Abstract

Effective play therapy supervision requires teaching, modeling, and encouragement of basic and advanced responsive skills. This article presents a detailed description of non-verbal and verbal basic skills, as well as advanced skills, in play therapy. In addition, the author provides information to supervisors on how to help supervisees implement these skills in play therapy. The article offers the Play Therapy Skills Checklist (PTSC) as a tool for supervisors to use when working with play therapists in training.

Supervision of Basic and Advanced Skills in Play Therapy

The use of play therapy is based on the developmental understanding of children. Piaget’s (1962) theory of cognitive development recognize the differences between the way that children understand and process information from the way that adults function. Most children at the elementary level function at two stages: Preoperational (2-7 years) and Concrete Operational (8-11 years). These stages are approximately identified with chronological ages, but it is generally accepted that development is specific to the individual.

At the Preoperational Stage, a child is acquiring the skill of language where symbols are used to mentally represent objects; his or her thinking is rigid and limited to how things appear at the time. Magical thinking in which children create implausible explanations for things that they do not understand is often present, while children’s play becomes increasingly imaginary and unassociated with reality. Gradually, play increases in complexity from make-believe to emerging cognitive patterns. The child improves understanding and knowledge, but lacks the ability to communicate this enhanced understanding. However, through play the child is able to naturally

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communicate this internal awareness of self and others (Piaget, 1959).

At the Concrete Operational Stage, children are able to reason logically and organize thoughts coherently. They are able to manipulate ideas and accept logical society rules. However, they can only think about actual physical objects and are unable to maneuver abstract reasoning or express certain complicated emotions, such as guilt or resentment. They have yet to develop the abstract thought necessary to understand such emotions. For those children operating in the Concrete Stage, play helps to bridge the gap between concrete experience and abstract thought (Landreth, 2002; Piaget, 1959, 1962).

In play therapy, significance is found through the symbolic function of play. Toys are viewed as the child’s words, and play as the child’s language (Landreth, 2002). Children can comfortably, safely, and meaningfully express their inner world through the concrete, symbolic representation of the toys. Through toys, children are provided with the opportunity to develop mastery and a sense of control over their world as they reenact their experiences directly in the safety of the playroom. In play therapy, regardless of the reason for referral, the therapist has the opportunity to enter into and experience the child’s world and actively deal with the issues that brought the child to therapy.

In summary, play is an important medium for children for several reasons. Play is the natural language of children. Developmentally, play bridges the gap between concrete experience and abstract thought, offering children the opportunity to organize their real-life experiences that are often complicated and abstract in nature. Through play, children gain a sense of control and learn new coping skills (Landreth, 2002).

Play therapy utilizes this understanding of children by offering children a therapeutic environment for their play. Play therapy is defined as a dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child to fully express and explore self through the child’s natural medium of expression, play (Landreth, 2002).

Supervision of Therapist Skills in Play Therapy

Some play therapists have addressed the general importance of play therapy supervision. Moustakas (1959) recommended initial didactic training in play therapy progressing to a focus on the growth of the play therapist in supervision. This focus on growth helps a play therapist to integrate self-awareness and professional skills, so that the relationship between the child and the therapist continues to be enhanced. Guerney (1978) also discussed the importance of teaching skills along with subsequent and consistent live supervision of the play therapist. Kranz and Lund (1994) recommended the supervisor serve as a role model to beginning play therapy supervisors.
therapists, demonstrating acceptance and genuineness, and reflecting the feelings of supervisees.

Among various theoretical schools, play therapists agree that the facilitation of play therapy requires supervision specific to the process. Supervisors should be trained in play therapy and limit supervision to the theoretical models of play therapy in which they are trained. Play therapy supervision generally follows the guidelines of a developmental model of supervision. Supervisees are initially very concrete and dependent, in need of specific skills and feedback. As the supervisory relationship grows, the supervisee moves into the role of peer, in need of mutual consultation and discussion (Stoltenberg, McNeill, & Delworth, 1998).

