Honoring the Person Within the Child: Meeting the Needs of Children through Child-Centered Play Therapy

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Abstract

Child-centered play therapy (CCPT) is the developmentally responsive application of Carl Rogers’ person-centered theory in helping children by incorporating selected play materials within a safe, therapeutic environment. A look at the differing views on the application of empathic listening in CCPT is explored. Some mental health professionals criticize CCPT as being limited in its application; however, research supports the effectiveness of CCPT in meeting a wide range of presenting concerns in contrast to the personal beliefs of some mental health professionals. The application of CCPT provides children a caring, accepting relationship that frees their inner ability to grow and heal through honoring the person within the child.

Keywords: child-centered play therapy, play therapy, person-centered therapy

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Honoring the person within... so much power lays within these simple words. Honoring (to hold in respect or esteem) the person (characteristics that make up an individual or self) within (in the mind, heart, and soul). ("Honoring," 2011; "Person," 2011; "Within," 2011) Carl Rogers was an astute observer of human interaction, particularly within the therapeutic relationship. (Raskins, Rogers, & Witty, 2011) In his work with people in general, and children specifically, Rogers noted that the accepted practice of psychotherapy held therapists as experts. In this position of authority, therapists presumed to know clients better than the clients knew themselves, the source of client distress, and the direction therapy needed to go. Rogers (1946, 1951, 1957) observed that when he provided a safe environment for clients, built upon the therapeutic attitudes of genuineness, empathy, and unconditional positive regard, he created a free space for change to occur. The respect Rogers demonstrated for his clients, truly honored the person within, freeing their innate ability to heal and to grow. This way of being with people holds true for children and may be even more important.

We will explore the roots of Child-Centered Play Therapy (CCPT), the power and appropriateness of play, the application of person-centered ideas in CCPT, creating a safe place for therapeutic change to occur in play sessions, and the how to be with a child client. We will also address some varying views on the application of empathic learning in CCPT and respond to the criticism of some mental health agencies, providers, and supervisors regarding perceived limitations of child-centered play therapy.

The Roots of Child-Centered Play Therapy

The foundation of Child-Centered Play Therapy (CCPT) extends back to the early days psychotherapy. Sigmund Freud (1909/1973) used play in his therapeutic work with children over one hundred years ago in his treatment of Little Hans, a five-year-old boy with a phobia of horses. Freud’s treatment of Little Hans
involved training the boy’s father in play-based analytic skills to use at home. Hermaine Hug-Hellmuth (1921) was the first known therapist to use play herself, in the diagnosis and treatment of children over six years of age, providing them with play materials in which to express themselves. (Landreth, 1987) In 1919, Melanie Klein (1955) employed play in her work with younger children as a basis for interpretations. She believed that the play of children was the motivational equivalent of adult free association and provided direct access to the child’s unconscious. During this same period, Sigmund Freud’s daughter, Anna Freud (1965) noted that children lacked the cognitive development necessary to participate in free association and began to use play.

In the 1940s, Rogers developed the nondirective (later renamed client-centered, then person-centered) approach to therapy, evolving from his experiences working with children and their parents. (Raskins et al., 2011) Axline (1947), one of Rogers’ students, adapted the client-centered approach in her work with children, calling it play therapy. According to Axline, play therapy is a therapeutic environment in which children use play to express their feelings and work through problems. Children naturally express themselves through play, as adults express themselves through talk. Axline’s approach involved the use of a playroom that served as a stable environment for weekly play therapy sessions. She developed relationships with her child clients by communicating empathy, unconditional positive regard, and genuineness. Axline based her nondirective method on the assumption that children have the innate ability to solve their own problems and to move forward towards mature behavior, rather than immature behavior. Play therapy provides children a permissive environment where they can explore and grow at their own pace. (Axline, 1947)

