assist with generic issues such as competence, boundaries, and confidentiality (Corey, et al, 2006; Koocher & Keith-Spiegel, 1990, 1998; Welfel, 2002; Woody & Woody, 2001). However, the trainee or clinician who specializes in play would benefit from more specific guidance in play therapy related issues, such as choice of modality or technique, selection of playroom materials, documentation, and physical contact.

Since those training to become Registered Play Therapists (RPT) and Registered Play Therapist-Supervisors (RPT-S) must first obtain a Master's degree, logic would suggest that graduate school be the first best place to learn about play therapy-relevant ethics. However, research has demonstrated that less than half of surveyed practicing play therapists have taken a graduate course in play therapy (Kranz, et al, 1998; Phillips & Landreth, 1995). These two research surveys, as well as that by Kranz, Lund & Kottman (1996) indicated that while curricular topics such as "clinical problems" and "current issues" are considered to be important training domains, play therapy-related ethics are rarely mentioned.

Another of the requirements for becoming either an RPT or RPT-S is 150 clock hours of formal play therapy education. This may take the form of university-based graduate coursework, continuing education available at local, state, or national conferences or online learning institutes. With this breadth of available learning options, it would seem that training in play therapy ethics would be readily available. However, this too is not the case. While more universities are offering at least one graduate level play therapy course (Jones & Rubin, 2005), play therapy curriculum standards are only suggested (APT, 2005c), and instructors are not required to include an "ethics" component in their course work. In a combined total of twenty-eight graduate play therapy course syllabi reviewed, "ethics" was referenced in less than half, and in none of them was it made clear how ethical issues could be addressed in actual clinical practice (APT, 2005c; Jones & Rubin, 2005). Further, as of this writing, the Association for Play Therapy currently has only a single

one-hour play therapy ethics program available through its directory of online courses (APT, 2005d). Finally, a review of the programs available at the national APT conferences over the last ten years indicated that on average, only 1.8 hours of training per annual conference were devoted directly to legal/ethical issues (Diane Leon, APT staff member, personal communication, 2005). Clearly, play therapy ethics training is limited in its availability in the classroom, online, or at national play therapy conferences.

The 28 syllabi noted above were culled for the texts most widely used to teach introductory play therapy courses: Bromfield, 1997; Giordano, et al, 2005; Kottman, 2001; Kottman & Schaefer, 1995; Landreth, 2002; O'Connor, 2000; O'Connor & Braverman, 1997; Schaefer, 1993; Schaefer, 2003; Schaefer & O'Connor, 1983. Of all of these texts, only Kottman (2001) had a chapter devoted specifically to ethics and professional issues. In the remainder of the texts, confidentiality, privacy, privilege and informed consent were usually addressed only in a broad clinical sense, while more general guiding principles such as autonomy, beneficence, justice, and fidelity were largely absent.

This foregoing discussion suggests that clinicians generally lack clear guidelines when it comes to ethics and ethical problem solving in play therapy. While the more popular ethics texts mentioned above may very well be useful in addressing generic counseling dilemmas, they are, for the most part linear, dilemmatic, and principle-driven in nature. They are also silent with regard to some of the unique multi-layered ethical dilemmas that are present to play therapists, such as competence, choice of treatment modality and materials, inclusion of siblings, physical contact, and confidentiality among the various principals in the system. Therefore, an integrative play therapy-relevant model of ethical decision making, the Principles, Principals, Process (or P^3) Model, is proposed for play therapists from many disciplines in applying their historical ethical guidelines to specific ethical challenges faced in play therapy.

THE PRINCIPLES, PRINCIPALS, PROCESS MODEL (P³ MODEL)

Background for Developing the Model

During the mid- and late-twentieth century, mental health professionals in psychology, social work, counseling, and family therapy developed professional ethics codes based in part from medical codes developed through the centuries. Therapists specializing in services to children have contributed to the development of these mental health ethics codes to give more specific guidelines for their specialty area. With increasing numbers of therapists from each of these disciplines self-identifying as play therapists, there have been suggestions for the development of a more specific ethics code and decision making model for play therapy (Jackson, 1999; Jackson, Puddy, & Lazicki-Puddy, 2001).

