An Introduction to Child-Centered Play Therapy

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"The activities that are the easiest, cheapest, and most fun to do – such as singing, playing games, reading, storytelling, and just talking and listening – are also the best for child development."
~Jerome Singer

Yale University Professor, Professor of Psychology Emeritus

Child-centered play therapy (CCPT) is an approach to Person-centered Counseling that effectively blends Rogerian tenets with the natural way children communicate through play. The three core elements of Person-centered therapy are congruence, unconditional positive regard, and empathy. Axline (1947) expanded the use of these concepts to the treatment of children through child-centered play therapy. Axline writes that "play is the child's natural medium of self-expression" (1969, p. 9) providing children with a therapeutic relationship developed in a setting of acceptance, caring and empathy facilitates trust and provides the child with a safe place to explore their emotions.

The British Association of Play Therapists (BAPT, 2020) currently defines play therapy as "the dynamic process between child and Play Therapist in which the child explores at his or her own pace and with his or her own agenda those issues, past and current, conscious and unconscious, that are affecting the child's life in the present. The child's inner resources are enabled by the therapeutic alliance to bring about growth and change. Play Therapy is child-centred, in which play is the primary medium and speech is the secondary medium." The Association for Play Therapy (APT, 2020) defines play therapy as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development." Play therapy is

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a commonly accepted and widely implemented approach for working with children. Play is considered an important means of communication with children.

Axline (1969) developed eight principles to be used to guide the CCPT process. These principles involved the therapist attending to the following:

1. Develop a warm, friendly rapport with the child as soon as possible.
2. Accept the child just as they are.
3. Allow the child to express themselves freely and completely by establishing a sense of permissiveness.
4. Recognize the feelings the child expresses and reflects those them back to the client in a way that allows the client to gain insight into his/her own behavior.
5. Maintain and communicate a deep respect for the child's ability to solve problems, make choices, and institute change.
6. Allow the child to lead the way in all aspects of therapy, refraining from directing the child's play in any way.
7. Allow the therapy process to develop at its natural pace without being hurried in any way.
8. Establish limitations only when necessary to anchor the therapy to reality and with therapeutic benefit that provides insight into the child's aware of his/her responsibility in the relationship.

As Axline outlines, the expectations of the therapist are specific and require a child-centered focus in order to be most effective. The expectations placed upon a child-centered therapist are high, and therapists may need to be vigilant to remain true to this approach. Different from other therapeutic interventions for children that may offer clinical guidelines that are more lock-step, CCPT requires the clinician to remain ever present with and responsive to nuances in the child's behavior and demeanor in order to provide effective clinical support.

Therapists in agency, school, and hospital settings often have multiple roles and jobs which involve interacting and/or working with children. These roles and responsibilities do not always lend themselves to the individual taking a child-centered stance and many clinicians thereby integrate clinical theories to find an approach that both suits the demands of their workplace while also honoring clients. While CCPT tenets may be integrated with additional theoretical approaches, therapists should remain aware that slipping into a more parental, authoritarian or directive approach accepted by some clinical stances undermines the integrity of the CCPT process.

For example, a behavior therapist working in a school setting may wish to integrate their behavioral approach with CCPT. Such a professional would typically work with behavior data to reward students for what is perceived as positive behaviors based on the expectations of the school setting in order to shape the child's behavior to better meet the demands of the school setting; an approach quite deviant from the essence of CCPT. Although not impossible, this integration would take some sincere and thoughtful reflection to determine which tenets from each theory should be integrated to best support the client. Therapists wishing to integrate theories should remain aware that adhering to Axline's (1969) recommendations with fidelity is important for therapists who wish to see the full benefits of CCPT.

Logistics of Play Therapy

Office/Play Room

Setting up a playroom can be fun! It can also be a challenge. When working with children, more space and resources are always welcome to enhance clinical work that supports their growth and development. When working with young clients the clinician must remember that their clients are active beings who want to move and play. As a guideline, Landreth (2012) suggests that the ideal size room for individual work would be a 12 x 15 ft space and a 12 x 25 ft space for groups. Many private practices, hospitals, and agencies have well planned space designed specifically for play therapy. However, mental health professionals who wish to implement play therapy but do not have access to optimal conditions should not be discouraged. It is permissible to utilize child-centered play therapy techniques in alternative spaces and some clinicians even have mobile play therapy kits!