Axline (1947) outlined the following eight principles of conducting play therapy with children. Play therapists need to (1) establish a warm relationship; (2) provide unconditional acceptance of the child; (3) provide permissiveness in the relationship, allowing the child free expression of feelings; (4) be alert to the child’s expression of feelings and reflect them to the child in such a way that he or she gains insight; (5) maintain a respect for the child’s...
ability to solve problems and promote decision making and responsibility in the child; (6) avoid directing the child’s actions or conversations; (7) avoid hurrying the child along and recognizes the gradual process of therapy; and (8) establish only those limits necessary for anchoring the child to reality and instilling awareness in the child of his or her reasonability in the relationship. (pp. 73-74) Ginott’s (1975) ideas of limit-setting reflected Rogers’ (1946) own views on limits within therapy. Ginott also made major contributions to play therapy and played a major role in the development of CCPT. Ginott believed limit-setting helps reestablish children’s views of themselves in relation to adults as people and as protected by adults. He postulated that children manifesting acting-out behaviors do not trust adults to act consistently and feel the need to test limits. Ginott considered that limit-setting to be a key element in therapy as it helps to reinforce caregiver consistency in a child’s life and protect the therapeutic relationship, in turn allowing the play therapist to maintain a positive attitude toward the child. (O’Connor, 1991)

Landreth (2012) supported a child-centered approach and integrated the nondirective techniques of Axline (1947) and the limit-setting techniques of Ginott (1975) into a consistent approach that includes trained therapists utilizing a nondirective fashion in a playroom with developmentally appropriate materials. Landreth incorporated some of Axline’s basic relationship-building skills into his child-centered approach, such as tracking and reflections of feelings and content in the context of a nondirective and non-evaluative stance by the therapist. In addition to Axline’s methods, Landreth utilized Ginott’s limit-setting philosophy in developing an original model of limit-setting and returning responsibility entitled ACT. ACT reminds play therapists to Acknowledge feelings, Communicate limits, and Target alternatives. Landreth’s view of play therapy involves trained therapists facilitating the development of a safe relationship where children can express and explore feelings, thoughts, experiences, and behaviors through play. The ACT model allows for the development of self-acceptance, self-awareness, self-responsibility, and ultimately self-growth. (Landreth, 2012) The evolution of nondirective play therapy first presented by Axline, and most recently redefined by Landreth, led to the
development of child-centered play therapy, the person-centered approach to working with children. CCPT, a developmentally responsive approach to helping children, recognizes the importance of play in their lives.

Creating a Playful and Safe Environment

When engaging in traditional talk therapy with adults, the bare minimum of equipment is usually a few chairs and a room with four walls. However, when working with a child, the necessary environment and range of equipment is significantly more complicated. Child-centered play therapists must consider not only the room, an important consideration of the relationship, but also the materials. Another of Rogers' (1951) 19 propositions is that the organism (or for our purposes, the child client) is in the center of an ever-changing body of experience (phenomenal field) to which the child client reacts as it perceives and experiences it. Whenever a child walks into the therapy room, play therapists must consider and take responsibility for what they introduce to the child's phenomenal field. In this respect, the thoughtful play therapist considers the following principles of structuring a playroom environment: toys, organization of the room, structuring of the relationship, and limit-setting.

Playroom Materials

As discussed earlier in this article, play constitutes the primary means of expression for many young children, or in other words, play is their language. (Landreth, 2012) To extend this metaphor further, if play is the language of children, then toys are their words. To fully understand the implications of such a statement, one must consider how such a principle applies to talk therapy. Therapists do not start a course of counseling by handing a client a list of discussable topics, nor a list of non-discussable topics. However, this is exactly what happens when play therapists arbitrarily limit the toys in a playroom. However, it is also true that it is a practical impossibility to provide a child with every toy in existence, nor are all toys suitable to the therapy process. In light of
this knowledge, play therapists have two major tasks in furnishing a playroom with toys: (1) evaluating toys for properties that are conducive to the purposes of play therapy, and (2) providing the appropriate range of categories of toys so that the child can achieve a suitable level of breadth and depth of emotional expression in “play” language.