Early ethics codes for child therapists, such as the ones developed by Rest (1984) and Kitchener (1984) were based on *a priori* rules and principles derived from earlier codes and applied to specific clinical situations through a rational analysis. Cottone and Claus (2000), in a review of developing ethics codes, described how the liner-based ethics codes and decision making models have been evolving to more contextual-based process models. The linear, hierarchical approach of the principle-based models is not always readily applicable to the many factors present in any given clinical situation. Recommendations for a better ethics decision making model have included writers such as Koocher and Keith-Spiegel (1998), Corey, Corey, and Callanan (2006), and Welfel (2002). Betan (1997) has suggested that since the ethical decision is made in the context of a therapeutic relationship, then relational, as well as rational factors, should be considered in any ethics code and decision making model. There should be a deliberative process that evaluates the contextual factors as well as the *a priori* principles.

An ethics decision making model specifically for play therapists is proposed, the Principles Principals Process Model, which combines the historical ethics codes *(Principles)* of the professional disciplines providing play therapy with the contemporary voices of all the persons *(Principals)* involved in the ethics circumstance through dialogue

(*Process*). The P^3 Model recognizes that play therapists come from several disciplines, with some variety in training, professional identity, and ethical/legal obligations defined within their discipline (AAMFT, 2001; ACA, 2005; APA, 2002; APT, 2005a; ASCA, 2004; NASW, 1999). The P^3 Model builds on the premise that since psychotherapy is fundamentally relational, social context is crucial in any ethics guidelines for practice. The model also provides a balanced approach, following the suggestion of Betan (1997) for a model that is "an integration of the models emphasizing moral reasoning about rules and principles" (p. 357).

The Principles

The major ethics guidelines, often referred to as aspirational or virtue ethics (Corey, Corey, & Callanan, 2006), have been described by Kitchener (1984) and applied more specifically to child therapists by Daniels and Jenkins (2000). *Autonomy* emphasizes the client's freedom of choice and action, important to a child's development and maturity. *Beneficence* is promoting the child's welfare, what is in the child's best interest. *Nonmalfeasance* builds on the ancient Hippocratic Oath, with avoidance of anything harmful or damaging to the child. *Fidelity* is the quality of faithfulness and loyalty, of maintaining the child's trust. *Justice* refers to maintaining a sense of equity and fairness in the therapeutic relationship, avoiding any discrimination and advocating for client needs. *Veracity*, or truthfulness, emphasizes the importance of the therapist developing openness and trust needed for the therapeutic relationship.

These historic principles lend objectivity to ethical decision making, giving a balance to the excesses of moral relativism and the individual moral intuition of the therapist who simply believes, "this course of action feels right to me." The broadness of the principles does not always lead to a clear application in matters for example, of confidentiality, dual relations and competence. Purely rational approaches to applying the principles can lead to hazards of therapist detachment from the emotional, relational, and cultural factors of a given ethics circumstance. Emphasizing the rational process of the

therapist can silence the other voices in the circumstance: the voices of the child, family, community, and profession. The therapist as ethical decision maker is always in the end a participant-observer, and in this role has both an opportunity for a clearer view that comes from direct experience, and a blinded view that comes from personal difficulty in attending to all of the voices involved (Betan, 1997). The principles applied through only a personal rational process of the therapist results in violation of the very principles being applied: client autonomy and trust can be compromised, and justice can be reduced to arbitrary decisions that result directly or indirectly in some form of client harm.

In further consideration of the double-edged nature of ethics principles, the play therapy practitioner must consider that the very choice and implementation of a particular theoretical model is informed by its own unique and implicit ethical underpinnings and the implications that flow from them. For example, practitioners of non-directive play therapy conceptualize the locus of therapeutic change very differently than do directive practitioners. The fundamental perception of client autonomy dictates that it is the client rather than the clinician who determines the focus of and activities in each therapeutic encounter. Similarly, the fundamental deterministic perception of human nature by psychoanalytic play therapists may challenge client autonomy and compel more directive (interpretation-based) intervention. While authors (Kottman, 2001; Landreth, 2002; O'Connor & Braverman, 1997; Schaefer, 2003; Schaefer & O'Connor, 1983) of various theoretical persuasions do reference the practical importance of issues such as confidentiality, informed consent, and autonomy, rarely do they address the implications of their model for ethical practice. Without appreciation of these underlying ethical presumptions, the clinician is at risk of selectively applying theory-based techniques that undermine either their own ethical belief system or the guidelines noted above.