In spaces ideally designed for play therapy, a small sink with cold water is available to the therapist and child. If this is not available, a bowl of water will do the trick. A counter or desk area a storage cabinet for supplies will help the play therapist keep his or her materials organized and accessible, while a white board or chalk board and furniture appropriate for children should be readily available for your clients to access during therapy. Maintaining the cleanliness of toys, walls and furniture is important for facilitating creative play and the play therapist should have a plan related to how he or she will tidy and clean toys and materials between sessions.

In particular, cleaning and disinfecting these items has recently been at the forefront of consideration for child-centered play therapists due to the recent COVID-19 pandemic. The Center for Disease Control has published "Guidelines for Child Care Program" due to the Corona Virus – 2019

(COVID-19). Following these guidelines will allow child-centered play therapists to continue offering their important services in a manner aligned with best practice (CDC, 2020).

The design of the playroom where child-centered play therapy is conducted should hold paramount the child's ability to completely absorb him or herself in the play process. Location of the office/playroom in an area with low noise pollution is also recommended to limit distractions to the child during their session. While reducing noise outside the playroom helps to keep young clients focused on the play therapy session, managing noise levels within the playroom is also important for confidentiality. Ideally, acoustic tiles can be used help to keep sound confined to the therapy room. If possible, a playroom equipped with an attached bathroom (similar to many Kindergarten classrooms) offers a convenient way to minimize distraction for young clients. If training occurs at the site, a one-way mirror and video equipment can be useful as a means to reduce interruption to the child's play process. And, last but far from least, a chair, and/or pillow or other type of seating for the therapist so that the therapist can comfortably navigate the playroom while therapeutically serving the child. As indicated at the beginning of this paragraph, this would be the ideal space.

In many grant-sponsored programs and in agencies serving impoverished neighborhoods, space is not always optimal. However, that should not discourage clinicians from implementing child-centered play therapy and/or related techniques. When space is far from ideal, privacy, confidentiality and trust become concerns the therapist should work to achieve by altering the physical space layout and/ or processes involved in play therapy. Distance between the play therapy room and waiting area provides the space needed to maintain confidentiality and facilitates the development of the client's comfort level and confidence in the process. If possible, providing a space for the adults in the child's life to wait while the session takes place is helpful. If the waiting room is in close proximity to the office, a white noise machine is recommended to provide an audible buffer between the client and therapist and guardians in the waiting space. In the beginning stage of therapy, children often ask if their adults can hear what they are saying. The therapist should take this opportunity to build rapport and reassure the child that their privacy has been considered and accommodations have been made to maintain confidentiality. If space is not available for a formal waiting room, establishing a structured, consistent process for drop off and pick up is very important. Transitions can be difficult for young children, especially when beginning a new routine. Clear structure and support for both the child and caregiver can make all the difference in creating smooth transitions into and out of the therapy site which will ultimately strengthens trust and confidence in the process.

The usability of the space is critical and the child-centered play therapist should maintain a strategic and practical stance when considering how to best use whatever space is available to them. As a professional sets up a play therapy space, the clinician's self-reflection throughout that process will set the groundwork for success. Therapists are humans with human sensitivities and vulnerabilities and therefore should consider consulting with a colleague or supervisor when setting up the child-centered play therapy space to help them identify any 'blind spots' in their process that may impact the manner in which they lay out the space or select the toys for client use. The therapist's self-awareness as items are selected for the room is of utmost importance. Toys that the therapist may have strong feelings about may not ultimately be the best choice related to client needs. It is critical that the therapist be prepared for each and every item in the play space to be touched, tossed, damaged, and worn. No item in the room should be of sentimental value to the therapist or be considered "precious" to the therapist. Walls have been known to become a space for a child's self-expression, making washable wall paint well worth the investment.

Although the aforementioned recommendations represent an excellent goal for clinicians to strive for, it is important for CCPTs to keep in mind that child-centered play therapy can also be integrated with other theories and/or modified somewhat to meet the demands of the client and/or limitations of space. Importantly, CCPT can be implemented in all variations of spaces when careful thought and preparation is given to the setup of the office/playroom. The therapeutic relationship and alliance can be built, the child-centered approach can be used, and children manage within the space allotted.

