James Madison University

JMU Scholarly Commons

Spring 2016

Creative counseling techniques for elementary-aged children

Brian C. Caperton
James Madison University

Recommended Citation

Creative Counseling Techniques for Elementary-Aged Children

Brian C. Caperton

A research project submitted to the Graduate Faculty of

JAMES MADISON UNIVERSITY

In

Partial Fulfillment of the Requirements

for the degree of

Master of Arts and Education Specialist

Clinical Mental Health Counseling

May 2016

FACULTY COMMITTEE:

Committee Chair: Dr. Debbie Sturm, LPC

Committee Members/ Readers:

Dr. Lennis Echterling, LPC

Dr. David Ford, LPC

Dedication

Thank you, Niki, for agreeing to be my partner and fellow traveler on this life journey. As I wrap-up my graduate experience, one year after you, I look forward to many years of laughter, spontaneity, and creativity. I love you and consider all things new in light of you.

incredible vantage points wondering, "How did I get here?" Looking back, it's evident:

You led me to every lookout.

Table of Contents

*A child said, What is the grass? fetching it to me with full
hands;
How could I answer the child? . . . .I do not know what it
is any more than he.*

-Walt Whitman, *Song of Myself*

Abstract

Research suggests widespread decline of creative ability in elementary-aged children, particularly kindergarten through 3rd grade (Kim, 2012). The increase of mental health disorders in children, the exponential rise of technology use, and the surge of psychotropic medication use indicate the need for nuanced, divergent clinical interventions. Creative counseling fills this demand by offering children opportunities to engage in open-ended, reflective abstraction and other therapeutic processes. The author opens with an overview of creativity and psychology, conceptualizes the target population, and discusses theories, models, and interventions of creative counseling with elementary-aged children. The paper will provide clinicians with an understanding of creative counseling interventions – both in modality and application – in hopes to mitigate the creative crisis affecting children around the nation.

A. Introduction

Creativity and Psychology

Humans are creative beings. In his widely cited model of human development, Erik Erikson (1950) devotes 35 years, ages 30-65, to the conflict of generativity versus stagnation. Generativity, the ability to independently create unique content without outside influence, is a concern for anyone on a normal developmental trajectory.

Legendary humanist and psychologist, Carl Rogers (1954, p. 249) wrote, "Many of the serious criticism of our culture and its trends may be best formulated in terms of a dearth of creativity." In 2010, 1,500 CEOs acknowledged creativity as the best predictor of future success (IBM). We create across all hierarchy of needs, sometimes out of pleasure but often from necessity. Our ability to be generative is not always predicated on leisure or skill, but on the necessity of maintaining relationships and identity. In Jordan, Dr. Abo-Hilal conducts art therapy with children who have survived Syria's ongoing civil war (Treating the Trauma, 2015). Under his careful supervision, children articulate fears and nightmares through drawings, paintings, and music, and learn to manage difficult thoughts and emotions. This is but one example of how a therapist might work with children in a creative-arts setting to encourage situational and psychological resolutions.

Given the nearly limitless ways to become involved in creative experiences, clinicians may benefit from a more specific conceptualization of creativity, beginning with the 18th century and moving into contemporary psychology. Westernized understanding of creativity developed from the 18th century and the Age of Enlightenment, during which human interest shifted towards creativity and aesthetic (Albert & Runco, 1999). The direct and individualized study of creativity did not begin

until the 19th century following an increased interest in individual differences, such as creative genius, largely inspired by the arrival of Darwinism.

Over the past 50 years, following J. P. Guilford's address to the American Psychological Association regarding creativity in 1950, psychologists have endeavored in the psychometric measurement of creativity (Sternberg & Lubart, 1999). Dr. E Paul Torrence (1962), former Air Force instructor and one of the first psychologists to assess creative ability in children, was convinced that creativity is central to adaptability and personal achievement. He created the Torrence Tests of Creative Thinking (TTCT) in 1951, which tested divergent thinking and problem-solving skills across fluency, flexibility, originality, and elaboration. Today, the TTCT serves as one of the most statistically significant and reliable instruments to measure creative potential. Longitudinal studies indicate that the test yields strong, statistically significant correlations between childhood scores on the TTCT and real-world achievement (Cramond, Matthews, Bandalos, & Zuo, 2005; Runco, Millar, Acar, & Cramond, 2010).

Ten years after Dr. Torrence designed the first edition of the TTCT, Jacques Barzun (as cited in Rhodes, 1961, p. 306), dean of faculties at Columbia University, addressed human creativity at the University of California: "Creativity may stand for a conscious or unconscious denial of the tremendous range of human ability." He likened the potential creativity of a kindergarten's finger-painting to the actual potential of Rembrandt's masterpieces, noting the merit of creativity across age and ability. One year later, Rhodes (1961, p. 306) warned readers of an over-application of the creative label, suggesting, "In many examples creative means or implies nothing more than emotional freedom, relaxing of tensions, disinhibitions, or freedom from censorship." Of course,

today's mental health professionals recognize the therapeutic benefits of emotional freedom and relaxing of tensions, and have found ways to induce these positive psychological states through creative interventions.