Landreth (2012) made an important directive in amassing toys for use in a playroom. He stated that play therapists need to select toys, not collect them. In furnishing a playroom, a “toy collector” amasses great amounts of toys, but without particular purpose or attention to how each toy might facilitate the therapeutic relationship. (Rogers, 1961) We can liken a toy collector to therapists who say whatever thought comes through their minds without concern about how therapeutic such a comment is. In short, the toy collector orientation is a careless approach that does not apprehend the play therapists hold in providing responsible care to their clients. “Toy selectors” on the other hand choose toys carefully to meet their purposes, just as conscientious therapists carefully choose their words when speaking to a client. Landreth provided eight useful guidelines in determining the appropriateness of a toy for the playroom.

Toys and materials are selected that
1. Facilitate a wide range of creative expression.
2. Facilitate a wide range of emotional expression.
4. Facilitate expressive and exploratory play.
5. Allow exploration and expression without verbalization.
6. Allow success without prescribed structure.
7. Allow for noncommittal play.
8. Have sturdy construction for active use. (Landreth, 2012, p. 156)

As can be seen from the eight principles of toy selection, particular importance is placed upon how a toy facilitates personal expression, creativity, and relationship building. One toy that is frequently seen in play therapy, but that true child-centered play therapists will usually avoid, is the use of video games of many
kinds. Anyone who has spent any time around children cannot deny that video games engage a child’s interest (principle #3). However, video games rarely allow success without prescribed structure (principle #6), and it is certainly questionable whether they can provide a wide range of creative and emotional expression. Furthermore, the Rogerian principle (Rogers, 1951) behind all these guidelines for toy selection is: “Does it enhance the client-therapist relationship?” For videogames, the answer to the previous question is frequently, “No.”

Another issue pertinent to toy selection is the different categories of toys. Landreth (2012) listed several categories of toys. A fully furnished playroom should have the following kinds of toys to allow children the fullest expression of emotions: real life toys, aggression-release toys, developmental-mastery toys, art supplies, fantasy toys, and nurturing toys. Real Life or realistic toys are ones that allow children to engage in fantasy play that mimics the life of adults. Such toys may include phones, watches, compasses, binoculars, pagers, and others.

Aggression-release toys are especially suited to the expression of feelings of anger or aggression. Typical toys found in the aggressive toy category include rope, masks (bank robber), non-realistic toy guns, handcuffs, swords, and knight’s armor. Some aggressive-release toys (e.g., guns and/or knives) frequently cause some therapists discomfort. However, it is our opinion that few symbols in our culture symbolize anger and aggression at such a primal level as a gun or a knife. Child-centered play therapists must learn to look beyond the actual toys being used and more towards the contextual emotional expression. While Rogers’ commitment to world peace is well established, including a nomination for the Nobel Peace Prize 1987, (Kirschenbaum & Henderson, 1989) he also provided unconditional positive regard to clients expressing emotions such as anger. It is the expression of anger that frequently underlies the symbolism of the gun.

Developmental-mastery toys allow children to accomplish basic or more complex motor tasks such as building a structure with blocks, succeeding in a ring-toss game, and so forth. Rogers’ (1957) fifth proposition stated that behavior is basically goal directed and
aimed at satisfying the needs of the organism. As children develop, they frequently desire and need an experience in which they can demonstrate mastery of task, and be able to say, “I did it!” Developmental-mastery toys allow such an experience.

Art supplies are a critical part of the playroom. As discussed earlier in this article, children’s developmental level frequently does not allow them to fully express their emotions using language. Art supplies such as crayons, paint, markers, paper, and so forth allow children to say in art what they cannot or dare not say in words. The first author of this article once saw a child in play therapy who rather than telling the therapist how she felt, would draw a picture depicting her emotional state several times throughout the session. Child-centered play therapists endeavor to provide children with this sort of expression when they step into a playroom.

Fantasy toys cover a broad range of toys that allow for the construction of imaginative or narrative play sequences. These toys include dress-up clothes, doll families, animal figurines, and more. Children frequently need the opportunity to act out scenes from their life at home, school, and other places. Rogers’ (1957) 17th proposition stated that in an environment free from threat, an individual might further examine experiences not previously symbolized. Fantasy toys allow for a broad range of expression. Coupled with the characteristics of the play therapist and playroom, fantasy toys allow for broad range of expression and exploration.