Selecting Toys

In the office/playroom, the therapist should provide toys that will interest children and elicit emotional and creative responses. Toys should be sturdy and safe. Toys that provide play across the developmental stages is also important. Children may want a "re-do" on mastering tasks from a younger stage or have the opportunity to play with a toy that was somehow "off limits" to them. (Landreth, 2012).

The University of Texas' Play Therapy Center recommends the following criteria for selecting toys. "Toys should:

- Allow for exploration of real-life experiences including cultural values, traditions and roles
- Facilitate contact with the child by gaining the child's interest and attention
- Permit reality testing/limit setting

- Provide the opportunity for development of self-control
- Facilitate exploration of the self and others
- Allow children to express their needs symbolically (without any need for verbalization)
- Provide for expression of a wide range of feelings
- Provide opportunities for insight/self-understanding
- Allow for creative expression
- Toys should also be durable, simple, and easy to operate, allow for success & are fun."

The University of North Texas also recommends the following categories of toys:

- "Real-life" and Nurturing
  Doll family, doll house, baby bottle, variety of puppets, animal families, cars, money, cash, register, kitchen food, medical kit, phone, etc.
- Acting-out, Aggressive, Scary Toys
  Bop bag, toy soldiers, guns (colored plastic-not real looking!), scary/aggressive puppets and animals (alligator, shark, etc.), rubber knife, foam sword, handcuffs, etc.
- Creative expression and emotional release:
  Sand, water, paints, craft materials, clay, musical instruments, magic wand, dress-up clothes, etc." (Center for Play Therapy, n.d.)

Explaining the Play Therapy Process

Taking the time to explain CCPT to parents and children is the starting point for the therapeutic process. Play therapy often requires explanation to the parents in order to clarify the process and to dismiss any preconceived expectations. Having parents understand the CCPT process will establish clear boundaries and expectations.

The manner in which a clinician discusses the play therapy process with caregivers should be shaped around the understanding the parent or guardian has about mental health support in general and their perceptions about play therapy. To gauge this baseline, it is best to begin the conversation with an open-ended question such as, "So, [parent] tell me a little bit about your thoughts related to your child receiving support through play therapy." This type of question coupled with related follow-up questions will typically elicit helpful information such as a) how familiar the parent is with mental health interventions/ therapy, b) any preconceived ideas/ biases about the therapeutic process, and c) concerns or question the parent or guardian may have about play therapy.

Once the clinician has grasped the point at which the client and his or her caregivers are entering the therapeutic process, the therapist can then begin to explain a bit about the philosophy of child-centered play therapy and what the child and their family can expect through the process. It is greatly important that all involved understand that CCPT is different from traditional talk therapy models in that the child (client) expresses him or herself through play as this is the 'native language' of children and that, thereby, the therapist will enter into the child's world in order to meet them where they are in their therapeutic process.

Clinicians should let parents know that CCPT is a relatively slow process as compared with some other talk therapy models but can be much more successful and meaningful for young clients. The CCPT approach often unfolds at a gentler pace than traditional therapeutic approaches because communication occurs through the play process rather than through verbal communication. Play is the therapeutic modality. This exploration occurs organically and it not necessarily at the child's current level of awareness. With this in mind, the child-centered play therapist does not interrupt the natural flow of a child's play to ask questions or to engage them in a cognitive process as the child may find this interruption frustrating as it distracts from their most important work (i.e., play) (Kottman, 2011).

Parents/guardians are invested in their child's therapy and growth. Hence, they often seek immediate and frequent communication and updates about "what is going on" with their child. Child-centered play therapists are thereby intentional and supportive as they establish boundaries around communication with the parents. In most states, the parent or guardian of the child holds the right to confidentiality when the child is receiving mental health services. Because parents have the right to know what their child communicates throughout their play therapy session, it is important for clinicians to communicate the significance of child-counselor confidentiality and the clinical process inherent in play therapy. In other words, although a therapist must disclose information to parents or guardians upon request, caregivers will likely have less urgency to know the details of the play therapy session if they understand the overall nature of the play therapy process and are assured that the therapist will communicate with the parent/guardian should anything that is a cause for alarm (i.e., that the child's or someone else's safety is a cause for concern) arise during the play therapy process. It is important for play therapists to understand that cultural groups vary related to how they perceive a child having clinical privacy. Depending on a family's norms and customs the counselor and parents/ guardians should articulate a mutually agreed upon manner and regularity upon which to communicate about the child's presentation and progress.