J. P. Guilford first conceptualized divergent and convergent thinking, further distancing conventional understandings of intelligence from nuanced creativity (Guilford, 1967). Divergent thinking describes a cognitive process that involves identifying potential answers through creative, open-ended problem solving. Its cognitive opposite, convergent thinking, involves following a series of logical steps that arrive to a single solution. Guilford's work in divergent thinking, the preferred cognitive orientation for many play therapists, gave further understanding to free association, play-based therapy, and trait-based creativity. Lieberman (1965) drew parallels between playfulness and divergent thinking in kindergarten-aged children, and called for a longitudinal study to assess the relationship between elementary-aged playfulness and creativity in adulthood. Instead of converging on a single answer, clinicians may encourage their clients to think about many different ideas elicited from creative-arts interventions.

Divergent Thinking

Convergent Thinking
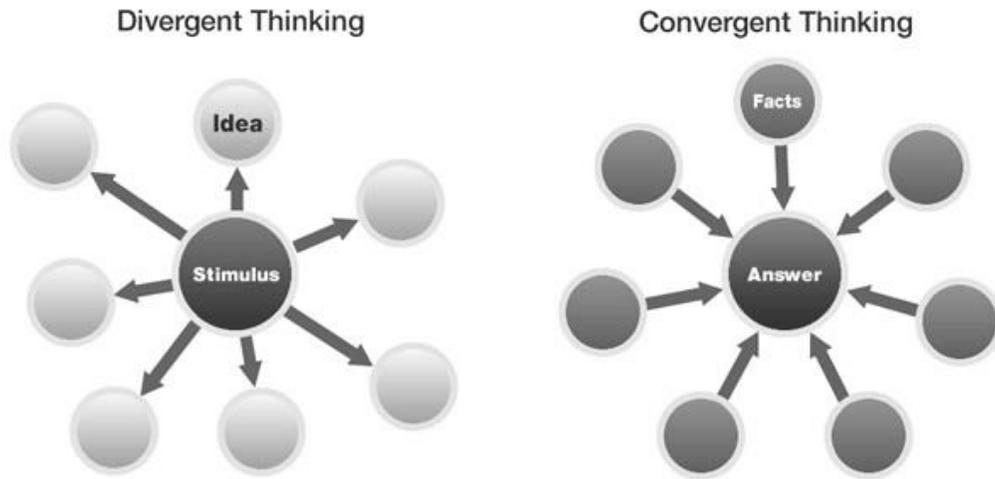
(Divergent thinking,

2016)

A child's life is a creative endeavor. The most basic developmental tasks –
learning to crawl, babbling, experimenting with objects – are creative exercises in
problem solving. These creative experiences in childhood, the ways one explores and
learns from interacting with the environment, determines much of adult experience.
Creativity killers, such as surveillance, competition, over-control, pressure, and a lack of
open-ended time may disrupt the creative-self with negative messages about self-
efficacy. Thus, therapists facilitate a child's divergent thinking skills in creative settings
to integrate positive cognitions and behaviors like autonomy, mastery, and interpersonal
resolutions.

The Creative Crisis

After a systematic review of TTCT scores, Dr. Kyung Hee Kim (2012) at the College
of William and Mary found indication of widespread creative decline among Americans

of all ages, especially in kindergarten through third grade. She cited a decline in reflective

abstraction, or an adolescent's acquisition of knowledge by thinking about their thoughts

and separating from personal reflections (Piaget, 1977). Reflective abstraction, a marked

indicator of the formal operation stage (ages 11-20), is established on other cognitive

skills acquired during childhood, such as conservation, centration, and

deductive/inductive reasoning. While children may appropriately engage in empirical

abstraction, thanks to academic-focused programs, the decline in reflective abstraction

should come to no surprise. An increase of technology use, hurried lifestyles, and an

over-scheduling of academic programs have sabotaged the conditions required for

reflective abstraction.

A decline in reflective abstraction is evident in American children of all ages (Kim,

2012), yet children of the 21st century face a number of other challenges to healthy

development. As indication, consider these statistics:

- A Kaiser Foundation study found that children between the ages of 8 and 18
spend a daily average of 7 hours and 32 minutes with digital media (Kulman,
2015).

- Mental health care for children has increased rapidly in the past few years,
coupled with an increased use of psychotropic medications, especially stimulants
and anti-depressants (Olfson, Marcus, Weissman, & Jensen, 2002).

