

Unconditional Positive Regard and Limits: A Case Study in Child-Centered Play Therapy and Therapist Development

**Jeff L. Cochran, Nancy H. Cochran,
Lindy C. Sherer
University of Tennessee**

Abstract

In this case study the therapist struggles to maintain unconditional positive regard (UPR) for a child whose behavior in child-centered play therapy creates a need for limits. CCPT was provided within a program to prevent juvenile delinquency among at-risk children at an urban, high poverty elementary school. The client was referred for highly disruptive oppositional behavior persisting months into his kindergarten year. Data evidencing progress is provided as a reference point, while analysis focuses on conceptualization of process and mechanisms of change. The client's experience of UPR, as well as use of limit testing to explore possibilities in relationships and self-concept, is related to his apparent progress, as is his therapist's growth and development toward providing consistent UPR, even when behavioral limits are needed.

Keywords: Play therapy, unconditional positive regard, delinquency

Author's note: Jeff L. Cochran and Nancy H. Cochran are faculty members in the Department of Educational Psychology and Counseling at the University of Tennessee; Lindy Cohen Sherer was an intern with the University of Tennessee REACH Project at the time of this research and is now an alumna of the UT Mental Health Counseling Masters Program. Correspondence regarding this manuscript should be sent to Jeff L. Cochran, 535 Bailey, Department of Educational Psychology and Counseling, University of Tennessee, Knoxville, 37996-3452.

When Unconditional Positive Regard Encounters a Need for Limits: A Case Study in Child-Centered Play Therapy

Rogers (1957; 1961; 1980) and other scholars in the person-centered approach have illustrated the therapeutic importance of unconditional positive regard (UPR; Mearns & Thorne, 1988; Wilkins, 2000). Rogers (1961) explained that UPR is “A warm caring for the client – a caring which demands no personal gratification. It is an atmosphere which simply demonstrates ‘I care’; not ‘I care for you if you have behaved thus and so’” (p. 283). Mearns and Thorne (1988) explained, “The counselor who holds this attitude [UPR] deeply values the humanity of her client and is not deflected in valuing any particular client behaviours” (p. 59).

There are decades of evidence supporting the power of Rogers (1957) core conditions, including UPR (Bergin & Lambert, 1978; Farber & Lane, 2002; Orlinsky & Howard, 1986; Patterson, 1984; Peschken & Johnson, 1997) and consensus as to the importance of UPR. Wilkins (2000) concluded that UPR is “a major curative factor in any approach to therapy” (p. 23). Bozarth (1998) described UPR as the curative factor in client-centered therapy. Farber and Lane (2002) explained that at a minimum, UPR “sets the stage” for other positive interventions and, at least in some cases “may be sufficient by itself to effect positive change” (p. 191).

However, providing UPR may not be as simple as it sounds. Wilkins (2000) pointed out the complexity of this simple sounding concept of UPR. Cochran and Cochran (2006) explained that UPR might have to be viewed as an action verb rather than an attitude, because clients’ actions or ways of being may continually challenge the limits of what counselors can accept while remaining congruent. Thus UPR is not a state that counselors reach and maintain, but a way of being that requires continued effort and growth.

This article presents a case study in which a child’s need to test limits in child-centered play therapy (CCPT) challenges his young therapist’s ability to maintain UPR. Yet, his work in testing limits in CCPT and his experience of his therapist’s UPR are seen as the major factors in his apparent behavioral progress. Outcome data are provided suggesting apparent progress in behavior change, while

the foci of this article are analyses of the child and therapist's process.

Limits in CCPT

Adults in counseling may rarely need to hear a response from their counselor along the lines of, “[Client name], one of the things you may not do in counseling is [e.g. physically hurt yourself or others; intentionally break things in my (the counselor's) office].” However, as Axline (1947) showed the way through play therapy to provide children with a permissive relationship that facilitates free expression and self-exploration, she also explained that at least some limits will be “necessary to anchor the therapy to the world of reality and make the child aware of his responsibility in the relationship” (p. 76). Cochran, Nordling, and Cochran (2010) explain that limits are a normal, essential, and unavoidable part of play therapy. Consider the following three most common needs for limits in play therapy: first, every session must end, even though many times children are not ready to end when the clock and schedule dictate that the counselor must end; second, even though it can be a very satisfying element of expression for some children to break toys, if too many toys are broken (or materials wasted) the counselor's budget for toys is quickly exhausted, and opportunities for children to self-express are diminished; and, third, but perhaps most importantly, children cannot be allowed to hurt themselves or their therapist in play therapy, even though the urge to do so may be understood by the therapist and provided empathy for.

Additionally, as Cochran, Nordling et al. (2010) clarified, learning the balance of setting as few limits as possible, yet enough to maintain safety and the therapeutic environment, as well as the therapist's UPR and congruence can be a delicate balance requiring supervision, practice, self-awareness and personal growth on the part of many therapists. This case study explores the importance of that balance in the work of a young, novice counselor with a child client who appeared to have a great need to test the limits of his relationship with her and to experience UPR from her.