The Principals

In an attempt to minimize harm that can occur when virtue ethics are applied primarily through the personal rational application of

the therapist, some writers have suggested balancing the therapist's voice with the voices and experiences of the other people involved in the therapeutic relationship. The principles of virtue ethics need to be applied with input from all of the principals of the therapeutic relationship, who are the"4 C's": client, counselor, collaterals, and community.

The client's voice is vital in applying the ethical principles. Feminist (Hill, Glaser, & Harden, 1995) and empowerment models (Daniels & Jenkins, 2000; McWhirter, 1991), with an emphasis on the principle of autonomy, remind play therapists of the power differential between them and their clients. This can be even more challenging for the play therapist, who as an adult, can be seen by the child as automatically aligned with all other adults, including parents and collateral relationships such as teachers. The therapist's voice, through self-awareness (or lack of self-awareness) influences both the therapeutic relationship and any ethical decision making within the relationship (Bernard & Jara, 1986; Bernard, Murphy, & Little, 1987; Weinberger, 1988; Smith, McGuire, Abbort, & Blau, 1991).

A play therapist needs to be keenly aware of countertransference with child and client family members and how personal distraction of the therapist can have a bearing on ethical decision making. Factors external to the therapeutic relationship, such as the therapist's family stress, health, or financial circumstances can influence the ethical decision making process. Each of these factors need to be within the therapist's awareness and control to minimize negative ethics impact. As stated by Betan (1997), "in addition to moral reasoning, the context of the therapeutic relationship and the therapist's subjective responses are fundamental considerations in the interpretation and application of ethics interventions" (p. 348).

Collateral voices of family members, other professionals working with the child (such as teachers or other clinicians), and the supervising therapist are also added to the ethics discussion and decision making process (Cottone, Tarvydas, & House, 1994). These voices are a part of the social context which has contributed to the child's

and family's efforts to define problems presented in play therapy and potential solutions to those problems. Depending on therapeutic approach, play therapists practice a range of approaches to include family members in session. Play therapy models vary to the degree that collateral voices are directly included in the therapy session. Whatever the model, therapists are mandated by both ethical guidelines and legal requirements to include the parent(s) or legal guardian(s) in all treatment and decisions regarding minor children (Corey, Corey, & Callanan, 2006; Koocher & Keith-Spiegel, 1998, 2002; Woody & Woody, 2001). The social context provided by the inclusion of collateral voices enhances the therapist's ability to better understand how to apply major ethical principles, particularly autonomy (context of human development in relationships), beneficence/non-malfeasance (discovering the full range of resources and options in the best interest of the child), and veracity (maintaining clarity of purpose and communication to child, family, and collateral members).

Community voices also need to be included in ethical discussion and decision-making. Play therapists need to be aware of the principals in the community as they represent the influences of gender, race, ethnicity, and culture that are impacting the therapeutic relationship (Canino & Spurlock, 2000; Gil & Drewes, 2005; Pederson, 2000; Roopnarine, Johnson, & Hooper, 1994; Sue & Sue, 1999; Webb, 2001). Cultural influences shaping the context of the child and family can include such dimensions as male/female roles for children, parenting styles reinforced by the culture, and ethnic variations in family structure and function. Professional ethics codes and licensing laws are based on an implicit understanding that the codes and laws are present to protect the public (Corey, Corey, & Callanan, 2006; Woody & Woody, 2001). When play therapists work in highly regulated settings such as licensed treatment centers or hospitals, there are additional guidelines that have to be heeded. Play therapists employed by organizations will also have the influence of agency policies and possibly administrative accountability to non-clinical supervisors. All of these voices shape the final ethical decision made in any particular clinical situation.

Ethics Discussion and Decision Making Process

The P^3 model is a heuristic process through which play therapists can apply the historical principles of virtue ethics in the context of the therapeutic relationship and the many factors affecting that relationship. With many voices inherent in any therapeutic context, the play therapist can become well-attuned to each of these voices and be prepared to interpret the priorities imposed by the principles to clinical situations that will have competing "goods." According to this model, the play therapist facing an ethics question can follow three steps. First, the therapist identifies the specific principles (virtue ethics, specific professional ethics codes, and legal codes) and principals (client, counselor, collateral, and community voices) that can offer guidance to resolving the ethics question. Then, the therapist reviews those principles from the perspective of each of the principals, directly involving the principals where possible. Finally, the therapist facilitates a recursive dialogue concerning the principles (Betan, 1997; Corey, Corey, & Callanan, 2006; Hill, Glaser, & Harden, 1995; Koocher & Keith-Spiegel, 1990, 1998; Welfel, 2002) with the principals to develop a shared understanding that will inform an ethical decision.