- At least 12% of youth ages 9-17 have a mental health disorder, yet few receive
formal services (McLennan, Reckord, & Clarke, 2008).

While completing my clinical training, I worked as an after-school caregiver with

elementary-aged children. The fight against technology for a child's attention seemed like

a daily struggle. I often wondered, "Against the barrage of information and computer

screens, how do we promote learning that exhibits tangible, not technological, realities?"

A child's need for developmentally appropriate interpersonal skills, reflective abstraction,

and self-awareness is greater than ever. Creative counseling offers an alternative to the

technological noise, busy schedules, and haste that pervade children's lives.

In order to best serve their population, clinicians must hold a conceptualization of

their clients. Healthy childhood development involves attention to behavior, cognition,

interpersonal skills, and even parenting styles; all of these concepts are further discussed

in the next section.

B. Conceptualizing Elementary-Aged Development

Elementary-aged Development

Erikson's (1950) fourth stage of psychosocial development is industry

(competence) versus inferiority and typically takes place between the ages of five to

twelve. Erikson denoted this stage with an increased role of teachers and peer groups, and

the demonstration of specific competencies. If a child fails to develop the specific skills

they feel society is demanding (e.g. being smart in school, making friends) then they may

develop a sense of inferiority. A common goal of therapy is allowing a child to display

and experience mastery over situations.

Jean Piaget's (1977) theory of cognitive development suggests that elementary-

aged children on a normal developmental trajectory will experience a preoperational

stage (ages two to seven) and a concrete operational stage (ages seven to eleven). The

preoperational stage is marked by symbolic play and manipulation of symbols. While

conducting a number of safe, ingenious clinical trials with children, Piaget

conceptualized two cognitive concepts: conservation and egocentrism. A child's

cognitive capabilities do not account for conservation, a concept of logic used to

determine consistent quantity across variable containers, until the age of five. Many

creative counseling interventions promote concepts of conservation, as they allow

children to access their spatial intelligence and engage an object with its surrounding

parts. Egocentrism is defined by a child's preference towards self in communication and

thinking. A child's egocentrism may be activated during interventions like sand-tray

therapy, where a child asserts subjective feelings and emotions on an object, like a lion or

a knight.

The concrete operational stage marks the beginning of logical, operational

thought, and usually onsets around the age of seven (1977). Around this age, children's

cognitions begin assimilating concepts of logic and organization. Children are able to

engage in perspective taking and decentration, the ability to concentrate on many

different aspects of a situation. While children developing in the aforementioned

preoperational stage might struggle with concepts of conservation, children whose

cognitions perform in concrete operations are able to assess different parts as remnants of

an original whole, even if those parts have been separated or manipulated. These

cognitive skills are the foundation for formal operational thought, characterized by

higher-order reasoning, classification of items, and abstract thinking.

Dr. Jean Piaget's (1932) ideas of moral development were revisited and further

developed by Dr. Lawrence Kohlberg in 1958. Elementary-aged children, before the age

of 9, will make judgments according to pre-conventional morality. A child operating at

the pre-conventional level accepts morality defined by the standards of adults and

caregivers, and learns implicit rules according to the consequences of breaking their

rules. This first stage of preoperational thinking is characterized by obedience and

punishment orientation. As children move into concrete operational thinking, around the ages of seven to nine, the also engage stage two of pre-conventional morality: individualism and exchange. At this stage, children recognize that there exists more than one correct view handed down by authorities, and behavior is driven by self-interest (Piaget, 1977). This "what's in it for me?" mentality implies egocentric morality, and good behavior is associated with avoiding punishments.

As children integrate perspective taking and adopt a more realistic theory of mind, Piaget offered two healthy interventions to promote cognitive development (Broderick & Blewitt, 2006). Clinicians may aid a child in decentering, the ability to hold multiple ideas at the same time, and receiving feedback, the continual give-and-take of social interaction. Children begin to make healthy cognitive accommodations when they are engaged in turn-taking conversations and when they discuss mental states. For example, if a child is taking care of a doll, the play therapist might aid a child in becoming aware of his actions by noting, "You're picking up the cotton wrap and putting it on her arm. You've made her all better!" Clinicians can aid a child's cognitive development by inoculating the therapy space with accurate feedback and back-and-forth interactions.

Knock and Cazdan (2001) assessed 405 parents for pre-treatment expectations for their child's therapy (ages 2-15). Results indicated that negative parental expectations create barriers to treatment attendance and treatment participation, and may predict early termination. Other predictors of low parent expectations include severity of diagnosis, socioeconomic disadvantage, parental stress, and ethnic minority status. Shuman and Shapiro (2002) suggested attendance may be a function of many variables, therefore clinicians should hold a multidimensional perspective when initiating engagement

procedures and informing parents. A child therapist may promote therapeutic cohesiveness and consistency by informing caregivers of age-appropriate psychosocial and cognitive development.