Methods Setting

The client was served in a large, urban, Title I, high poverty elementary school. The school has over 700 students, a free or reduced meals rate over 90% and a mobility rate over 40%. Many children apparently come to the school underprepared, as achievement test results are persistently well-below national and state averages. Teachers at the school normally expect to help students with misbehavior and learning readiness, especially considering that many are known to have quite difficult home lives. Services to the client were made possible through a grant funded program that provides child-centered play therapy for children whose behavior and life circumstances predict high risk of delinquency or other juvenile court involvement.

Treatment Model

Treatment was provided in 30-minute sessions, scheduled twice weekly. The therapist (third author of this study) was an advanced graduate intern completing her masters in mental health counseling, working under the supervision of an experienced child-centered play therapy supervisor (second author of this study). The therapist had completed one course in CCPT. As the words therapist and counselor may often be interchangeable, we refer to her as “therapist,” fitting with the name of the approach and to clarify that we are referring to that particular person, while we use the term “counselor” to refer to most persons who would apply the approach and “therapist” when referring more narrowly to CCPT in this article.

The treatment is CCPT (Axline, 1947), in the model developed by Louise Guerney (Cochran, Nordling et al., 2010; Guerney, 1983). Therapist’ empathy and UPR and the child’s free self-expression are paramount in the approach. Cochran, Nordling et al. refer to the limit-setting procedure in the approach as, “the empathy sandwich” (p. 132). Necessary limits are sandwiched between 1) the therapist’s empathic acknowledgment of the child’s apparent motivation for engaging in the behavior, and 2) the therapist’s empathic response to the child’s reaction to the limit.

Limits are stated in a firm, yet warm and nonthreatening manner. Limits are worded to be specific in order to only restrict the smallest number of behaviors necessary. If a child were to persist toward a known and previously stated limit, for instance throwing a ball directly at the therapist's head, he would be informed with wording like the following:

Responding empathically to the child's intent: [When a child seems very curious about a limited behavior] "you want to know what happens when you throw the ball right at my head" ... or [When a child shows obvious enjoyment or obvious anger while trying a limited behavior] "you like throwing the ball right at my head" or "you are mad, and want to throw the ball right at my head."

Stating the consequence of proceeding with the limited behavior:
 "Child's name...throwing the ball at my head is one of the things you may not do. If you throw the ball at my head again, our special play time will end for today."

Responding empathically to the child's next response after the stated limit or asserting the consequence, if necessary: [The child has moved on to another activity] "You have a new idea. You have decided to punch the bop-bag." [The child argues the point] "You want me to know that's not what you were doing!" [Child repeats the previously limited behavior and throws the ball at the therapist's head. The therapist picks up the ball and get's child's attention by calmly saying his name] "Child's name, you threw the ball at my head again. That is what you wanted to do, but that is one of the things you may not do. Our special play time is over for today [heading toward the door]. We will have special playtime again next week."

It should be noted that it is very rare in CCPT that children engage the consequence. A calm and firm tone of voice and empathic acceptance conveyed through facial expression and open body posture when stating a limit are usually enough to help even the most limit testing child know that "you still have control *and* a choice...however, this is one thing you may not do in special playtime." Should the consequence of the session ending be necessary, the therapist remains empathically accepting and sensitive to the child's reactions and feelings, but also firmly maintains that "special playtime is over for today."

The Guerney approach to CCPT also provides guidance for therapist participation in children's play and a stage model for understanding children's process in CCPT (Cochran, Nordling et al., 2010; Cochran, Cochran, Nordling, McAdam, & Miller, 2010; Guerney, 2001; Nordling & Guerney, 1999). Therapist participation provides for rich relational work. Recognizing the stages of a child's work in CCPT provides a view of children's internal therapeutic process, a process that may not be as evident as it is in counseling with most adults.

Briefly, the typical stages of CCPT can be described as:

Warm-up: relationship is formed, including the child's understanding of his and his therapist's roles, the unique potential of the playroom and therapeutic relationship, and a feeling of safety that facilitates free expression. Children work to discern just who this person (their therapist) is to them, what is possible in the relationship, what will be OK and not OK in the playroom.

Aggressive stage: children work on issues of power and control, and often express aggressive tendencies or thoughts through characters and actions in role-play.

Regressive stage: children explore issues related to attachment and nurturing, and often play in younger seeming ways than would be expected for the child's age; themes of protection, giving and receiving nurturance predominate.

Mastery: signals readiness to begin to end therapy; children exhibit a growing awareness of competence and self-mastery, while integrating the gains of earlier stages into their personality.

Data Collection and Analysis

Protection of client identity. To protect his identity, we refer to the client in this study with a pseudonym, Darian. Additionally, some playroom actions that could possibly be identifying, but are seen as important to understanding his process, are changed by inserting parallel behaviors that the authors considered true to his process without risking identification. Study procedures, including parental permissions and data collection, are approved by the institutional review board of the first author's university.

Panel consensus. The authors formed an expert panel in order to conceptualize the client, his use of CCPT, and apparent mechanisms of change. As a panel, we have 45 years combined experience conceptualizing client difficulties, planning and assessing treatment, providing and supervising CCPT, and particular expertise in applying the stage model of CCPT. The first two authors have extensive experience in teaching, supervision and research in the person-centered approach. This first author also has extensive experience across a wide range of counseling approaches, especially cognitive and behavioral approaches, and regularly teaches, supervises and encourages counseling students in finding the paths to effective work that resonate for them.