The play therapist facing an ethics question begins by listing all of the principles involved in the dilemma. On the broader scale, what are the major virtue ethics principles that will guide the therapist? From the ethics codes of the therapist's primary discipline and license, what are more specific guidelines that may clarify the best course of action? Are there guidelines from other sources such as local regulations or employer policies that may be applied? With all of this information, the play therapist then turns to the principals involved in the dilemma. What are the beliefs and values of the client and client family that come to bear in this situation? What are the play therapist's personal beliefs and values, and the therapist's awareness of how they may effect both the assessment and the outcome of the ethical dilemma? What suggestions may the play therapist get from consultation with clinical colleagues or supervisors? What additional voices of diversity may need to be heard to illuminate the ethics issue in its fullest social/cultural

context? Including these dimensions of principles and principals becomes a complex process that reflects the complexity of most ethical dilemmas. The following two cases (drawn from the authors' clinical experiences) will illustrate how a play therapist may apply this model on a day-to-day practice.

APPLYING THE P³ MODEL

Bobby's Story

Bobby, age seven, was referred by his school counselor whose initial concern was his "immaturity" (dependency, tantrums and low-frustration tolerance) and difficulty working under the pressure of time during standardized testing. Bobby, the younger of two siblings, struggled during early childhood with vision and hearing problems, which impacted academic achievement and self-esteem. These factors, in conjunction with his short stature, an uninvolved father and a highly competent older brother led him to view himself as inadequate and as something of an outsider in his own family. As a result, Bobby was prone to tantrums when he did not get his way, when task success was not imminent, and whenever he perceived his brother receiving more attention or privileges than himself. After several sessions of play assessment, which included both Bobby and his family, it was decided that individual child-centered play therapy would be alternated with parent counseling by a licensed mental health counselor/Registered Play Therapist. Bobby was typically accompanied to counseling by his mother and brother, who both sat in the waiting room. However, Bobby's brother, being only three years older, expressed the desire to join his brother in session and was captivated by the toys and games and wondered aloud "what does he do in there all the time...play?" Aware of Bobby's need to have a special place apart from his family (particularly his brother) as well as his right to confidentiality and treatment, the therapist struggled with whether and how to include the brother without violating boundaries and privacy, or exacerbating the sibling rivalry.

P[1]*: Identify the Principles.* Given the intensity of Bobby's struggle for a place of power in both his family and in his life, and the need to resolve the larger systemic conflicts, it was crucial to promote his personal growth *(autonomy),* to help all involved *(beneficence)* while maintaining allegiance to any statutory and/or ethical requirements *(fidelity).* With this in mind, the primary ethical principle of concern was that of *confidentiality.* In this context, Bobby had the right to express and play out his concerns without his brother knowing them. Secondarily, and even though he was only seven years old, and his parents did have the legal right to know the details of the treatment, Bobby still had the right to work in privacy. The next principle concern was that of *who is the client?* While it takes a family system to engender and maintain a sibling rivalry, and all could clearly benefit to a greater or lesser degree from intervention, Bobby had been identified as the primary client. In this context, the issue of *competence* had to be considered as the therapist asked himself whether or not he had sufficient systemic training to work with the family or should instead refer to a clinician who specialized in this form of treatment. This brought to light the final principle, following the mandates of *appropriate treatment.* In weighing this particular consideration, the therapist weighed the appropriateness of including or excluding Bobby's brother based on the changing linear and systemic demands of the case. Relatedly, he determined whether or not the boundaries and goals of client-centered play therapy would be violated by inclusion of the brother, even if Bobby consented to it.

P[2]*: Identify the Principals.* As the identified client, Bobby was the primary principal in this case, and as was noted above, his treatment and confidentiality needs were the therapist's primary concern. While Bobby's brother was not identified as struggling with social, emotional or behavioral issues, he contributed, both knowingly and unknowingly to the rivalry that oppresses his younger sibling. It was considered that he would also benefit from inclusion in select sessions with Bobby, in which context, confidentiality could be explained to him, and as a result of which, sibling relations could be directly addressed by the therapist. Bobby would also be consulted regarding this possible course of action.