Parenting Styles

A clinician's practice might not directly involve the parent in each session, like the modalities put forth by Filial Therapy; due to the enormous effects parenting has on childhood development, however, clinicians will benefit from an understanding of different parenting styles (Baumrind, 1967).

Parenting affects a child's developing self-system and temperament traits in many ways (Broderick & Blewitt, 2006). Children's self-esteem is related to their caregiver's warmth and responsiveness and children's self-regulation is related to parenting style. Children are more cooperative when they share warm, responsive relationships with caregivers. Dr. Diana Baumrind (1967) conducted extensive research on the relationship between parenting style and child development. She suggested that the majority of parents display three parenting styles: authoritative, authoritarian, and permissive. Maccoby and Martin (1983) furthered her research by positing a fourth parenting style: uninvolved.

Children of authoritarian parents are expected to follow strict rules; failure to follow rules often results in punishment (Broderick & Blewitt, 2006). Authoritarian parents place high demands on their children, but are not responsive to their children. Baumrind (1967) described these parents as obedience and status-oriented. Authoritative parents establish rules, yet engage their children with a sense of democracy, and respond to their children with willingness and nurturing. Authoritative parents are assertive, but

not restrictive or overly intrusive. Permissive parents have few demands to make of their

children and allow considerable self-regulation. This style of parenting takes engages the

child with the equanimity of friendship. An uninvolved parenting-style is characterized

by few demands, low responsiveness, and little communication. While these parents may

fulfill their child's basic needs, they are disconnected from their child's life. Extreme

cases of uninvolved parenting result in neglect of the child.

Maccoby's (1992) research suggests a strong relationship between parenting

styles and the socialization of children. Authoritarian parents who demand obedience yet

lack emotional responsiveness may raise obedient, proficient children who score lower on

assessments measuring happiness and self-esteem. Authoritative parents tend to strike a

balance between emotional responsiveness and age-appropriate expectations. These

parents encourage happiness, positive self-appraisals, and autonomy in their children.

Children of permissive parents may lack self-regulation skills required for highly

structured environments. They may experience problems following directions from

authority figures, such as a clinician or a teacher. Uninvolved parents may raise children

with obvious developmental deficits and disturbed attachments, such as a lack of self-

control, low self-esteem, and low competence. Maccoby and Martin (1983) analyzed

adolescents between the ages of 14-18. They scored the children across four areas:

psychosocial development, school achievement, internalized distress, and problem

behavior. Children of authoritative parents received the highest scores across the four

dimensions, while children of neglectful parents scored lowest across the four

dimensions. Baumrind (1967), Maccoby, and Martin's research indicates a strong

relationship between parenting styles and child development across a number of

paradigms, giving further credence to the impact of nurture on a child's psychology.

Dr. David Crenshaw and Dr. Anne Stewart (2015, p. 114) discuss John Bowlby's

(1958) revolutionary work in attachment theory. They highlight one of Bowlby's most

novel and influential ideas: relationship experiences shape a child's emotion, behavior,

and automatic thoughts. Children whose parents are accurate in their observations and

caregiving responses are more likely to develop secure attachments. Children raised

within this caregiving paradigm my develop neurological structures that exhibit soothing,

self-regulation, and partnership behaviors. Conversely, children whose caregivers face

continual stressors (financial, emotional, physical, etc.) may experience disorganization,

which leads to patterns of overarousal and anxiety.

C. Theories and Models of Creative Counseling with Children

Creative Counseling Fundamentals

When expert play therapist Gary Landreth was asked what advice he would give

beginning counselors, he replied, "I don't think it's possible to be effective in counseling

with people if you aren't grounded solidly in a theoretical approach. A theory provides

consistency in the counselor's approach. Children need consistency … a child cannot feel

safe in an unpredictable relationship" (Carnes-Holt, 2014, p. 52). Baumrind's (1967)

research on parental styles reaffirms Dr. Landreth's assertion that, in order to fully

engage in the therapeutic process, children require healthy, predictable relationships with

their clinicians.

Creative counseling demands consideration beyond *what* a client creates; questions of *why, how,* and *for whom* a client creates may yield meaningful therapeutic content. Competent creative therapists investigate many aspects of their client's creative process. Dr. Landreth states, "Children don't need solutions to their problems. They need a relationship that allows them to express and explore their world at their own level of communication and at their own pace." (Carnes-Holt, 2014, p. 60) Thus, creative counseling does not necessarily seek immediate solutions, but space for a therapeutic relationship and resolution achieved only by listening and validating a child, and understanding their world without need to problem-solve (Presbury, Echterling, & McKee, 2008).