Our process of reaching consensus included the following steps. The first author interviewed the therapist regarding Darian and their work together. The 1.5 hour interview was shaped by a protocol of questions (e.g., reasons for referral, understanding of Darian and his difficulties before CCPT, general descriptions of his play, thoughts of his play in stages, why the intervention seemed to work or not work for him, why CCPT would seem to make or not make sense for him, anecdotal evidence of change, other interventions or factors possibly related to change, other comments), with ample opportunities for follow-up and open discussion from interviewer/first author and interviewee/therapist. The two also discussed possible meaning of quantitative, standardized, and anecdotal indicators of progress in this meeting, which took place four months after treatment ended.

The first author drafted a report of the interview with: a description of Darian's work categorized into the typical stages of CCPT (Nordling & Guernsey, 1999), a conceptualization of his difficulties, and his mechanisms of progress in CCPT. The first author included follow-up questions in this report as well as a request to confirm or correct the report from her experience. Differences in understanding (there were almost none), were discussed until a comfortable consensus was reached. The second author/therapist's supervisor reviewed this work, adding her input which was discussed with the first author to consensus. Discussions and adjustments continued through the drafting of this manuscript.

The three authors were involved as project director and internship instructor, program coordinator/supervisor.

Process data sources. All sessions were recorded. The second author/supervisor reviewed about 33% of sessions on a weekly basis. The third author/therapist pointed out particular areas of potential struggle, difficulty or inconsistency with the model for her to review. The first author reviewed occasional segments pointed out for him by the therapist for additional perspective and for him to understand her work and progress. Transcripts were not used due to the prohibitive nature of that task and due to the understanding that much more from play therapy sessions is understood through observing what is done and how so vs. the specifics of wording.

Session notes were kept by the therapist with emphasis on Darian's important seeming actions, play themes and tone, and stage analysis. The second author/supervisor reviewed the therapist's case notes on a monthly basis. The first author reviewed case notes when drafting the report of the therapist's interview and drafting analysis of behaviors into stages.

Outcome data sources. There were two sources of outcome data: the school administration kept a count of office referrals and teacher ratings through the Teacher Report Form (TRF) of the Child Behavior Checklist (Achenbach & Rescorla, 2001). Teacher ratings were collected by the therapist, before beginning treatment, after Darian's first eighteen 30-minute sessions (a minimum treatment length assumed prior to his CCPT start), and at the end of the school year. She scored and gave the ratings to the first author for storage and review. The therapist was aware of his teacher ratings and school behavior reports.

The TRF includes 118 items that ask teachers to rate the presence of behavioral symptoms on a 3-point scale of frequency. The TRF enables score reports of Total, Internalizing and Externalizing Composites, and eight syndrome scales: Anxious/Depressed, Withdrawn/Depressed, and Somatic Complaints make up the Internalizing Composite; Aggressive Behavior and Rule-Breaking make up the Externalizing Composite; and Social Problems, Thought Problems, Attention Problems contribute to the Total, but neither composite.

Strong validity evidence for TRF scores has been established through multiple studies across decades. Internal consistency of problem area scales is supported by alpha coefficients of .78-.97. Test-retest reliability for the TRF is established at correlations of .90 for Total Score and .91 and .92 for the Internalizing and Externalizing Composites. Standard errors of measurement (SEM) are provided by referred and non-referred norm groups. SEM allows the determination of confidence intervals at the 90% level, which allow statements of significance (i.e., that we can be 90% sure that the score difference is actual behavior change vs. errors in measurement or normally occurring variation) (Achenbach & Rescorla, 2001).

Client Background

By early October of his kindergarten year, Darian's teacher was exasperated and no longer confident in being able to handle his defiant, disruptive behavior in the classroom. She explained in frustration, "If he does not get his way, he cries, kicks, and throws things." School administrators saw Darian as having severe and persistent pattern of defiant and aggressive behaviors markedly different from peers. His teacher and school administration had implemented behavioral interventions prior to referral that were not seen as effective. His teacher had become convinced, in her view, that he had a diagnosable disorder such as attention deficit hyperactivity or oppositional defiant disorder. His teacher and school administrators suggested reasons for his behavioral difficulties as stemming from his background, including that his biological father was in prison and he had no other father figure, that his home was undisciplined and he lived in a high crime area, and that he was the baby of the family, accustomed to getting his way. Although his mother reported wanting help for Darian and signed informed consent for services and research, she did not respond to repeated invitations to meet with counseling or other potential parent support staff.

Results

External Indications of Change

In the just over eight school weeks before beginning treatment, Darian had six disciplinary referrals to the office for behaviors determined to be beyond his teacher's control. He was referred to the office for discipline only once after beginning treatment.

His Total and Externalizing Composite scores on the TRF were in the clinical range pre-treatment. Each of these improved beyond the 90% confidence interval for referred children around his pretreatment score, with his Total Score improving more than twice that measure. His subscale scores of Aggressive Behavior, Social Problems, Attention Problems, and Rule-Breaking Behavior were in the borderline range pre-treatment. Of these, his Rule-Breaking and Attention Problems scores improved beyond the 90% confidence interval for referred children and his Attention Problems score improved more than three times that measure. See Table 1 for score change details.