Formal training in play therapy is an effective way of teaching basic skills. When therapists attend formal training, they are able to learn a variety of skills and how they fit into a basic play therapy philosophy. Formally trained play therapists can then practice their skills and seek out supervision on the improvement of those skills. However, it is common practice for therapists to begin seeing children and then seek out supervision on how to work with children. Ethically, of course, this is problematic, because children are considered to be a special population for which therapists should receive special training. Yet, supervisors will often move into the role of instructor and trainer, teaching basic skills to novice therapists, unaware of what to observe and how to provide feedback to their supervisees.

Basic Skills in Play Therapy

In order to assist play therapy supervisors in the role of developing supervisee skills, certain basic skills will be discussed in detail and presented in concrete description so that supervisors can begin to observe and provide feedback on these specific competencies. Certain therapist skills are considered to be essential to the play therapy process (Axline, 1947; Guerney, 1983; Kottman, 2003; Landreth, 2002; Moustakas, 1997; O’Connor, 2000). Basic skills include non-verbal skills of leaning forward, appearing interested, seeming comfortable, applying a tone congruent with child’s affect, and applying a tone congruent with the therapist’s response. Basic verbal skills include delivering quality of verbal responses, tracking behavior, reflecting content, reflecting feeling, facilitating decision-making, facilitating creativity, esteem-building, and facilitating the relationship. These are specific skills expected to be demonstrated in most play therapy sessions. The extent to which they will be used depends on the needs of the child and, possibly, the theoretical orientation of the therapist.

Non-Verbal Skills

Play therapy is heavily reliant on non-verbal skills. Because play therapists believe that play is the language of children, the verbal world becomes less important in a play therapy session. Although non-verbal skills are critical to any therapy, they are especially critical to play therapy.
1. **Leaning forward, open stance.** The play therapist is physically directed toward the child at all times. As the child moves, the therapist moves so that he or she is always squarely facing the child. Arms and legs are positioned to convey a sense of openness to the child.

2. **Appearing interested.** The therapist looks as if he or she is interested in the child throughout the session and not appearing preoccupied with other thoughts or matters.

3. **Seems comfortable.** The therapist seems comfortable with the child and the situation, remaining relaxed throughout the session.

4. **Therapist’s tone (Expression congruent with child’s affect).** The therapist matches the level of affect displayed by the child. Often, new play therapists will present themselves as overly animated to the child. This is generally the way that many adults relate to children. Therapists new to working with children often carry the idea that their role is to make the child happy and use their tone of voice toward this end. As with counseling adults, the therapist should strive to be congruent with how the child expresses himself.

5. **Therapist’s tone (Expression congruent with therapist’s responses).** The therapist should not only match the child’s affect but should also convey a sense of genuineness. The skill of matching the verbal response with the non-verbal response is indicative of the therapist’s level of genuineness with the child. Specifically, the therapist would not flatly present the response, “You’re excited by how you made the bubbles.” In this example, the therapist would need to add the affect of excitement to the response. In addition, this skill also addresses the tendency of some therapists to end their responses in a higher tone, indicating a question. When making definitive responses, therapists should avoid this habit, which is confusing to the child. The child is left to figure out how to respond to the therapist, “Should I answer or not?”

**Verbal Skills**

The play therapist’s delivery of verbal responses to the child is almost as important as the words chosen. Supervisors will want to encourage play therapists (supervisees) in their tone and style of response delivery. Additionally, in the initial supervision of play therapists, it helps to present concrete categories of verbal responses from which supervisees become aware of variety and effect of responses. These categories provide them with structure from which to work when the situation is new and foreign. For experienced play therapists, the construct of categorical responses can help them to review the basics when they are feeling unfocused or confused about specific cases. The following are several relevant categories of verbal responses.

1. **Delivery of responses.** Two specific delivery skills are observed in the supervision of play therapists: (a) succinct, interactive responses, and (b) rate of responses. Because play therapy recognizes the limited language ability of children, the importance of short therapeutic responses is key. It is
important that supervisors help play therapists to communicate their intent in as few words as possible. A maximum of ten words is a good rule of thumb. Lengthy responses lose the interest of the child quickly, confuse the child, and often convey a lack of understanding on the part of the therapist.