Effective creative counseling, regardless of intervention tools and theoretical framework, demands integration of fundamental clinical skills. Clinicians who approach creative counseling with patience, active listening, understanding, and validation towards their clients – not relying on client mastery or competency as indicators of therapeutic process – will likely provide greater therapeutic relief (Presbury, Echterling, & McKee, 2008). Dr. Eric Green (2014) encouraged play therapists to remain analytical and patient with their clients, working to establishing trust and acceptance with clients before moving into more advanced therapy modalities.

Jungian Play Therapy

Jungian Play Therapy (JPT) is an approach to counseling that engages a child's relationship to the symbolic life (Green, 2014). Children activate their self-healing archetype through a therapeutic alliance with their clinician (Allen & Brown, 1993). JPT assumes that children adopt characteristics of their caregivers through identification

(strongly relating to values and feelings of others) or introjection (internalizing beliefs of others). As children identify or interject negative values and beliefs, they require the psychological space to achieve individuation.

Dr. Eric Green (2014) highlighted a number of JPT goals: to maintain an analytical attitude, to ground children from their symbolic rage, and to internalize symbols of the "good enough mother and "good enough father". The goal of treatment is not to resolve atypical behaviors and feelings, but through symbolic exploration, to generate acceptance towards all parts of the self. Clinicians may practice grounding, through drawing or meditation, to gently move a child between the symbolic world and back to reality. As therapists work with parents in consultation, they should remain forward-thinking, in that therapists confront and help children become aware of difficulties, thereby beginning to assume a "good enough mother" or "good enough father" archetype. Green suggested that this archetype emerges in the playroom when a child voluntarily invites the therapist in play.

Jungian therapists note that children, when allowed unconscious free expression through play, express three reoccurring themes: chaos, struggle, and resolution (Allen & Green, 1993). A child first externalizes internal conflicts into the playroom and onto toys, while the counselor holds these emotions in a safeguarded place. As play emerges and the child projects his or her ego onto the play space, bad guys (or painful feelings) may take precedence. With continued play sessions, good guys will take control, indicating positive ego development and emerging themes of resolution. These themes of resolution can be solidified towards the end of each therapy sessions, as the therapist connects a

child's symbolic world with reality through grounding techniques, such as drawing and meditation.

The method of JPT deals with a struggle of opposites and assumes that a child lives in two words at any one moment (Allen & Green, 1993). This is particularly true for school counselors, who must consider the adaptive struggles and ego-mediation taking place between school and home. Competent Jungian Play Therapists will mediate a therapeutic dialogue between the conscious and unconscious, that is maintaining the relationship between the symbolic world and objective realities. Sometimes therapists will take photographs of a sand tray or retain collections of a child's drawings, in order to maintain thematic consistency across sessions.

When a child gravitates towards a positive symbol, the therapist should be ready to build on the symbol across sessions. As a child integrates the positive symbol, he or she builds ego-resiliency. Play therapists are always working themselves out of the job and allowing the healing archetype to take root. As these interventions deepen a child's self-awareness and affective expression, they also instill symbolic messages of healing and resiliency – messages that will hopefully serve a child long after the therapist's absence.

Child-Centered Play Therapy

Child-Centered Play Therapy (CCPT) is a modality defined by unconditional acceptance of a child, a concept best described by Garry Landreth: "When you focus on the problem, you lose sight of the child" (Carnes-Holt, 2014, p. 56). CCPT is a practice established on consistency; clinicians must provide consistent, predictable safety for

children who may come from unpredictable, traumatic backgrounds. Children must feel a

secure attachment with their therapist before exploring psychic stressors and resolutions.

Play therapy receives continued interest from clinicians, yet child-centered and

non-directive approaches are the most widely used by therapists (Bratton, Ray, Edwards,

& Landreth, 2). Axline (1947) researched play therapy in the 1940s, and explained how a

safe, therapeutic relationship serves as a function of positive change. The therapist

searches for an opportunity to validate the child and maintain his or her import, even

during their first interactions in the waiting room. The first sessions in a playroom are

spent with open-ended play, and the therapist continues to enable the child with control,

decision-making, and a sense of mastery.