Table 1

TRF Scores and Note of Significance from Pre-Treatment

Score Area	Pre-Treatment Ratings	2 nd Rating, after 1 st 18 ½ hr. Sessions	Final Ratings, after Last 12 ½ hr. Sessions
Total	80	54**	52**
<u>Ext. Composite</u>	26	21	19*
- Rule-Breaking	6	4	2*
- Aggressive Behavior	20	17	17
<u>Int. Composite</u>	6	3	5
- Anxious/Depressed	6	3*	5
- W/drawn/Depressed	0	0	0
- Somatic Complaints	0	0	0
<u>Non-Comp. Scales</u>			
- Social Problems	7	6	6
- Thought Problems	0	0	0
- Attention Problems	35	24**	22***
Adaptive Functioning (higher is positive)	11	14*	13

* denotes change from Pre-Treatment scores beyond the 90% confidence interval created from the standard error of measurement for referred children ages 6-18

** denotes change from Pre-Treatment to Final scores more than two times the amount of this confidence interval

*** denotes change from Pre-Treatment to Final scores more than three times the amount of the confidence interval

Process through Stages of CCPT

Warm-up. From the moment Darian entered the playroom he relished the freedom, and the opportunity to be self-directed. In the first two sessions, through his excitement and exuberance, he inadvertently bumped into limits. For example, he bounced a ball that hit a ceiling tile. His therapist asserted the first limit with empathy, “[With excited tone matching his] Darian, you like bouncing that ball *hard*. You bounced it so high it hit the ceiling! [Dropping excitement from her tone] One of the things you may not do is bounce the ball so high that it hits the ceiling. [Responding to his frowning face and matching his wary affect] “You’re not sure you like that you can’t do that. [Picking up with his dropping the ball and quick shift to another activity] But now you have another idea.”

He soon found another action that had to be limited. As he painted vigorously, paint began to be “accidentally” slung in all directions. Slinging paint beyond the art table was limited, and though he still enjoyed his free and messy painting, this limit was accepted by Darian. As sessions progressed, his play developed into a pattern that seemed to suggest he was “feeling out” the situation, as if asking through his behavior, “Just what will be allowed here and how will *she* react?” Whenever a limit was found, he seemed to see if he might be able to push through it, trying the behavior again or coming very close to it with an attitude appearance of, “I don’t care if I do break this limit or how you react.” However, when the limit was reasserted, along with the consequence of possibly ending the session, while he would initially get mad and yell or stomp around, he would also eventually calm himself and move onto another activity.

As Darian continued in CCPT sessions, he seemed to find some limits that he could likely sense had an effect on his therapist’s anxiety level. For instance, after a bit of paint splattered near or actually on her, and noticing her “tense up” due to this, he moved immediately to the idea of painting his therapist! And after asking a few questions about the video camera that was recording sessions for supervision, he again likely noticed a small flinch of discomfort or incongruence in his therapist. With this, he immediately became very interested in physically exploring, touching and playing with the

camera! When these ideas and actions were limited, Darian didn't easily move on. Instead he found it a way to engage his therapist, and test her resolve. He pressed these limits even after being told that doing so would mean that the session would end for the day, and a few sessions had to end early due to this.

As Darian's play sessions continued, he became much more absorbed and focused on his self-generated activity. With this change, his desire to continue his work in relationship with his therapist grew such that he came to his most extensive struggle with limits, that which involved the ending of sessions. When play time was up for the day, his therapist was sensitive in the structure of giving the notice of "five minutes left," and then "one minute left." Nonetheless, after the one minute time warning, Darian would continue to play, he would dawdle, and ignore the therapist. He would ask (and cry) for more time. Again, this was an area of structural limit setting which was still new to his therapist, and so his testing around this limit left her easily frustrated at times.

Many beginning therapists understandably become nervous in such situations. When the session time is up, there is no consequence to fall back on at that point. In the school setting, the delay in ending can become public if the child is not back to class on time, and the rest of the therapist's schedule with other children she serves can be affected by the delay. Darian's pattern was to linger a bit at first, as if the delay was not intentional, but then to get very argumentative when the fact of their "special playtime being up for today" was gently reasserted. He cried in these moments, and it was clear to us that it was more than manipulation. He was crying genuine tears of frustration at not getting what he really, really wanted – to stay in special play time with his therapist.

His therapist had a mix of feelings and reactions in these moments. On the one hand she would tense with the thought, 'What if I can't control him now? That's not going to look good.' But then she also felt for his very real upset and asserted the limit empathically, "[Kneeling down to his level for a moment, affected by his upset and speaking tenderly] Darian, You really, really want to stay. You have more you want to do. [Moving toward the door to wait for him and shifting to a neutral tone] but our special play time is up for today."

Whenever he saw his therapist outside of sessions at school even through this period of many limits needed in sessions, he was all smiles and hugs, very much glad to see her. This heavy limit testing “warm-up” lasted about 12 sessions all together, with a gradual reduction in intensity as the sessions went on.