Rate of responses is a second skill in the delivery of verbal responses. The therapist should match the interaction of the child. If the child is quiet and reserved, then the play therapist will slow his responses. If the child is highly interactive and talkative, the play therapist will want to match this level of energy with increased number of responses. In initial sessions with the child, play therapists often have a quicker rate of response, because silence can be uncomfortable for the child in a new situation. In subsequent sessions, the therapist will learn to create a pace that matches the child. Both delivery skills regarding the length of responses and the rate of responses are typically problematic skills for the beginning play therapist. These skills, however, are quickly acquired, and most supervisors will not address them with the experienced play therapist.

2. Tracking behavior. Tracking behavior is the most basic of play therapist responses. The therapist tracks behavior when he or she verbally responds to the behavior of the child simply by stating what is seen or observed. Tracking behavior allows the child to know that the therapist is interested and accepting. It also helps the therapist immerse him or herself into the child’s world. Examples of tracking behavior include, (as a child picks up the clay) “You’re picking that up” or (as child runs in a circle) “You’re running around and around.”

3. Reflecting content. Reflecting content in play therapy is identical to reflecting content in adult talk therapy. To reflect content, the play therapist paraphrases the verbal interactions of children. Reflecting content validates children’s perceptions of their experience and clarifies children’s understanding of themselves (Landreth, 2002). An example of reflecting content includes, (child excitedly shares detailed story of building a rocket with his dad) “You got to build something cool with your dad this weekend.”

Although tracking behavior and reflecting content are essential to the play therapy process, they are the most basic skills in play therapy. They help to build a relationship with a child so that the child can benefit from higher-level skills. The following skills facilitate self-concept, development of self-responsibility, creation of awareness, and the building of the therapeutic relationship.

4. Reflecting feeling. Reflecting feeling is the verbal response to emotions expressed by children in play therapy. Reflecting feeling is considered a higher-level skill, because children rarely communicate by verbally expressing emotion. However, they are quite emotive. In addition, the reflection of feeling can sometimes be threatening to children and should be presented carefully. Reflecting
feeling helps children become aware of emotions, thereby, leading to the appropriate acceptance and expression of such emotions. Examples of reflecting feeling include, (child throws the spider across the room while saying, “He’s bad, I hate him.”) “You are really angry with that bad spider,” or (child tries several times to take the top off marker unsuccessfully and then throws it on the floor) “You’re really frustrated with that.”

5. Facilitating decision-making, returning responsibility. One of the play therapist’s goals is to help children experience a sense of their own capability and take responsibility for it. The therapist does not do for children what children can do for themselves (Landreth, 2002). Responses that facilitate decision-making or return responsibility help children to experience themselves as able and empowered. Examples of responses that facilitate decision-making or return responsibility include, (child wants to draw a picture and asks, “What color should the car be?”) “In here, you can decide the color you want it to be”, or (without making an attempt, the child asks, “Can you get the ball from behind the shelf for me?”) “That looks like something you can do.”

Facilitating creativity, spontaneity. Helping children experience their own sense of creativity and freedom to experience creativity is another goal of play therapy. Acceptance and encouragement of creativity sends a message to the child that he/she is unique and special. Maladjusted children are often trapped in rigid ways of acting and thinking. Experiencing the freedom of expression allows them to develop flexibility in thought and action. Examples of responses that facilitate creativity or spontaneity include (child asks, “What do I make with these straws?”) “You can create whatever you want with those”, or (child moves from one project to another in play session) “You changed to do just what you want.”

6. Esteem-building, encouraging. Encouraging children to feel better about themselves is a constant objective for the play therapist. The use of esteem building statements works to help children experience themselves as capable. Examples of esteem building and encouraging responses include, (child tries a few ways to reach the top shelf) “You’re not giving up, you just keep trying” or (child tries and tries to fit doll into car, after a few attempts, she succeeds) “You did it. You figured it out.”