In CCPT, maintaining the foundations of the therapeutic alliance (e.g. unconditional positive regard, freedom to express difficult feelings) is challenged if the child does not feel that they have privacy in what they express. Providing parents with clear information in the informed consent process will communicate respect for the parent/guardian's rights while requesting their approval to maintain the child's privacy. Informed consent will provide parents with the assurance that they will receive updates on the progress of the therapy and would immediately be contacted if there was any concern for the health and safety of their child (Cochran, Nordling & Cochran, 2010), however, the therapist should also maintain a culturally sensitive posture to ensure that parents are not left feeling anxious about their child's growth and progress. For instance, if a parent feels strongly that they need some level of detail regarding the play therapy session and/ or meetings with the therapist that are scheduled more regularly than normal, the therapist should work to negotiate the child's care so that it is both culturally sensitive as well as clinically appropriate. These challenges are often successfully addressed through parent education and rapport building through conversation at the onset of the therapeutic process.

As the explanation of CCPT is provided to parents/guardians, it is important to be cognizant of and value the parental relationship and investment in their child's therapy. Post (2014) highlights the importance and benefits of consultation with parents prior to and during CCPT. Post (2014) recommends the following "practical guidelines in describing CCPT to parents learning about the child and developing a trusting relationship with parents:

- Addressing objectives and goals
- Relating established goals to the child-centered approach in the playroom
- Providing ongoing parent consultations

Every four or five sessions therapists should meet with the parents without the child being present. The purpose of the ongoing consultations is to maintain and foster a strong therapist-parent alliance, allow the parents and play therapist to collaboratively assess the progress toward goals, and further educate parents about child development, parenting skills and community resources" (Post, 2014).

Children should be informed of what play therapy is, of the limits of confidentiality in therapy, and what steps would be taken if the therapist were concerned about health and safety concerns impacting the child and/or others. The therapist should also explain the method and level of communication that will occur with their parents/guardians. Discussion

with the child about how, when and what will be discussed with their parents/guardians provides an opportunity to develop trust in the relationship. One approach to communication with parents is to inform the child in real time of when you will be speaking with their parents and what you plan to say. At that point, the child can provide input on their level of comfort with what is being shared. An open dialogue can then take place between the child and the therapist on how best to communicate mutually agreed upon information. Circling back to the child about the communication with the parents/guardians further establishes a process of transparency and trust.

This process can be particularly sensitive with a child who is part of a traditional, hierarchical family in which the parent is seen as authoritarian. In these cases, it can be challenging for a child to trust the therapist to do what they say they will do (i.e., maintain confidentiality, support the child, etc.). In circumstances such as these when the clinician senses anxiety or dis-ease from a child when broaching the topic of dialog with a parent/guardian, it is exceptionally important for the therapist to slow down the process and seek to understand how a child is feeling. In these instances it may be important for the therapist and the child to have a conversation about trust, trusting new people, and taking risks with trust. If the counselor has successfully developed genuine rapport with the child, these circumstances offer a fantastic opportunity for the client to grow by finding a working alliance with the counselor as new information is safely disclosed to caregivers and the child learns to take measured relational risk.

Play Therapy: The Process

The initial play therapy session centers around the child getting to know the play area and becoming comfortable with the setting. While the child becomes familiar with their surrounding and the toys, the therapist will begin to establish rapport with the child. Each child will respond according to who they are, and the therapist will respond with unconditional positive regard and empathy. The therapist, following Axline's eight guidelines, establishes an acceptive, caring environment that is a safe, judgement free environment for the child to explore their emotions. The therapist's posture is non-directive and confident that the child will be able to solve problems and challenges that arise as they progress through the therapeutic process. Children typically take a few sessions to acclimate to the play therapy setting as the therapeutic relationship develops. During this time children have been working through some of the easier topics to discuss. This beginning period is known as the *Warm Up* Stage of CCPT. (Cochran, Nordling & Cochran, 2010; Nordling & Guerney, 1999)