Aggressive-regressive stage play. As is often the case in shifting from one stage to another, his shift from warm-up to aggressive-regressive stage play was gradual. Back during the sessions we categorized as mostly warm-up, he began role-plays that included much scolding of his therapist, which may have been a combination of relational testing and expressing deep seated aggression (for examples of role play in CCPT, see Cochran, Cochran, Fuss, & Nordling, 2010; Cochran, Nordling et al., 2010). For example, he would paint something simple, a circle, and instruct her to copy it, and then fiercely scold her for not getting it right. He would repeat the cycle with escalating anger for what he saw as her apparent incompetence. We classified these interactions as mini role-plays as these interactions seemed more like a game of “Angry Teacher – Bad Student” than something real and directly between Darian and his therapist. His expression of anger seemed to be no longer genuine tears of frustration, but an exorcising of something deeper that he needed to bring to the surface.

His emotions and words in these role-plays were often highly critical, and his therapist acceptance of “being scolded” seemed to embolden Darian in this “role.” He came to have a constant tone of anger and disgruntlement through his sessions. He seemed to be constantly “mad” at his therapist in sessions (yet always all warm greetings and hugs outside of sessions). He gravitated to frequent and increasingly elaborate solitary doll play, while his therapist empathically watched and tracked his actions (for more on tracking with empathy in solitary role play, see Cochran, Nordling et al., 2010). At times, he would become deeply relaxed while involved in solitary play, and his therapist was careful to sensitively be there with him while quietly tracking. During these times he’d sometimes seem to suddenly remember his therapist, and look up at her, point, and exclaim, “I’m mad at you!” This exclamation seemed much more a reminder to her (and perhaps to himself) of his “bravado” and need for power and control than of actual anger at her. Maintaining

this “posture” seemed an important component to allowing for his more vulnerable, regressed play.

He became increasingly nurturing with the dolls, even when still disgruntled and scolding with his therapist. His early doll play was mostly scolding and punishing the babies, but grew to increasingly include nurturing: feeding them, telling them they needed to go to the bathroom and playing out their wetting and his clean up, fixing their clothes and hair. But even when nurturing the dolls, his tone could vacillate from calm and silent to quickly gruff and angry again.

This angry, gruff tone in sessions was in contrast to his actions outside of sessions. While he certainly tested the limits in his classroom and broke down in tears of frustration with things he wanted but could not control, he did not generally seem angry, but was almost always seen to be grinning, carefree, and happy-go-lucky. Darian had about nine sessions that we classify as mostly aggressive-regressive stage.

Regressive-aggressive stage play. Darian had about five sessions that we classify as mostly regressive-aggressive stage. As with his shift from warm-up to aggressive-regressive stage play, there was no clear moment of shift to more regressive-aggressive stage play. These sessions included his mostly nurturing doll play and also “dress up,” during which he often dressed as a woman and seemed to delight in the power and control he felt with a purse and money, and “being in charge!” He nurtured and cared for dolls during this period, but also was quick to “give orders” and “whippings” (to the beanbag chair) if needed. In this period of his play, his angry tone toward his therapist noticeably decreased. He seemed comforted, open, and content with his therapist “being right there with him” as he role-played, and he seemed to more fully trust her as his “confident companion” while he became immersed in his therapy time.

Ending without mastery stage play. Darian’s ending sessions did not feel complete to his therapist. While his behavior had improved significantly outside of his sessions, he did not yet show signs of mastery stage play. The countdown of his final six sessions began due to the impending end to the school year. His therapist would not be able to continue with him, and so was careful

to have this countdown of sessions to make Darian aware of this. In his last two sessions, he reverted back to some of his earlier limit testing and angry tone. In returning to these behaviors, he again cried real tears of frustration and sadness. Yet, he never seemed “full out” in struggling over limits in those sessions. Rather his behavior seemed to convey, “I can push you back to this comfortable distance for us to part. And I can also use this struggle to do some of the crying that I need to do over ending.”

Therapist’s Challenges in Helping Darian

As one might expect, Darian’s limit testing was nerve-racking for his novice therapist. As she exclaimed in one supervision meeting during his heavy limit testing warm-up, “I just about have NO empathy left!” We see his limit testing as aimed at testing the limits of her patience, and certainly it did. As her supervisor (2nd author) noted, her usual way with children was warm acceptance without influence of “like” or “dislike.” Yet, early on, Darian seemed to seek and find the way a way to frustrate her. Through what felt like constant limit testing, Darian tested her normally high level of acceptance.

She struggled with this frustration openly in individual supervision and group supervision with fellow interns. As he repeated limits in areas in which he seemed to sense he had “hit a nerve,” his limit testing did hurt her personally (although certainly she remained the adult therapist, who could take perspective and remind herself that his actions are parts of his important work). His challenges over behavioral control, especially around his struggles not to have his sessions come to an end, understandably raised her fears of a) not being able to control him, b) not getting him back to class on time, and c) causing her next session to be delayed, which would put off the levels of consistency needed through the day for other children in need and their teachers – perhaps even causing sessions to be missed. Because this setting and many school settings require very tight and highly regimented schedules, his extensive testing of session endings intensified frustration for his therapist. The fact that she knew that the school wanted or needed rapid progress (a lack of rapid progress could bring painful consequences for Darian –

including removing him from our services and into much less child-centered services) intensified her frustration resulting from worry that he must quickly develop self-control and return to class on-time and under-control.