Finally, playrooms need toys that are nurturing. Nurturing toys allow children to engage in play that is centered on healing, caretaking, and providing for the needs of others. Nurturing toys include a kitchen and cooking toys, cleaning toys (e.g., vacuum cleaner or broom), a doctor’s kit, baby dolls, baby bottles, and so forth. Just as aggression toys allow for the expression of anger, nurturing toys allow children to express or receive nurturing that may be unique or previously not experienced by them.

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Playroom Environment

However, it is quite possible to have all the toys needed in a playroom, but still not have the proper environment for a child to engage in emotional exploration. First, a playroom must be inviting. Too frequently children are told, “Don’t touch that,” or “Stop playing with that.” The playroom should be a place where the child feels welcome. To make a playroom inviting, toys need to be openly visible and accessible to children without the need to ask an adult where the toys are or for help in reaching certain toys. To create a welcoming playroom, play therapists must properly maintain the room and toys. Broken toys indicate missed opportunities for emotional expression. A poorly maintained room indicates a lack of valuing for the room and the time with the child. To appreciate the full implications of this disarray, imagine if an adult therapist brought a client into a room in which the paint was peeling, trash was on the floor, and the chair had wobbly leg. This space would inhibit clients from feeling valued and free of threat enough to facilitate emotional growth.

A second major characteristic of the playroom is that it must be consistent. Just as adult therapists must provide consistency in terms of access and emotional availability to an adult client, play therapists must provide both a personally and environmentally consistent experience for a child. One central facet of consistency in the playroom is the toys. The same toys need to be available every time, in the same order/place. Additionally, the same playroom should be used (if there are multiple playrooms) to provide as consistent and safe place as possible. Frequently, children referred for play therapy have disorganized or chaotic lives at school or home; the therapy hour is to be a safe place, and therefore it should provide them with a clean, consistent, and organized experience, freeing children to explore emotional issues.

A final important characteristic of the playroom environment is that it must be free of distraction and somewhat private. It is rare for a child to have the complete and unadulterated attention of an adult for a sustained period. Brothers or sisters frequently interrupt time with parents, and other students frequently interrupt time with teachers. However, the play therapy hour is a special time that is just

for the child. Ideally, the playroom is free of frequent traffic and communal supplies. Parents, teachers, or student therapists should not be allowed in the room when therapy is being conducted. Play therapists must be able to focus their attention on a child for the full therapy session, as this may be the only time a child gets for facilitated emotional development during the week. Interruptions devalue the person and process of all those involved in therapy, distracting play therapists from a job requiring all of their mental faculties.

Another significant part of the playroom involves limit-setting. All play therapists at some time perceive children engaging in activities that can be dangerous to the child, destructive to the room, or damaging to the child-therapist relationship. While the play therapy room and experience are meant to be nondirective and permissive, just as Rogers' (1940/1992, 1946, 1951) original conception of therapy was, this does not mean that there are no boundaries. Rogers (1961) once described therapy like being on a walk with a client. Sometimes we might fall a step behind, sometimes we might step a bit ahead, but for the most part, we are with our clients, being companions as they travel through their own emotional experiences. In the same way that we do not leave adult clients to process frightening emotions without our support or presence, we do not allow a child to venture into things that might endanger them physically or emotionally. Physical or emotional threats can inhibit the ability of a child to work through difficult emotions in the playroom.