The parents, particularly the father, were also principals who needed to be considered in making the decision. Given the father's isolation from his family, inclusion of Bobby's brother, and perhaps even the parents, was considered helpful in repairing the larger family system. Still another principal in this case was the therapist, who as it turned out, struggled during his own childhood with intense feelings of rivalry toward his older brother. Countertransference feelings had the potential to interfere with the therapist's willingness to include Bobby's brother in session. Expanding the circle of principals beyond the immediate family, the therapist had to consider the potential role of the school counselor who initially referred Bobby, as well as the possible impact on the referring community of expanding treatment beyond the "identified client."

P³: Identify the Process. In light of the principles and principals identified above, the therapist had to consider whose interests were paramount, Bobby's, his brother's or those of the family. While inclusion of Bobby's brother may have exacerbated the rivalry and his feelings of displacement, the issues could also have been directly addressed in session with both brothers. In this context, confidentiality would have been expanded to both boys, and Bobby's right to privacy would be considered secondary to assisting them to better the sibling relationship. An expansion of Bobby's treatment to include not only the brother, but the parents, may have helped to repair the systemic damage that fuels both the sibling rivalry and the father's alienation from the family. These decisions would have been contingent, on the therapist's willingness and ability to explore and resolve the therapist's own countertransference, as well as competence in sibling and/or family-based child-centered play therapy. Once the therapist was able to balance the competing demands of the principles and principals in this case, he could then begin to assist Bobby and his family while maintaining Bobby's autonomy and the therapist's own fidelity to the therapeutic process. Further, by having addressed the therapist's countertransference feelings in supervision, consultation or counseling, the therapist could more easily resolve the dilemma in the therapeutic

relationship.

Bill's Story

Bill (age 9) was seen for six play therapy sessions during the past 10 weeks to help with difficulties in behavior and performance at school. In parent sessions, it was discussed how family stress may be distracting Bill. At the next session, Bill's mother informed the therapist that she had taken the therapist's feedback about family stress seriously and that she saw an attorney and decided to divorce Bill's father. She reported that the attorney asked her to ask the therapist if he would testify at the custody hearing to the opinion that Bill's father was problematic, hence custody should be awarded to the mother. The next day, Bill's father appeared at the therapist's office unannounced and demanded that he be immediately given a full set of copies of all of Bill's records.

P[1]*: Identify the Principles.* This example illustrates how the ethical principles intertwine with each other. The strain of current family stress limited Bill's autonomy by constricting his ability to perform well at school and maintain acceptable behavior. Bill's parents were exercising autonomy through decisions of the future of their relationship and family structure, and the therapist's views began to shape that autonomy. With decisions pending, the principle of beneficence and justice placed the best interest of the child in the center of the discussion, as the person most vulnerable in the family. The therapist had an influential role in shaping the outcome for this child and family, so the therapist needed to be sure to avoid doing harm (non-malfeasance) by increasing the reactance of any of the persons involved. In further sessions, the therapist would need to take action to maintain a trusting relationship with the child and to attempt to build trust with the parents to demonstrate the principles of veracity and fidelity, giving the best opportunity for the family to self-direct (autonomy) their future with minimal intrusion of the therapist's point of view (non-malfeasance).

In addition to these broad ethical principles, Bill's case included some specific issues addressed by state laws concerning professional licensure, and state and federal laws regarding children, family life, and

the provision of mental health services. Had the therapist appropriately provided fully informed consent to Bill and his parents? Had the therapist defined the roles of play therapist and family therapist/family consultant clearly? Were they made aware of the limitations of therapy outcomes and the role and responsibilities of the therapist in high family stress with possible separation and divorce? Were the rights of each person made clear? Were the guidelines for accessing records clear and was there an office policy in place to appropriately respond to the father's request?

P²: Identify the Principals. While Bill as the primary play therapy client was at the center of the therapist's concern, there were several layers of relationships present in his story. The closest circle was Bill and his parents. Ethically, any "best interest of the child" outcome for Bill will need to be built on the pragmatic assumption that the best therapeutic outcomes will be those that can be sustained by those in his immediate environment, so the concerns of Bill's parents and therapeutic approach for them should be considered. A second circle includes the therapist with Bill and his parents, and if the therapist was working under supervision, then the supervisor was present in some fashion. Other principals may have included Bill's teacher, the parents' attorneys, and the therapist's office staff. Additional principals were the people in Bill's larger social and cultural context and the therapist's larger practice context of professional colleagues and regulators. The principles of beneficence and justice put the greatest weight on Bill and his best interests. The principles of non-malfeasance and justice pointed toward the necessity of any therapeutic intervention moving toward solutions that could have been sustained through a positive, cooperative effort of therapeutically engaging principals (directly or indirectly) throughout Bill's social and cultural network.