As there seemed to be so much repetition in Darian's limit setting, it often felt to her like he was making no progress at all. She worried that his levels of angry disgruntlement were also growing in class (we find such a shift almost never the case in CCPT). She was surprised in checking with his teacher every few weeks, to hear of his steady growing progress in reducing misbehavior and increasing positive behavior in the classroom. Considering his limit testing, scolding tone and disgruntlement toward her in sessions, she was perplexed that he almost always came to play sessions happily and willingly (he had refused two sessions early on) and that he always greeted her with eager warmth and hugs in school hallways or during events outside of sessions.

Client Conceptualization

In retrospect, we conceptualize Darian as struggling with incongruence between outer posture and inner experience. On the outside he appeared confident and happy. His behavior seemed to say, "I'll just do what I want, and I'll be just fine." His attitude seemed to say, "I'm fine with myself. I'm not concerned with you." Yet, when he could not have his way, at least in some school situations, it seemed that painful emotions from loads of real or perceived hurts came pouring out. His apparent attempts to unnerve and challenge his therapist suggest that he was actually very much concerned with others and their views of him.

We surmise that his attention difficulties may have been driven by emotional agitation, even though he often "looked" happy. His social difficulties may have been driven by low self-esteem and doubt - even though he appeared self-assured, he seemed to expect rejection. His defiance seemed aimed at exploring limits of personal power, a need to know what his limits were - a way to limit his anxiety, as if needed to confirm the belief, "I can be controlled." We suggest that while he postured as if needing no one, he in truth deeply feared rejection and aloneness, and would rather not risk

relationships that might end in rejection. Therefore, it seemed he often worked to drive those away who tried to get close.

Non-Therapeutic Factors

There were few non-therapeutic factors that might have contributed to changes for Darian. He attended a lunch group with a school social worker at times. He received regular speech therapy services, provided in small groups. His mom's boyfriend moved into their apartment at one point during therapy. This seemed, anecdotally, to cause an increase in acting out behavior outside of sessions. The timing of the change would be difficult to pinpoint, but was generally between his second and final teacher ratings.

Mechanisms of Change

Darian seemed to need his therapist's unconditional positive regard within the private, safe space she created to vent his emotions and show parts of himself that he kept hidden. It seemed that he had to first test rejection and test the capacity of his therapist to love and accept him – even when he was acting out. He seemed to need to try all his usual actions for driving others away before expressing his vulnerable, inner self. Placing adult like thoughts over a child's behavior for illustration purposes, it was as if he questioned, "Am I acceptable? Is all of me acceptable? Well, *she* [my therapist] really KNOWS me. She's seen me mad. I've annoyed and tested her. She's seen me cry out in frustration. I've scolded and criticized her in role-plays, but she still accepts me. She has been my companion while I pretended, and while I played out my feelings of helplessness, and my need for power and control. All this and she has barely wavered. She still comes to get me for my special playtime. She accepts and cares for me as I am...perhaps I can accept and care for me. Perhaps I can also let others (teachers, caring adults) become close with much less to fear than I expected." Most important in our view, when we think of why Darian seemed to change to a stronger, more congruent boy, is that possibly for the first time ever in his very difficult life, he experienced consistently empathic, unconditional positive regard.

Discussion

Limitations of the Study

The primary limitation of this study would be that it is a case study. Conclusions may not generalize to other cases, as each person and therefore each case is unique. The value of a case study can be that it provides a look into what happened in that unique situation that might advance our understanding.

While the author's backgrounds provide an opportunity to suggest conclusions of what happened and implications from those conclusions, their backgrounds also create further limitations. As the authors are oriented to the stage model used in the study, this provides an opportunity to classify behaviors into the stages, but also carries the limitation that the authors may have preconceived Darian's work into the stage model. And as the authors are oriented to the person-centered approach, this provides an opportunity to see the value of the core conditions, but also carries the limitation that the authors preconceived these values in Darian's work.

Implications

Unconditional positive regard vs. a need for limits. Darian's work seemed to put unconditional positive regard on a direct collision course with a need for limits. Unconditional positive regard seemed to be what he needed most – he needed to use it to reach self-acceptance, to bring the surly, challenging, and angry parts of his inner self into relationship, and then to express parts of his inner self that seemed to seem even more vulnerable to him. But in his doing so, his therapist had to set some limits on behaviors. He could not be allowed to destroy parts of the playroom or equipment that would then limit other children's work. He could not stretch the length of sessions to his preferences as this could also limit other children's work. As Virginia Axline (1947) explained, limits are needed to anchor the play to reality.

Of equal importance, Darian could not be allowed to push the limits of his therapist's acceptance beyond her capacity for congruence. As his therapist was just beginning her work in CCPT,

his work challenged her unconditional positive regard. When Darian sensed that his actions had prompted even a hint of critical feeling toward him, he seemed to need to test out and explore what would happen if he pushed even more. This work and the requirements for a therapist's self-awareness, limit setting ability, and empathy is difficult for even more experienced child-centered play therapists.