Once unconditional positive regard and empathy have been communicated to the child and the therapeutic relationship established, the child moves into the *Aggressive* stage. At this stage, children tend to work on the underlying issues that are central to their behaviors and concerns in school or at home. The child may be working on emotions, situations, behaviors that are very challenging for them. At this phase, some children may regress, some move through this stage without upset, and others may become angry, frustrated, sad, etc. This stage may last multiple sessions and the level of aggression, anger, sadness, etc. can be very intense. An essential aspect of this phase is the reaction/response of the therapist to the child's emoting. The role of the therapist is to remain accepting and empathic while the child is displaying emotions which may include anger, aggression and resentment. This may be challenging for the therapist, however, maintaining and communicating to the child unconditional positive regard is essential to the child to feel secure in expressing their base emotions. (Cochran, et al., 2010)

Stage three is called the *Regression* Stage. The content of this stage may vary, but the core issues that children work on are nurturance, attachment, identity, and relationships. (Cochran, et al., 2010; Nordling & Guerney, 1999). During this stage, the child may engage in age regressed behaviors, such crawling, word pronunciation from an earlier age, etc. The final *Mastery Stage* of PPCT is when the positive changes are integrated into the child's personality. The child is now able to demonstrate self-control, express their emotions appropriately, and has a sense of competency.

CCPT: Considerations for the Current Global Landscape

Currently, the world-wide community is in the middle of the Corona Virus pandemic (COVID-19) challenge. This global reality offers us pause to consider the impact of this pandemic on children. Although current research has not yet caught up to quantifiably measuring the impact of the pandemic on the mental health and well-being of young people, a recent article in Time Magazine suggests that what data does exist is concerning; citing studies indicating that after approximately one month of quarantine about 20% of Chinese children experience anxiety with similar results for depression (Kluger, 2020). The same article warns about the possible long-term effects of a shaken global economy due to COVID-19 will have on today's youth.

Whether internationally or domestically, many children's lives and security have been shaken by the COVID-19 pandemic and it is a critical time for child-centered play therapists to take several considerations into

account as it relates to their work. First, to take note of how their current client's lives have been affected. For instance, many children who typically had the support of caring adults in school settings are now struggling to engage with web-based learning modalities whereas other children have been home-bound with abusive care takers. Additionally, some therapists may find themselves in situations where they are prohibited from providing services in their typical model (i.e., mobile therapy or at a particular agency). Additionally, most therapists must wear a mask to provide services due to COVID-19 related regulations, challenging their ability to connect with young clients. In all cases, child-centered play therapists must remain focused on how they can best serve children by using the means of their play as an ever-important point of communication.

As the current global and domestic sociopolitical and health climates challenge the work of child-centered play therapists, play therapists may wish to rely on the following tips in order to leverage their clinical skills to help individual clients and the collective heal and recover:

- Remain committed to the value of play therapy and its impact on children.
- Maintain a flexible clinical posture when considering alterations in space or toys available, sanitation schedules, physical proximity to clients, and/or session schedules.
- Consider using mobile play therapy kits to create 'pop up' play therapy rooms wherever you are able to meet with clients (i.e., schools, churches, client homes, hospitals, etc.).
- Partner with parents to allow for 'live time' video-based play therapy sessions wherein the clinician is able to provide therapy virtually with the parent present to ensure safety.
- Check in with clients regularly and consider virtual methods of contact (i.e., phone, video conferencing if/when physical meetings are not possible.
- When time between sessions is longer than usual, consider remote parent consultations as a way to support young clients and their families.
- Create mini play therapy kits for families to use in the safety of their own homes that include one or two small toys from each of the toy categories.
- Consider using filial therapy tenets to help parents apply the basic tenets of play therapy with their children.

- Use video conferencing as a means to offer caregivers feedback related to their implementation of filial therapy tenets with their child.
- Encourage parents to record themselves providing filial therapy for their child and offer feedback and support through phone or video conferencing.
- Remember that even if it is not implemented in its most efficacious form, play therapy will bears therapeutic value to the client, even if just by the therapist being fully present with the child for a period of time.

Conclusion

While child-centered play therapy efforts may be challenged by economic or circumstantial hardships, it is the responsibility and burden of the child-centered play therapist to identify ways to continue to support the growth and development of children by using their play as the most valued form of their self-expression. While this process ideally occurs in a carefully appointed play therapy room with a specifically curated toy selection, the universal Rogerian therapeutic factors (i.e., congruence, unconditional positive regard, and empathy) can be applied anywhere, anytime, with anybody! The child-centered play therapists maintains this posture, knowing that they will positively impact children by genuinely prizing them throughout their play process.

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