Initially, play therapists may struggle with the difference between praising and esteem-building responses. Supervisors must often assist play therapists to determine how an esteem building response is more effective than a praising response. A praise response, such as “That’s a pretty picture” or “I like the way you did that” encourages the child to perform for the therapist and continue to seek external reinforcement, thereby eroding a sense of self. An esteem-building response, such as, “You’re really proud of your picture,” or “You made that just the way you wanted,” encourages children to
develop an internal sense of evaluation leading to an internal sense of responsibility.

7. Facilitating relationship. Responses that focus on building the relationship between the therapist and child help the child to experience a positive relationship. Because the therapy relationship serves as a model for all intimate relationships, the therapist should respond to any attempt by the child to address the relationship. Relational responses help the child learn effective communication patterns and express the therapist’s care for the child. Example of responses that facilitate the relationship include, (child is building something in sand and stops to look up at therapist but says nothing) “You’re wondering what I think about that,” or (therapist sneezes, child gives therapist a bowl and says, “Eat the soup so you’ll feel better.”) “You really want to take care of me” or (after therapist sets limit, child responds, “I hate you. I hate you.”) “You’re really angry with me for this.” Relationship responses should always include a reference to the child and reference to self as therapist.

Advanced Skills in Play Therapy

The basic skills in play therapy seem to be integrated early in the development of the play therapist. Supervisors might have to occasionally revisit these skills but, mostly, attention will continue to be drawn to the advanced skills. Skills identified as advanced typically remain sources for supervision and consultation throughout a play therapist’s professional career. For the purposes of this article, advanced skills include enlarging the meaning, identifying themes, connecting with children and limit-setting (Kottman, 2003; Landreth, 2002; Moustakas, 1997; O’Connor, 2000).

1. Enlarging the meaning (facilitating understanding). Enlarging the meaning is the most advanced of the play therapy skills. According to theoretical orientation, a therapist might enlarge the meaning by noticing and verbalizing patterns in the child’s play (“You always make sure to play with the Mommy doll.”) or by providing interpretation (“You seem to want to work out the problems with your Mommy.”). The purpose of enlarging the meaning is to provide the child with awareness or understanding regarding their process of play therapy.

Child-centered play therapists are hesitant to offer interpretation but enlarge the meaning by bringing observed and felt experiences to the child’s awareness, such as (after being in a therapeutic relationship for a long period), “Sometimes, when you come into the playroom, you really want to be the one in charge.” Other theoretical modalities support the inclusion of interpretation in the play therapy process. Jungian (Allan, 1988), Gestalt (Oaklander, 1988), Psychoanalytic (Freud, 1965; Klein, 1932), and Adlerian (Kottman, 2003) play therapies all support some level of interpretation in the play therapy process. From any theoretical perspective, enlarging the meaning is difficult to maneuver and the timing is critical. Children may experience enlarging the meaning responses as evaluative and invasive and cause them to become less
engaged in the process.

Supervisors discourage new play therapists from the use of enlarging the meaning responses, because it can be damaging if demonstrated without skill. It is recommended that supervisors initially get to know a supervisee’s case and then introduce the skill of enlarging the meaning. The supervisor might want to role-play the use of this skill prior to the therapist’s use directly with the client.

2. Identifying play themes. As children speak the language of play, patterns begin to emerge, and meaning is communicated. Play therapists attempt to define this meaning through the identification of play themes. A play theme is a coherent metaphor from which children communicate the meaning they have attributed to their experiences. Play themes allow therapists to understand the subjective experience of children and provide ways to conceptualize children’s play. The identification of play themes offers play therapists responses for enlarging the meaning, ways to converse about children, and ways to communicate meaning and progress to parents. There are numerous identified play themes; a few include Power and Control, Dependency, Revenge, Safety and Security, Mastery, Nurturing (self and others), Grief and Loss, Abandonment, Protection, Separation, Reparation, Chaos and Instability, Perfectionism, Integration, Hopelessness, and Anxiety.