Landreth (2002) suggested that toys in play therapy reflect a wide range of

emotions, evoke positive relationships, relate to normal social experiences, and establish

some form of communication. With a little imagination, a creative therapist will find a

number of toys and objects that fit Dr. Landreth's criteria. CCPT involves reflecting

accurate content in therapy, such as responding to specific information following a

child's story about a video game. True reflection of feeling involves more than positive

verbal appraisal; a child must sense a kindred alliance from the therapist, one rooted in

emotional understanding. Imagine a significant, secure caregiver responding a child's

disappointment or elation. When a therapist refuses to stifle or redirect these emotions,

but allows the child to become aware and share them, the child begins to activate internal

systems

Child-centered play therapy is wholly non-directive and sterile from significant

outside influence; clinicians must communicate therapeutic boundaries with their

children's parents. This form of advocacy protects the child's therapy space as a place

without parental restrictions, pressure or expectation, or ego-restrictions. One clinician at

the author's practice writes a verbal contract with his children's parents; he requests that

they never ask if their child "enjoyed" or "had a good time" during therapy. Such

dialogue might disrupt a child's therapeutic process and set a precedence for therapy.

CCPT remains child-centric, therapist-facilitated, and non-directive; other modalities of

therapy openly invite parents into their child's therapeutic process.

Filial Therapy

Dr. Rise VanFleet (1994), expert Filial Therapist, believes in strengthening the

parent-child relationship through play. This modality assumes parents are the primary

change agents in their child's lives and should be involved in their child's healthy

psychosocial development. Filial Therapy shares many qualities with CCPT (Bratton,

Ray, Edwards, & Landreth, 2009): unconditional acceptance, accurate reflection and

responsiveness, and a warm, consistent therapeutic relationship. Filial Therapy should not

be used if a parent is incapable of comprehending the skills, if a parent feels

overwhelmed by his or her own needs to engage in therapy, or when a child may have

been abused by one of the parents. The first two conditions would limit a parent's

involvement necessary for quality Filial Therapy, while the third scenario would prevent

a child from full disclosure.

Filial therapy involves thorough assessment of the child and family (VanFleet,

1994). Clinicians first meet with parents to gather a more comprehensive clinical picture

of the child. The therapist also establishes a play therapy observation session, during

which the parents interact with the child while the therapist observes. Skilled Filial

Therapists and observers will look for interactions between the target child and parents, locus of control within the family system, methods used to control the child, nonverbal signals from the child, and any problem interactions with the target child.

Rise VanFleet (1994) outlined four basic skills that clinicians may transfer, through modeling and dialogue, to the parents. The first is structuring skill, which helps children establish an overall framework of play therapy. The therapist initiates play by using positive, child-centered talk, such as, "Jonathan, this is your special play room. You can do almost anything you want, and I will let you know if there's something you cannot do." The therapist also teaches parents to enforce these boundaries with acceptance (reflecting feelings), firmness, and finality (enforcing the boundary). The second skill is empathic listening. When a child feels understood by an empathic caregiver, he or she is able to branch out emotionally and display a healthier range of expression. Children who experience acceptance from parents often learn to experience self-acceptance. Parents who learn to respond with immediacy to their child's creative art may say something like, "Colleen, your drawing is so beautiful. You are very talented and use such nice colors."

The third skill Filial Therapists may model for parents is child-centered imaginary play (VanFleet, 1994). Parents who engage their children in play may do so on a directive level, not allowing the child to assume an open-ended play. Children who receive permission from parents to be creative and open-ended learn to integrate decision-making and perspective taking skills. The fourth skill is limit setting. Parents who are too permissive or too quick to intervene may benefit from Filial Therapy aimed at enhancing limit setting. Ironically, parents at both ends of this spectrum feel as if the child is in control of most situations. Therefore, parents learn to skillfully set appropriate boundaries

that does not feed their fear or want of control, but honors their child's security, vulnerability, and autonomy. Filial Therapists may model unrestrictive limit setting during play therapy, when a child is supposed to engage the environment in an open, expressive manner. When a child ignores or continuously breaks playroom limits, therapists walk parents through a three-step process of enforcing the limit: stating the limit, giving a warning, and enforcing the consequence.

Working with the therapist-child-parent triad requires sensitivity towards the nuances of a child's developmental needs and directedness towards a parent's strengths and limitations in therapy. Filial Therapy enhances the relationship between child and parent, which means the therapist must withhold the need to assume control or precedence over a parent. When given the tools to engage in open-ended, validating play and implement age-appropriate boundaries, parents become healthy agents of change in their child's lives.

Dr. David Crenshaw and Dr. Anne Stewart (2015, pp. 129-140), informed by decades of research on the subject of parent-child therapy, outline an amazing 10-session Filial Therapy Model. Therapists train and closely support caregivers in their effort to be therapeutic change agents for their children. Child-parent relationship therapy (CPRT) is extremely challenging, as it requires consideration of parental emotional support, necessary parameters for continuous supervision, and a therapist's ability to train and articulate information. In their clinical case example, Dr. Crenshaw and Dr. Stewart suggest that during sessions 1-3, the therapist should encourage safety, trust, and normalization of difficult parent-child conflicts. Sessions 4-10 involve supervised play sessions, skill refinement, and client mastery. When parents embrace their role as the

primary agent of change in a child's life, they encourage secure attachments within the family system.