P³: Identify the Process. Having identified all of the principles guiding the ethical dilemma, and all of the principals whose voices might inform the final decisions of the ethical dilemma, the therapist would have summarized the contributions of principles and principals to develop the therapeutic response. The therapist may have needed to

consult with the written documents of specific professional codes or laws, which should always be close at hand to the practicing professional. Principals, such as supervisors, professional mentors, consultants with professional organizations, and state regulatory staff could have been asked for guidance on appropriate guidelines to follow in the case, or to clarify their concerns and needs regarding the case. The entire process required that the therapist follow confidentiality guidelines through authorized releases of information, informed consent descriptions of supervisory relationships, and appropriate disguising of personal information in consultations.

In Bill's case, the therapist would have needed to clarify with Bill's mother the therapist's comments on family stress. The therapist would also need to address her expectation of the therapist shifting from a therapeutic role to a custody evaluation role (and the ethical, legal, and clinical ramifications of that). Future plans might have included adding an additional therapist specifically for the custody role, or a therapist (or therapists) for the parent (or parents) to have adequate support for the stressful period of time. For Bill's father, it would be hoped that the therapist had clarified in the first visit that informed consent had been thorough, obtained from the parent who could provide it, and that clear definitions were given on a number of issues. These issues include the therapist's roles and limits, guidelines for including other family members, confidentiality guidelines for records and communication, and office guidelines so that office staff can stay within legal guidelines and handle requests in a polite and fair manner that reduces reactivity of family members. It could be that in future sessions, Bill's therapist would have to address these issues from a more tenuous position: re-negotiate the therapeutic contract with Bill's parents during a time of high stress (or offer appropriate referral and transition care, if requested), attempt to restore the therapeutic relationship with Bill, and respond in a legally appropriate, ethically sound, and therapeutically productive way to the demands of Bill's father. If the therapist would be able to do this, then it would be time to address the administrative issues regarding informed consent, communication, and confidentiality so that

the likelihood of future problems can be reduced.

Summary of Cases

Bobby's and Bill's case studies demonstrate the variations on how the P³ Model may be applied in play therapy practice. Bobby's case illustrates how the therapist balances the basic ethical principles and the developing inclusion of principals in the therapeutic direction of the play therapy. Bill's case illustrates how the therapist would apply the P³ Model in preparation for a play therapy session and in responding to sudden pressures placed on the therapeutic setting. In each case, the play therapist identifies and expands on the principles implied in the dilemma, and then identifies and gives voice to each of the principals in the dilemma to complete the process of making the ethical decision.

CONCLUSION

Over the past several decades, play therapy has evolved into a highly specialized discipline of study, as well as an effective modality of treatment. Its practitioners represent all of the major counseling and psychotherapy organizations, and provide services to diverse clientele with a breadth of clinical issues. As a result, play therapists have been confronted with an expanding array of complex ethical dilemmas. Recognizing the importance of ethical guidance, along with the fact that it is a secondary credentialing body, the Association for Play Therapy has encouraged its practicing members to utilize the ethical codes of their respective primary disciplines. In doing so, as the cases in this article demonstrated, play therapists have found that they regularly contend with many of the same ethical challenges as do non play therapists, such as confidentiality, melding linear and systemic orientations, informed consent and boundaries. As a result, they must rely on shared guiding principles such as beneficence, fidelity and non-malfeasance. However, they will invariably also encounter a number of ethical dilemmas unique to the practice of play therapy, such as physical contact with clients, the choice of play materials, and competence in

therapeutic play. All of these issues, whether unique to play therapy or not, mandate a functional and flexible ethical problem-solving model.

The Principles, Principals, and Process (P^3) Model provides a method that play therapists, coming from their respective primary disciplines (with specific ethical codes and legal requirements), can utilize in determining an ethical course of action. Play therapists, engaged in a process of thoroughly reviewing the ethical and legal principles and actively giving voice to all principals involved, will make ethical decisions that are respectful of both the historical and clinical context of the ethical dilemmas faced in practice. Play therapists from all disciplines can now add to their existing ethical decision making models the P^3 Model as an integrative and innovative approach to applying ethical standards to their clinical practice.

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