Many supervision sessions center on the attempt to understand a child’s play. At some point, in most cases, play themes inevitably become the focus of supervision. The supervisor should be certain to cover several concerns in identifying play themes. One concern is that play themes are not definitive constructs. Hence, a therapist must be willing to be flexible in thinking. In one session, a theme may seem perfectly clear but play therapists need to be open to changing their conceptualization of that theme in subsequent sessions. Just as a child is a dynamic changing being, so is play therapy. It is also important that play themes be conceptualized outside of the playroom and serve as an effective focus for supervision and consultation. However, when play therapists attempt to analyze play themes during play therapy, they lose sight of connecting with the child in the moment.

Additionally, play themes are derived from the subjective understanding of the therapist. This is an especially important point for the supervisor. As in all supervision, supervisees are limited by their own personal issues outside of their awareness (Malchiodi, 1996; Pearson, 2000). Play therapists who are operating from their own childhood issues are likely to place these burdens on children when conceptualizing cases. Supervisors need to be aware of the personal and professional limitations of supervisees and how they might affect the children with whom they work.

3. Connecting with children. Connecting with children is fundamental to the work of play therapists, yet this can be a concern that needs to be addressed by the supervisor. Because therapists work with children who are maladjusted and
have experienced damaged relationships, children’s ability to damage the play therapy relationship is sometimes high. Some play therapy children are skilled in rejecting, hurtful, and vengeful behavior (Kottman, 2003). Even the most experienced play therapist will occasionally have difficulty connecting with a child. In supervision, it is often helpful to process the supervisee’s feelings of anger, frustration, hurt, and sometimes vengeance. Generally, it is the case that if the play therapist can process through negative feelings raised by a child, the supervisor can help make the connection between the way the play therapist feels and the way the child has experienced life thus far. More clearly, the way the play therapist feels is often the same feeling that the child has experienced from someone in his or her life. This connection helps to evoke empathy and connection for the therapist with the child.

Another issue that interferes with the connection between child and therapist are therapists’ expectations of play therapy. Therapists who choose play therapy as their professional career path often have preconceived ideas that if they choose to work with children and work through the modality of play, then therapists and children will experience a fun, working environment in which therapists receive emotional affirmation from children regarding their skills and personality. In these situations, therapists become sorely disillusioned with the process of play therapy and with their child clients. In such cases, supervisors must assist supervisees in assessing their chosen career path and change expectations, or consider another career.

4. Limit-setting. Limit-setting is undoubtedly the most discussed issue in play therapy supervision. What limits to set, how to set limits, and what to do when limits are not followed are generally the top three concerns of the play therapist. The supervisor’s and play therapist’s theoretical orientations and personal preferences impact the supervision of limit-setting. In an attempt to provide a therapeutic environment that allows for self-direction and self-responsibility, minimal limits are encouraged, with the goal being to help the child move toward the ability to self-limit. This philosophy of a permissive environment is sometimes antithetical to the beliefs of many adults. Hence, play therapists may struggle with their own belief systems regarding limit-setting.

Typically, limits are set when children attempt to damage themselves, another person, and certain expensive or irreplaceable toys or if the child’s behavior does not promote therapist acceptance (Kottman, 2003; Landreth, 2002). The first three guidelines of limiting behavior when it is damaging seem clear. However, setting limits to promote therapist acceptance is often controversial and is subject to individual preferences. One play therapist might be accepting when a child paints her face, while another play therapist might find this interferes with his or her ability to accept the child fully. One play therapist might feel positive about a child making a huge mess in the playroom, while another play therapist might have a
second client scheduled directly following
the current client, so that it is impossible to
clean up the room in the time allotted.
This type of decision-making concerning
limits is helpful to address in supervision,
so that the play therapist can better clarify
his or her own issues regarding children
and working with children. In discussing
limits, the supervisor will want to assess
whether the use or non-use of a specific
limit will inhibit the therapeutic work of
a child.