D. <u>Creative Counseling Interventions</u>

Sand Trays

Professionals may want at least 300 miniatures at their disposal, as this will ensure a fuller, more accurate representation of the child's world. Miniatures can include people, animals, buildings, vehicles, household items, fantasy characters, spiritual/religious symbols, and even items with a negative valence, such as guns or drugs. Some children may incorporate these items in order to address real-world situations in the families or communities. Therapists engage any symbolic representation as important to the child's inner world and are vigilant of the relationship between characters. While therapists avoid over-interpretation, they are vigilant for themes about the child's inner world. Does the sand tray represent a scene of chaos or a rigid world? Does the child move about the scene with a sense of freedom, or does he or she remain tentative towards the play space? These acute behaviors and long-term partialities yield meaningful information about a child's conflicts, which are ultimately addressed (first symbolically, then perhaps more explicitly) in the safety of a sand tray.

Mandalas

Carl Jung described mandalas as windows the soul and first introduced them to contemporary psychology. Mandalas and decorative circles, however, can be found throughout ancient history. Children are able to individualize with mandalas, as they

represent a wholeness of the psychic self. Jungian psychology suggests that the ego maintains a relationship with unity and completeness, concepts outlined by the mandala. Therapists may encourage children to draw mandalas as a grounding exercise following intense interpersonal or symbolic processing, thus solidifying themes explored in session.

Music Therapy

Music therapy offers creative counselors a rich opportunity to nonverbally engage children who might find talk therapy difficult. A well-equipped playroom may include a few hand-drums, xylophones, stringed instruments, and other percussion instruments. While therapists may think that quality music therapy requires musical skill, the benefits of music therapy are founded in the child's sense of relatedness and understanding created through musical expression. When a child is encouraged to play "anger" on an instrument, the notes, just like in real life, do not have to make much sense. Instead, a therapist may track a child during a music exercise, attempting to establish musical collaboration through difficult emotions.

Following an emotional gradient, therapists may first encourage a child to join them in playing a positive emotion, like joy or excitement. If a child is interested in a sport, like basketball, the therapist might relate the kinetic playing of music to the sport: "Show me how you would play the instrument if you just made a three-pointer!" Music therapy may address more difficult emotions, like loneliness or sadness, and enable them to manifest in the therapy space. A child willing to engage difficult emotions, even nonverbally, indicates an awareness of self and the integration of psychological resolutions.

Conclusion

At a small mental health practice in Richmond, Virginia, and in other mental health agencies across the country, clinicians eagerly search for tangible, creative interventions that will enliven their client's therapeutic experience. Clients want to be seen, heard, and considered with sincerity in their creative endeavors – much like an artist wants patrons to thoroughly investigate their panting rather than offer it a passing glance. Much like an artist whose paintings are hung in a gallery, young children are self-aware of their work and on the hunt for proof of achievement and accomplishment. A therapist's work begins with a genuine expression of care and excitement for a child's ability to create in the most fundamental ways.

Clinicians must allow children to explore their inner world with divergent thought processes, open-ended reflections, and supportive facilitation. Creative-based interventions offer children psychological relief from the idiosyncratic messages, rapid information systems, and hurried lifestyles that pervade their environments. As psychotropic medication use and mental health needs continue to rise in younger populations - now more than ever - children must feel empowered to engage their entire self through creative expression.

References

Albert, R. S.; Runco, M. A. (1999). "A History of Research on Creativity". In Sternberg, R. J. *Handbook of Creativity*. Cambridge University Press, 6.

Allan, J. & Brown, K. (1993). Jungian play therapy in elementary school. *Elementary School Guidance & Counseling, 28*(1), 30.

Axline, V. (1947). *Play therapy: The inner dynamics of childhood.* Boston: Houghton Mifflin.

Baumrind, D. (1967). Child-care practices anteceding three patterns of preschool behavior. *Genetic Psychology Monographs, 75,* 43-88.

Bowlby, J. (1958). The nature of the child's tie to his mother. *International Journal of Psycho-Analysis, 39,* 350-373.

Bratton, S. C., Ray, D. C., Edwards, N. A., & Landreth, G. (2009). Child-centered play therapy (ccpt): Theory, research, and practice. *Person-Centered & Experiential Psychotherapies, 8*(4), 266-281.

Broderick, P.C., & Blewitt, P. (2006). *The life span: Human development for helping professionals.* Upper Saddle River, NJ: Pearson Merill Prentice Hall.