Play therapists must also set limits regarding harm directed towards them. Child-centered play therapists, as person-centered counselors for adults, seek to provide unconditional positive regard, congruence, and empathy to their clients. However, when a therapist experiences a legitimate threat of physical harm, it makes it difficult to provide any of those conditions. Just as therapists have respect for the personhood of their clients, so they must have respect for their own personhood. When therapists do not set limits to protect themselves, it frequently results in therapists not being mentally and emotionally present for the client. Therefore, by setting limits to protect oneself, ultimately the therapist is also protecting the client.
Child-centered play therapists typically use a limit-setting model that can be easily committed to memory by using the acronym ACT. (Landreth, 2012) First, the play therapist (A)cknowledges the feeling or desire that a child is currently displaying. Next, the play therapist (C)ommunicates the limit or boundary that a child is attempting to breach. Finally, the play therapist (T)argets alternatives to which the child can direct her or his energy. Play therapists start with acknowledgment of feelings because of the deeply held respect for personhood and unconditional acceptance of thoughts and feelings that is so central to person-centered counseling (Rogers, 1957). Play therapists then communicate a limit or boundary. Finally, play therapists identify acceptable alternatives for children to direct their feelings. Just as person-centered counselors accept their clients' feelings, they also must acknowledge that a person cannot simply will away anger. Sometimes the emotion needs somewhere to go and play therapists help direct children to a proper receptacle for their feelings. For example, if a child named Jimmy was attempting to hit the therapist, the therapist might say, “Jimmy, I know that you really want to hit me. But I’m not for hitting. You can choose to hit the bop bag.”

**Play Therapy in the Person-Centered Relationship**

Founded in person-centered counseling and philosophy, CCPT utilizes and applies Rogers’ (1951) principles to working with children. However, due to the developmental level of children and their difficulty with verbal expressions, CCPT attempts to bridge the gap between traditional person-centered counseling and the verbal and nonverbal play of children. Similar to person-centered therapists, child-centered play therapists hold strongly to the belief that all individuals have the internal capacity for forward growth. It is this humanistic belief that serves as the premise of the therapeutic relationship. Each child entering the playroom for the first time meets another individual (the play therapist) who genuinely wants to communicate sensitive understanding. This sensitive understanding is defined by the child’s perception of the play therapist’s demonstration of the three core conditions of change (Rogers, 1957);
unconditional positive regard, genuineness, and empathy. When children perceive these three conditions from the play therapist, they free themselves to explore their true feelings and to grow.

In order to develop the demonstration of the three core conditions, Rogers (1957) emphasized the importance of establishing safety within the confines of the client-therapist relationship. Play therapists must be willing to take a warm, empathic interest in their child clients, accepting them for the individuals they are in the present moment. The following summarization is Rogers’ (1951) description of the importance of the relationship. The client experiences a feeling of safety in the warmth of the relationship with the therapist. Within this relationship, he is able to explore, perceive for the first time certain aspects of his behavior, and understand why it has been necessary to deny awareness of his behavior. As he voices his new perceptions of himself, the therapist perceives and accepts them. The client, experiencing in another acceptance, finds that he can accept himself without guilt. He is enabled to do this because another person had the capacity to adopt his frame of reference and perceive with him while demonstrating acceptance and respect. (Rogers 1951, p. 41)

**Unconditional Positive Regard**

Child-centered play therapists promote unconditional positive regard for the child by demonstrating acceptance of the child and by allowing a permissive environment in which the child leads the direction of the play within the playroom. This communication of freedom within the playroom environment sends the message to children that they are in control in the play session and that the therapist respects their internal abilities to move toward completeness. This permissiveness is a vital part of the therapeutic process. (Rogers, 1946, 1951) By not dictating the direction of the therapy, play therapists allow the inner, forward-moving direction of children to take the therapy where they need it. For example, the second author worked with a child whose younger cousin had died. Each play session she would go to the sand tray and place sand in a small container. The meaning of this repetitive play became apparent when the child’s guardian shared that the child’s cousin had drowned.
after reaching into a bucket of water within which the child had placed some glitter.