That being said, it is important to clarify that the conflict between unconditional positive regard and a need for limits was not between his actions and hers. His actions were simply the work that he needed to do. The conflict was *within the therapist*, between her empathic unconditional positive regard, the limits she had to provide to remain congruent, and her very understandable and remarkably small, but perceptible critical responses to the challenges of Darian's work.

The openness of the child-centered/person-centered approach vs. pressure for external change. Darian's therapist felt the pressure for external behavioral change to be evident quickly. Especially as his limit testing behavior, known to be parallel to his classroom misbehavior escalated, the pressure mounted. Yet, external behavioral progress suggests that his behavioral progress outside of CCPT was increasing even while his limit testing in CCPT escalated.

To us this suggests the strength of the structure for growth that CCPT creates. It reinforces that the therapist does not have to force or manipulate what the child is working on, that she need only maintain the structure and warmth that facilitates his work. It also suggests that the therapist does not need to know *what* a child is working on to know that the child is working. To a person with limited understanding of the approach, it might seem that a child is learning all the wrong things in therapy, when indeed the opposite is true – because the process is self-generated - he is learning the exact things that he needs to learn!

In addition to presenting a case study to help understand the CCPT approach, to us Darian's story suggests the value of collecting accurate data when possible. We acknowledge that this is not always easy, but as Cochran, Nordling et al. (2010) point out, if a counselor uses a scale that can broadly measure maladaptive behavior, increasingly adaptive behavior will almost always be evidenced from

the child-centered approach. Cochran and Cochran (2006) pointed out that data collection can contribute to counselors avoiding burn-out. Without it, Darian's novice therapist might have unduly worried over his outward behavior in sessions and become discouraged and directive, rather than working to develop her skills in limit setting with empathy to remain congruent and child-centered in her sessions.

Self-integration and the challenge for the new therapist.

We may look to the Integrated Developmental Model (IDM; Stoltenberg, McNeill, & Crethar, 1994; Stoltenberg, McNeill, & Delworth, 1998), an often cited framework for understanding counselor development (Anderson & Bang, 2003; Leach, Stoltenberg, McNeill, & Eichenfield, 1997; Lovell, 1999; Tryon, 1996; Warnke & Duys, 1998) for understanding the therapist struggle to maintain congruent unconditional positive regard, while asserting necessary limits in this case. Three overriding structures (self- and other awareness, motivation, and autonomy) and eight clinical domains (intervention skill competence, assessment techniques, interpersonal assessment, client conceptualization, individual differences, theoretical orientation, treatment planning, and ethics) of counselor development are described in the IDM.

In this case, as a practitioner very early in her career, the therapist needed to develop efficient awareness of her thoughts and feelings in for the moments when Darian challenged limits. While such awareness may really be sensory and emotional, especially when the awareness needs to be instant or automatic, the following thought chain may be used to represent the internal process,

I am tensing up. My worry is that I cannot control him. He may get hurt or important things may get broken! [Then the responding, corrective thought] It's OK. [And redirection to his experience] What is going on inside him? [This redirection should be more of an empathic striving than a calculation]

Such processes from awareness of self to other helped the therapist build to consistent unconditional positive regard, even when needing to assert limits.

As a practitioner very new to the model, the therapist also needed to develop confidence in the theoretical orientation and commitment to the approach as the appropriate treatment plan. In our experience, the child-centered approach is counter intuitive for many in our society and thus for many beginning therapists. *Knowing* that the approach works comes from experience. Thus one cannot begin already equipped with confident knowing. A thought chain to represent the internal conflict follows,

My supervisors are confident that CCPT will work for Darian, but I keep having the thought that I should do something to make him learn to behave – or else won't he keep misbehaving and suffer through more trouble at school?

In time, it helped the therapist in this study to hear of Darian's progress in teacher reports and ratings, but these affirming signs could not come until she had helped him through much of his limit testing difficulty. Later, she reported she could *feel* his shifts, as well as the change in his comfort level in relating. She began to notice this also with other clients. Then she became more confident in the model. But in the beginning, when challenged with a limit testing client, she could only trust the theory, literature, and her supervisors while working through self- and other awareness toward intervention skill competence.

The meaning of the premature or arbitrary ending. With each of us having known Darian, we hurt for his arbitrary ending. We worry that his apparently great progress might have become reversed. We do not think so, as his school behavior improved significantly, and this improvement continued steadily throughout the school year. Darian moved to another school district the next year, so follow-up wasn't possible. This was out of our control, but still we wish we knew more.

This for us brings up an important question in serving many at-risk children: Being "at-risk" often means low socio-economic status (SES) and low SES often means multiple moves with little advanced notice to counselors serving children in schools and agencies (i.e., parents move due to not being able to pay the rent, or have a sudden opportunity for a different apartment to save money;

parents move due to better work opportunities; and parents move due to divorce, insecure relationships, or abusive situations). Being at-risk often means multiple disruptions within the family, which also can mean multiple moves. And so, the question becomes is it then better (or in good judgment) to start a therapeutic service that may not be completely finished? We believe so. Even if all a child has is one relatively brief relationship in which he can be himself and be completely known and accepted, we believe this acceptance may be a life changing event. So if it can be done, then it is always the right thing to do. Because child-centered play therapy strengthens the child from within – we also believe *it is this something within that stays with the child* – no matter how many moves or life disruptions.