Carnes-Holt, K. (2014). An interview with Gary Landreth: Play therapy, humanism, and the future of counseling. *Counseling Journal of Humanistic Counseling, 53*(1), 47-62. Doi:10.1002/j.2161-1939.2014.00049.x

Cramond, B., Matthews M. J., Bandalos, D., & Zuo, L. (2005). A report on the 40 year followup of the Torrance Tests of Creative Thinking: Alive and Well in the New Millennium. *Gifted Child Quarterly*, *49*, 283-291.

Crenshaw, D. A., & Stewart, A. L. (2015). *Play therapy: A comprehensive guide to theory and practice.* New York, NY: The Guilford Press.

Divergent thinking. (n.d.) Retrieved February 2, 2016, from http://america.pink/divergent-thinking_1277050.html

Erikson, E. H. (1950). *Childhood and society*. New York: Norton.

Guilford, J. P. *The Nature of Human Intelligence.* New York: McGraw-Hill, 1967.

Green, E. J. (2014). *The handbook of Jungian play therapy with children and adolescents*. JHU Press.

IBM 2010 Global CEO Study: Creativity Selected as Most Crucial Factor for Future Success. http://www-03.ibm.com/press/us/en/pressrelease/31670.wss(link is external)

Kim, H. K. (2011). The creativity crisis: The decrease in creative thinking scores on the torrance tests of creative thinking. *Creativity Research Journal, 23*(4), 285-294.

Kohlberg, L. (1958). The Development of Modes of Thinking and Choices in Years 10 to 16. *Ph.D. Dissertation,* University of Chicago.

Kulman, R. (2015). How much time do kids spend with technology? LearningWorks for Kids. Retrieved January 02, 2016, from http://learningworksforkids.com/2015/07/how-much-time-do-kids-spend-with-technology/

Landreth, G. L. (2002). *Play therapy: The art of the relationship.* New York: Brunner-Routledge.

Lieberman, J. N. (1965). Playfulness and Divergent Thinking: An Investigation of Their

    Relationship at the Kindergarten Level. The Journal of Genetic Psychology, 107,

    219-224.

Maccoby, E. E., & Martin, J. A. (1983). Socialization in the context of the family: Parent-

    child interaction. In P.H. Mussen & E. M. Hetherington, *Handbook of child*

    psychology: Vol. 4. Socialization, personality, and social development (4th ed.).

    New York: Wiley.

McLennan, J. D., Reckord, M., & Clarke, M. (2008). A Mental Health Outreach Program

    for Elementary Schools. *Journal of the Canadian Academy of Child and*

    Adolescent Psychiatry, *17*(3), 122–130.

Nock, M. K., & Kazdin, A. E. (2001). Parent expectations for child therapy: Assessment

    and relation to participation in treatment. *Journal of Child and Family Studies,*

    10(2), 155-180.

Olfson, M., Marcus, S. C., Weissman, M. M., & Jensen, P. S. (2002). National trends in

    the use of psychotropic medications by children. *Journal of the American*

    Academy of Child & Adolescent Psychiatry, 41(3), 514-521.

Runco, M. A., Millar, G., Acar, S., & Cramond, B. (2010) Torrance tests of creative

    thinking as predictors of personal and public achievement: A fifty-year follow-up.

    Creativity Research Journal, *22*, 361-368.

Rogers, C. R. (1954) Toward a theory of creativity. *A Review of General Semantics,*

    11(4), 249-260.

Piaget, J. (1932) *The moral judgment of the child.* London: Kegan Paul, Trench, Trubner

    & Co.

Piaget, J. (1977). Gruber, H. E.; Voneche, J.J. *The essential Piaget*. New York: Basic

Books.

Presbury, J.H., Echterling, L. G., & McKee, J.E. (2008). *Beyond brief counseling and*

therapy: An integrative approach. Upper Saddle River, NJ: Pearson Merrill

Prentice Hall.

Rhodes, M. (1961). An Analysis of Creativity. *The Phi Delta Kappan*,*42*(7), 305–310.

Retrieved from http://www.jstor.org/stable/20342603

Sternberg, R. J. & Lubart, T. I. (1999). "The Concept of Creativity: Prospects and

Paradigms". In ed. Sternberg, R. J. *Handbook of Creativity*. Cambridge University

Press. ISBN 0-521-57285-1.

Torrance, E. P. (1962). Guiding creative talent. Treating the Trauma of Young Syrian

Refugees. (2015). Retrieved February 10, 2016, from

http://www.nytimes.com/2015/10/13/health/treating-the-trauma-of-young-syrian-

refugees.html

Torrance, E. P. (1971). Are the torrance tests of creative thinking biased against or in

favor of ''disadvantaged'' groups? Gifted Child Quarterly, 15, 75–80.

VanFleet, R. (1994). *Filial therapy: Strengthening parent-child relationships through*

play. Sarasota, FL: Professional Resource Press.