Guerney (1983) elegantly stated that the goal of CCPT is “to promote maturity in children without directing them but respecting the directions they set themselves. Most behaviors of the play therapists are designed to facilitate the child’s self-direction, self-exploration, and self-growth.” (Guerney, 1983, p. 23) Complete acceptance by the play therapist allows children to experience a relationship in which they feel valued, and hence worthy of being oneself. Experiencing genuine acceptance provides children an opportunity to reexamine how they truly feel and experience themselves, others, and the world around them, thus redefining their identity and freeing themselves to live and be more authentic. Additionally, child-centered play therapists trust the child’s potential and enter the play session free of their own personal or specific goals and conditions that they may place on the child. By not inserting their own expectations onto the child, play therapists create an environment where the child is free to experience and direct the play session in ways that are useful for the child and promote self-growth.

**Genuineness**

Being genuine for the child-centered play therapist involves courage: courage to be honest with the child while remaining open to being intimately involved in the development of a relationship deeply embedded in self-discovery. It is within this unique relationship that play therapists exhibit careful, undivided attention to the child by remaining fully present with the child. This attention includes “interacting with the child by observing, listening, and making statements of recognition.” (Landreth, 2012, p. 97) It is within the state of being fully with a child that the child experiences the play therapist as genuine and caring. Within this full attention, play therapists hold a genuine interest in the child and a yearning to build rapport that communicates sensitive understanding. It is within this relationship that children open themselves to experiencing their positive and negative experiences of the world. While some hardships and/or vulnerabilities communicated by the child may leave both play therapist and child emotionally raw, the honor and
sacredness of the relationship continues to authenticate the child’s genuine need to share experiences of self. Play therapists have a strong desire to fully know and be with the child, as if to see the world from the child’s perspective.

**Empathy**

The communication of understanding is vital to the establishment of the child-therapist relationship. The use of empathy and being able to accurately and consistently project understanding of the child’s internal world and experiences is key to the appreciation of the child’s true self. Landreth (2012) described the therapist’s role in projecting empathy to the child as “The attitude of the therapist is to sense as deeply as possible the experiencing of the child at that moment and to accept as fully as possible the emerging intuitive empathetic responses within herself as being sufficient for the moment.” (p. 73) It is from the play therapist’s gentle, accepting reflections of the child’s current emotions that the doors can open for a child.

**A Discourse on Empathic Listening in Child-Centered Play Therapy**

In terms of the use of empathy in play therapy sessions, we have a unique perspective that is somewhat divergent from many child-centered play therapists. “When using empathic listening during play sessions, the therapist puts his or her own thoughts and feelings aside and pays close attention to the child’s verbal and non-verbal behaviors.” (VanFleet, Sywulak, & Sniscak, 2010, p. 66) While we do in fact agree that the child’s feelings and thoughts must necessarily take center stage in a play session, we would make a distinction between placing the child first and setting aside the therapist’s own thoughts and feelings. Skilled person-centered therapists, and by extension skilled child-centered play therapists, must not be a “blank slate” or a “mirror” without thoughts or feelings of their own. Rather, play therapists must have access to their own thoughts and feelings at any moment in time so that they are not just a professional facilitating a therapy session, but a human

being making connections with another human being in a manner that promotes the activation of inner resources. An alternative viewpoint about congruence comes from Virginia Ryan’s nondirective play therapy.

Ryan and Courtney (2009) promoted that play therapists share their emotional reactions/experiences with the child to be entirely genuine with the child. While we appreciate Ryan and Courtney’s emphasis on the importance of being genuine within the session, we caution against over-burdening the child with information that may not be facilitative to the child’s progress. Alternatively, VanFleet and colleagues (2010) stated that empathic listening requires therapists to “get out of their heads and into the heads of the child.” (p. 25)

As counselor educators who advocate for play therapy, we appreciate the importance of nascent play therapists transitioning from person pre-occupation with their own thoughts and interventions to the thoughts of the child client. However, getting into the head of the child is only a portion of what we believe is the quality CCPT experience. Cochran, Nordling, and Cochran (2010) stated the “heart of the matter” of deep empathy is not about “figuring it out,” but rather about feeling the emotion of the moment. Practicing clinicians may appreciate the above theoretical discourse, but at the heart of therapy is practice. Theory loses purpose when it begins to resemble a child’s musical instrument that sits in a closet never used. Theory and philosophical abstractions only matter when they directly affect the reality that play therapists provide for their clients. Therapists’ empathy and access to their own emotions in subtle ways connects with all decisions they might make, one example is limit setting.