Conclusions

Our hope from this study is for all counselors and therapists to see the importance of expanding unconditional positive regard for all children in need, and to maintain faith in the healing power of the child-centered/person-centered relationship, no matter what the challenges. We expect all who read this will learn from and be encouraged by this novice therapist's and Darian's work and progress.

We additionally hope to shed light on the oft time necessity in CCPT for unconditional positive regard and necessary limits to coexist, and some of the challenges and the possibilities that result. While unconditional positive regard and necessary limits in therapy may sound like contradictions, we hope for readers to see in this study how the two together facilitated the growth of both child and therapist, and helped them develop a solid, curative relationship as well.

References

- Achenbach, T.M., & Rescorla, L. (2001). *Manual for the ASEBA school-age forms and profiles*. Burlington, VT: Achenbach System of Empirically Based Assessment.
- Anderson, C.E., Bang, K. (2003). Using the Integrated Development Model in substance abuse practicum. *Journal of Teaching in the Addictions, 2*, 67-82.
- Axline, V.M. (1947). *Play therapy: The inner dynamics of childhood*. New York, NY: Houghton Mifflin.
- Bozarth, J.D. (1998). *Person-centered therapy: A revolutionary paradigm*. Ross-on-Wye, UK: PCCS Books.
- Bergin, A.E., & Lambert, M.J. (1978). The evaluation of therapeutic outcomes. In S.L. Garfield and A.E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (2nd ed.) (pp. 139-189). New York, NY: John Wiley.
- Cochran, J.L., & Cochran, N.H. (2006). *The heart of counseling*. Belmont, CA: Brooks/Cole.
- Cochran, J. L., Cochran, N. H., Fuss, A., & Nordling, W. (2010). Outcomes and process through stages of child-centered play therapy for a boy with highly disruptive behavior driven by self-concept issues. *Journal of Humanistic Counseling, Education & Development, 49*, 231-246.
- Cochran, J. L., Cochran, N. H., Nordling, W., McAdam, A., & Miller, D. (2010). Monitoring two boy's processes through the stages of child-centered play therapy. *International Journal of Play Therapy, 19*, 106-116.
- Cochran, N.H., Nordling, W.J., & Cochran, J.L. (2010). *Child-centered play therapy: A guide to developing therapeutic relationships with children*. Hoboken, NJ: Wiley.
- Farber, B.A., & Lane, J.S. (2002). Positive regard. In J.C. Norcross (Ed), *Psychotherapy relationships that work*. New York, NY: Oxford University Press.
- Guernsey, L.F., (1983). Client-centered (nondirective) play therapy. In C.E. Schaefer, & K.J. O'Connor (Eds.), *Handbook of play therapy* (pp.21-64). New York, NY: John Wiley.
- Guernsey, L.F. (2001). Child-centered play therapy. *International Journal of Play Therapy, 10*, 13-31.

- Leach, M., Stoltenberg, C., McNeill, C., & Eichenfield, G. (1997). Self-efficacy and counselor development: Testing the Integrated Developmental Model. *Counselor Education and Supervision, 37*, 115-124.
- Lovell, C. (1999). Supervisee cognitive complexity and the Integrated Developmental Model. *The Clinical Supervisor, 18*, 191-201.
- Mearns, D., & Thorne, B. (1988). *Person-centered counseling in action*. London, UK: Sage.
- Nordling, W., & Guerney, L. (1999). Typical stages in child-centered play therapy. *Journal for the Professional Counselor, 14*, 17-23.
- Orlinsky, D.E., & Howard, K.I. (1986). Process and outcome in psychotherapy. In S.L. Garfield and A.E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed.) (pp. 331-381). New York, NY: John Wiley.
- Patterson, C.H. (1984). Empathy, warmth and genuineness: A review of reviews. *Psychotherapy, 21*, 431-438.
- Peschken, W.E., & Johnson, M.E. (1997). Therapist and client trust in therapeutic relationship. *Psychotherapy Research, 7*, 439-447.
- Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95-103.
- Rogers, C.R. (1961). *On becoming a person*. Boston, MA: Houghton Mifflin.
- Rogers, C.R. (1980). *A way of being*. Boston, MA: Houghton Mifflin.
- Stoltenberg, C. McNeill, B., & Crethar, H. (1994). Changes in supervision as counselors and therapists gain experience: A review. *Professional Psychology: Research and Practice, 25*, 419-449.
- Stoltenberg, C. McNeill, B., & Delworth, U. (1998). *IDM supervision: An Integrated Development Model for supervising counselors and therapists*. San Francisco, Jossey Bass.
- Tryon, G. (1996). Supervisee development during the practicum year. *Counselor Education and Supervision, 35*, 287-294.

- Warnke, Ml, & Duys, D. (1998). When experienced counselors address unfamiliar tasks or concerns: A developmental approach. *Counselor Education and Supervision, 37*, 179-188.
- Wilkins, P. (2000). Unconditional positive regard reconsidered. *British Journal of Guidance and Counselling, 28*, 23-36.