Landreth (2002) proposed a specific
method for setting limits in play therapy.
This method has been widely adopted by
play therapists as the initial response to
setting a limit in the playroom.
The A-C-T model of limit-setting
includes Acknowledging the feeling,
Communicating the limit, and Targeting
an alternative. In this model, the play
therapist recognizes and addresses the
child’s feelings in the moment, “You’re
really angry with me.” Secondly, the
therapist sets a short, concrete, definitive
limit, “but I’m not for hitting.” Finally, the
therapist provides an alternative to the
action, “You can hit the Bop bag.” When
children have directed energy in the
moment, it is important to provide them
an alternative for that energy so that they
do not feel the need to act on impulse.
Although there are other methods for
setting limits, the A-C-T model is short,
direct, and works effectively.

In supervision, play therapists should
practice their limit-setting skills on a
consistent basis. The need for limit-setting
is usually immediate and unexpected, so
play therapists need to be prepared. When
delivered with firmness yet objectivity, the
A-C-T method works with most children.

However, play therapists will have
cases where children do not respond to
limits. In supervision, this is usually
addressed by a brainstorming session of
possible solutions. The therapist and
supervisor generate a list of ideas that
might work with this particular child. To
increase the likelihood of success and the
therapist’s comfort level, the therapist and
supervisor decide on a course of action
based on the list of ideas. When success
does not occur, supervision continues to
focus on generating possible ideas.
Experience in play therapy teaches that the
majority of significant limit-setting
problems are preventable. Hence, the
supervisor should go through a step-by-
step process with the supervisee covering
each detail of the situation where the child
did not respond to the limit. In most cases,
a child has a specific intent in choosing to
not follow a limit, such as establishing
power in the relationship, gaining the
attention of an adult, or being overly
focused on finishing a project. When the
supervisor and supervisee can identify the
intent of the child, there is likely to be
more success in finding a solution to the
problem. The following are case examples
of preventable limit-setting.

A child with an identified and
noticeable need for attention finishes her
play therapy session before her mother
finishes her own counseling session. The
child runs out of the playroom to find her
mother so that she can show her a
drawing. When the child does not find her
mother, she begins to run and scream
around the facility. When the therapist begins to set limits with the child, the child hits and kicks the therapist repeatedly. After this case was staffed, it was decided that the two therapists involved would coordinate their sessions, so that the mother was always out of session before the child.

A child, whose mother works full-time and is experiencing marital problems, refuses to come to the playroom. After many attempts to get him into the playroom, he finally complies but then runs in and out of the playroom with different excuses, such as the need for a drink of water, or to go to the bathroom. The therapist notices that he also stops to wave to his mother each time he runs out. After staffing this case, it was decided that it would be best to change the approach to filial therapy from individual play therapy.

A child who has an identified need for power and control in the playroom begins to tear up paper in session. The therapist does not respond but just looks at the child. The child continues to throw every toy in the playroom in the middle of the room. The therapist is minimally responsive and smiles. The child walks toward the therapist in an aggressive way, the therapist sits up abruptly and says, “You are not allowed to hit or hurt others in the playroom.” The child attempted to hit her but the therapist pushed her hands away. In supervision, the therapist and supervisor processed the therapist’s discomfort with the child’s level of aggression and how she non-verbally sent these messages of unacceptance to the child. Also, her use of the ACT model of limit-setting was discussed, because an objective use of the limit by saying, “I’m not for hitting,” rather than “You are not allowed...” is less likely to encourage the need for the child to demonstrate power in an aggressive way.

In all three cases, the child’s breaking of the limit was an attempt to get a need met. Solutions were successfully found to meet the needs of each child. If the supervisor and play therapist are able to identify a child’s specific need, they are more likely able to target successful alternatives to limit-setting.

**Play Therapy Skills Checklist**

The Center for Play Therapy, located at the University of North Texas, has advanced the supervision and training of play therapists through the use of the Play Therapy Skills Checklist (PTSC) (see Appendix). This instrument is not used for collecting data; hence, it has not been formally reviewed for reliability or validity. However, the instrument has been subject to scrutiny from many experts in play therapy over the years. It is currently used as the primary agent of feedback for play therapists in training and supervision.