Play therapists must be aware of their own personal emotions as they set limits, in addition to experiencing and displaying empathy for the child. For example, the first author had a strong personal reaction to a child client’s actions, as well as a need to provide empathy for the client in limit setting, while involved in a play therapy research study that explored the effect of play therapy on aggressive behavior in children. (Ray, Blanco, Sullivan, & Holliman, 2009) When I informed the child that play session was
over – following Landreth’s (2012) protocol for ending a session – the child became angry. The play session was conducted in multi-purpose portable school building that included non-play therapy toys outside of the play therapy area. The child picked up a hammer and threatened to throw it at me. As a play therapist, I felt strong feelings coming up for myself of impending head trauma and being aware that my feelings could fester into something non-therapeutic. I was aware of the child’s experience of feeling desperate for more time in the playroom. Both my own feelings and the child’s experience (not only the thoughts and feelings, but the full experience) were important. As I set limits, I had to be aware of my own emotions as not to project a judgmental attitude towards the child, while at the same time acknowledging the dignity of such an experience.

Therapists who attempt to simply “push away” or deny their feelings of frustration at a child who is demonstrating aggression, give the feelings more power, not less. In this denial of the self, which is in truth an incongruent act, therapists do not have access to the full range of expression due to the denial of experience. In the same moment that therapists are aware of their own feelings, they must also honor the experience of the child (e.g., having a desperate desire for a play session to continue). Therapists who accept both themselves and the child will view this not as a petulant child demanding to “get their way.” Rather, therapists will view it as a valid experience that can be emotional painful, and experienced therapists validate the feelings as a fellow traveler with the child, while still communicating limits. In this way, we believe that play therapists practice deep empathy by knowing and acknowledging the experience of the child, as well as having access to the therapist’s emotions and expressing them in a mature facilitative manner.

The Power and Appropriateness of Play

While play therapy has a long-established history as a therapeutic intervention, the question remains, why use play as opposed to talk therapy or other interventions? Landreth (2012) postulated play as a central activity of childhood that is spontaneous, enjoyable, voluntary, and non-goal directed. These qualities make

play an essential element of therapy with children. Furthermore, Axline (1947) stated that play is the natural medium of expression for children, suggesting that play therapy provides children the opportunity for emotional expression and exploration, as talk therapy provides the same for adult clients. Frank (1982) stated that play teaches children what no one else can teach them and is their way of orienting to the world. Based on the aforementioned conclusions about play, it would seem that incorporating play into therapy with a child is a direct and concrete application of the seventh of Rogers’ (1951) 19 propositions, namely, that the best frame of reference for understanding people is their own internal frame of reference. Since play is the natural medium of expression for children, play therapy provides a way of meeting children and attempting to understand the world from their viewpoint and through their natural language of play. Attempting to use a primarily talk-based intervention with a child is an unnecessary imposition of an artificial frame of reference. Talk therapy and its necessary implications (e.g., the focus on abstract thought, the primary use of spoken language, etc.) are a uniquely adult mode of interaction. When explaining play therapy to parents, play therapists frequently use the following metaphor, “Talking with children, as opposed to playing with them, requires them to use a language that is not their primary language; it would be no different than trying to conduct a talk therapy session in German, when you (the client) only spoke English.”

In addition to the natural place of play as the language of children, there are several developmentally appropriate reasons to use play in therapy with children. The first of Rogers’ (1957) six necessary and sufficient conditions for therapeutic personality change is that two individuals be in psychological contact with each other. It is our opinions that when we do not modify our therapeutic interventions to be developmentally appropriate and sensitive to the individual client, then we are unavoidably failing to make psychological contact. Piaget (1962) outlined four basic stages of cognitive development for children: Sensori-motor (ages birth-2 years old), Pre-operations (2-7 years old), Concrete Operations (7-11 years old), and Formal Operations (12+ years old). Piaget’s theory provides a developmentally responsive rationale as to why
play therapists eschew talk therapy in favor of play. The capacity for abstract thought, a key requirement for someone to benefit fully from talk therapy, develops within formal operations. Furthermore, in the forefront of pre-operations is the development of children to use symbols. (Piaget, 1962) The ability to use symbols to represent abstract concepts allows children to construct play sequences and narratives that enable them to explore emotionally significant events in manageable play sequences using toys in the playroom.

"Limitations" of Child-Centered Play Therapy

While person-centered therapy may have been embraced by the psychotherapeutic community in Carl Rogers’ prime, it has been our experience that the person-centered approach, while still powerful for those who have the patience and inner strength to trust the process and their clients, is much misunderstood and maligned by current practitioners. Cochran and colleagues (2010) identified prevalence among clinicians, supervisors, and clinical directors that play therapy is only helpful when it leads to clients “talking” about their issues and that the appropriateness of CCPT only applies to some clients.

One major issue that has plagued us, and the interns who we have supervised, is the widespread view that CCPT possesses the necessary components of therapy, but is insufficient in and of itself. In fact, we are aware of many agencies that do not allow interns to use CCPT as their sole, or even primary, intervention and require interns to utilize more directive approaches. The viewpoint communicated by these agencies is that CCPT is “not enough” for serious problems and that CCPT is not “real therapy” but simply a supportive technique. This bias is incongruent with current play therapy research.

VanFleet, Sywulak, and Sniscak (2010) stated that play therapy is effective for children with attachment disorder, posttraumatic stress disorder, anxiety, obsessive-compulsive disorder, and oppositional-defiant disorder in helping children reorganize and manage emotional experiences. Further research has demonstrated the effectiveness of CCPT with children with

academic achievement, conduct disorder, aggressive behaviors, ADHD, and self-concept driven issues. (Blanco & Ray, 2011; Cochran & Cochran, 1999; Cochran, Cochran, Fuss, & Nordling, 2010; Dogra & Veeraghavan, 1994; Post, 1999; Ray et al., 2009; Ray, Schottelkorb, & Tsai, 2007) Continuing research evidence supports the applicability of person-centered approach to almost any situation when applied by a mature and skilled practitioner. Indeed, VanFleet and colleagues stated that CCPT could be applied to a number of presenting concerns with little modification.

A Way of Being With Children

Landreth (2012) stressed the importance of being with a child. CCPT is “not a cloak of techniques the play therapist puts on upon entering the playroom,” (p. 53) but a way of being, of “living one’s life in relationships with children.” (p. 53) This way of being echoes Rogers’ (1961/1989b) stance that “the attitude held by the counselor toward the worth and significance of the individual” (p. 20) is primary to the therapeutic relationship.

As illustrated earlier, Rogers’ (1951, 1957, 1980) core beliefs about relationships and therapeutic change provides the foundation of CCPT. CCPT play therapists embody the core conditions of caring acceptance, empathy and understanding, and genuineness, in turn creating a nurturing and protective environment. Within this safe space, children experience freedom from the expectations of others, enabling them to explore how they really experience themselves, others, and the world around them. (Landreth, 2012) Within this relationship, children allow themselves to try new ways being, feeling, and thinking, becoming more congruent with their true selves.

Rogers (1951, 1986/1989c) affirmed the effectiveness of play therapy with children when based from a person-centered perspective. He recognized that children communicate more through actions than words. (Rogers, 1942/1989a) Play therapists appreciate children’s ability to communicate their full experiences through non-verbalizations and symbolic language. (Dorfman, 1951; Rogers, 1940/1992, 1946, 1951)

With nearly 30 years of combined experience in providing CCPT, we have witnessed the beauty, joy, and power of this developmentally responsive approach to being with and helping children. We have provided and researched CCPT with children who present with a wide variety of presenting concerns, including academic performance, loss and grief, divorce, abuse, environmental and personal trauma, and we continue to wonder in the resiliency of children. Children are capable of great growth when they experience a caring adult within a safe, permissive relationship who honors the person within the child.
References