The PTSC divides basic skills into the two categories of Non-Verbal Communication and Therapist Responses. The second portion of the form addresses four other basic skills central to the growth of play therapists. The final section provides the supervisor with the opportunity to provide feedback on the
Therapist’s Strengths and Areas for Growth. The PTSC reviews skills essential to developing an effective therapeutic relationship with a child.

The PTSC asks the supervisor to rate whether each skill is considered to be demonstrated too much (Too Much), too little (Need More), not at all (None), or effectively (Appropriate). The supervisor is then asked to write examples of the therapist’s actual responses that fit that particular category. In addition, the supervisor is asked to write other possible responses that might have been more effective for that situation. The Other Possible Responses category is crucial for beginning play therapists. Examples provided by the supervisor help to direct the therapist in choosing appropriate language for that skill.

The second section of the form addresses four additional skills: (a) Limit-Setting, (b) Immediacy/Spontaneity, (c) Connectedness, and (d) Identified Themes. The form offers the supervisor more room to provide subjective comments regarding these factors. Often, these four areas require a more extended explanation of the situation, such as reviewing the details of the limit setting process to see which responses were effective and which were less effective.

The final section of the form offers the supervisor the opportunity to provide an overall general impression of the play therapy session and the play therapist’s skills. The supervisor can use the more objective feedback presented in previous sections or the supervisor can use this portion to give a holistic conceptualization of the play therapist’s style and effectiveness.

In following the developmental model of supervision (Stoltenberg et al., 1998), this form can be tailored to meet the supervisee’s professional needs. In the initial training of the play therapist, the supervisor would use the PTSC by completely filling out all sections and discussing it with the supervisee. In the middle stages of supervision, a supervisor might require that both the supervisor and supervisee fill out separate forms and compare them in the supervision session. In latter stages of supervision, when the supervisor has moved more into the role of consultant, the PTSC is completed by the supervisee to review sessions of concern and offer the checklist to the supervisor for discussion.

It should be noted that the use of the PTSC is based on visual supervision of play therapy sessions. This can occur through live supervision or through video recording of therapy sessions. The PTSC can be used on a limited basis through audio recording but it does reduce its effectiveness, especially feedback on Non-Verbal Communication. Yet, in supervising experienced play therapists, a supervisor might use the supervisee’s self-report on the PTSC to encourage self-review and continued areas of growth. This use of the instrument would not necessitate video recording of sessions.
Conclusion

Supervision of play therapy requires structure, and supervisor experience and knowledge. Supervisees benefit from the supervisor’s ability to identify and provide feedback on basic and advanced skills used in play therapy. Although theoretical philosophies will differentiate a play therapist’s approach in play therapy, basic skills will generally benefit all play therapists. The exploration of advanced skills by the supervisor and supervisee help the play therapist maneuver through the deeper and more difficult issues of play therapy. Through the supervisor-supervisee relationship, a play therapist will become effective at recognizing the partnership between enhanced play therapy skills and client progress in play therapy.

References

## Appendix

### Play Therapy Skills Checklist

**Center for Play Therapy/University of North Texas**

Therapist: ______________________________ Child/Age: ______________________________

Date: __________________ Observer: ____________________________________________

<table>
<thead>
<tr>
<th>Therapist Non-Verbal Communication: Lean Forward/Open</th>
<th>Too Much</th>
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<th>Areas for Growth:</th>
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| Reflecting Content | | |
|--------------------| | |
| Reflecting Feelings| | |

| Facilitating Decision Making/Responsibility | | |
|                                            | | |

| Facilitating Creativity/Spontaneity | | |
|                                   | | |

| Esteem Building/Encouraging | | |
|                            | | |

| Facilitating Relationship | | |
|                          | | |

| Enlarging the Meaning/Facilitating Understanding | | |
|                                                 | | |

| Succinct/Interactive | | |
|----------------------| | |

| Rate of Responses | | |
|-------------------| | |

| Limit Setting: | | |
|               | | |

| Child Made Contact/Connectedness | | |
|                                 | | |

| Identified Themes: | | |
|                   | | |

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