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Child-Centred Play Therapy

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Introduction

This article will describe aspects of child-centred play therapy, as a person centred therapeutic modality. Filial Play Therapy is also described briefly. For descriptions and discussions of other play therapy models, including Cognitive Behavioural Play Therapy, Gestalt Play Therapy, and Theraplay, the reader is referred to Landreth (2002), Shaefer (2003), and Wilson and Ryan (2005), all of whom also describe models of child-centred play therapy and are leading exponents.

At the heart of play therapy is the troubled child who is given freedom, within the structure the therapist provides, to explore his or her ideas and feelings about self and others through play. The experience is different from that of playing with friends, siblings, parents or other family members: the therapeutic relationship provides a specific environment. The play therapy session becomes a time for the child to experiment with change, learn about choice, self-responsibility and self direction, and resolve emotional difficulties and inner conflicts. The spontaneous play of children has long been recognised as a natural form of communication. In play therapy the added dimension is the child's developing relationship with the empathic and attuned (Stern 1995) professional Play Therapist.

Definitions of play therapy

> "Play therapy is 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." (British Association of Play Therapists…. [updated 2008])

The Association for Play Therapy (2001) 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."

All three definitions draw attention to the relationship between therapist and client. Most play therapists, particularly those who follow a child-centred (Landreth 2002) or non-directive (Wilson and Ryan 2005) model, will not use play in order to "get the child to talk". The play they witness and in which they participate is regarded as communication in its own right.

Children and young people who can benefit from play therapy

Play Therapy is suitable for children from about 3 to 16 years of age, although it can be adapted for young people in their late teens, and even for adults, including the elderly (O'Connor & Schaefer 1994). Some play therapists would also be able to give consultations and advice about therapeutic play interventions with babies and very young children (McMahon 2009). Play therapy is a developmentally sensitive intervention i.e. the therapist will always take into account the chronological age of the patient/client and the actual functioning age or ages. It is common for children to regress in their play to younger stages. The play therapist is alert to this and supports the child in revisiting early experiences through sensory play, symbolic play, and whatever other play opportunities the child chooses spontaneously in the session.

This article will refer to the patient/client as "the child". For convenience the child will be "he" and the therapist "she". Play therapy is used to help both typically and atypically developing children, that is children who have physical and/or learning disabilities. However, play therapy should not be confused with physical therapies: it is psychotherapeutic in essence.

Children with a wide range of mental health and diagnoses and other difficulties may be offered play therapy, including those who:

- have experienced physical, emotional and sexual abuse, physical and emotional neglect
- have experienced a single trauma
- have experienced multiple trauma
- have witnessed domestic abuse (domestic violence)
- have parents with physical and/or mental illnesses
- have parents with physical and/or mental disabilities or learning difficulties
- have had one or more bereavements and/or other significant losses.

Some children will have diagnoses of mental health problems such as:

- Reactive Attachment Disorder
- Oppositional Defiant Disorder
- Conduct Disorder
- Attention Deficit Disorder with/without Hyperactivity (ADHD/ADD)
- Asperger's Syndrome
- One of the eating disorders

Note that severely autistic children have not traditionally received child-centred play therapy, as a capacity or potential capacity for symbolic play is deemed necessary. Some children at the "higher" end of the spectrum can develop this, or else have an existing rudimentary capacity. The autistic child may receive a related or adapted version of child-centred play therapy, such as Greenspan and Weider's (1999, 2000) approach, the Developmental, Individual Difference, Relationship approach (DIR) known as "Floor Time", if the therapist can offer this.

With regard to diagnostic and other labels, Liles and Packman (2009) noted that these can become a source of negative feedback for children but that "child-centred play therapy

provides labelled children with a unique environment in which they experience unconditional positive regard, as well as a sense of control over their world".

Some children will present with a range of symptoms and particular behaviours at home, school and the community, but without a current diagnosis. These include those who:

- Are physically aggressive toward other children and/or adults
- Bully (victimise) others
- Are withdrawn, excessively fearful, anxious or timid
- Are selectively mute
- Are targets for repeated bullying
- Self harm
- Attempt suicide
- Refuse to attend school
- Abscond or truant from school
- Are temporarily or permanently excluded from their school (suspended or expelled)
- Have some sexualised behaviours
- Break the law e.g. stealing, criminal damage

Like other "labelled" children receiving child-centred play therapy, they can experience themselves differently in the playroom, through the relationship with the adult, gaining self-control while expressing their emotions safely (Liles and Packman 2009).

While the above lists are by no means exhaustive, it is also the case that many children referred for play therapy have a range of problems and complex histories. For example, a 12-year-old boy in residential care may have been physically and emotionally abused by his birth parents (natural parents), removed into foster care at school age, and have experienced a number of foster placements before being placed in a specialised unit or school. He may present with a wide range of symptoms and may have one or more diagnoses e.g. Reactive Attachment Disorder, Attention Deficit Hyperactivity Disorder, and Asperger's Syndrome. Another child may have a less complex history and no current mental health diagnosis but may be defiant with her mother and aggressive toward her younger brother, with violent temper outbursts at home and school.

The families may be of many different structures and constellations. Children may live with one or both parents, in blended (step) families, with grandparents or other family members. Some children will be in the care of the statutory social services, in foster families or residential care. Others will be in adoptive families.

It is important that play therapy is culturally sensitive. Glover (2001) explored the cultural sensitivity of play therapy and suggested that the therapist has to make herself familiar with the sociocultural context of the child, and within that the cultural system, values and views of the child's parents/caregivers. Three cultural groups are discussed in more detail. Kao and Landreth (2001) write about play therapy with Chinese children. There have been a number of studies that have explored filial therapy with different populations (see for example VanFleet and Guerney, 2003).

Non-Directive Play therapy in action – a child-centred model

In the fictionalized excerpts below from play therapy sessions for 7 year old "Martin" and 10 year old "Lily", the play therapist is following the child-centred model of play therapy known as Non-Directive Play Therapy or NDPT (Wilson and Ryan 1996, 2005). It is similar in many respects to other child-centred models. The therapist demonstrates her use of the core skills of unconditional regard, empathy, and congruence, together with her some of her skills in child-led play. "Congruence", as a specific skill has a special emphasis in NDPT. Like other counsellors and psychotherapists using a person-centred model, the Play Therapist believes that the offer of these three core conditions is sufficient to bring about change by activating what Rogers (1951) calls self actualization – a natural drive toward emotional health.

Example 1 – Structuring the session

As they enter the play therapy room the therapist says, "Martin, just like the other times you have been here, you can do almost anything you want to. I will let you know if there is anything you may not do." Martin stands in the middle of the room gazing around before moving slowly toward the dry sand and sifting it through his fingers. The therapist notices and comments on what he is looking at and where his interest seems to lie moment by moment. When he asks, "Can I paint?" she responds, "You are choosing to paint – you can do that in here."

Toward the end of a busy hour, the therapist says, "Martin, we have five minutes left to play today," and then, "Martin, there are two minutes left". She then ends the session on time by stating, "Martin, all our time is gone for today. We have to leave the room now."

Example 2 – Unconditional positive regard

Lily has decided to paint and wants the Play Therapist to do a painting too. Lily quickly becomes absorbed in mixing new colours, using them to paint flowers. The therapist responds with interest to what Lily is saying and doing, making descriptive comments such as, "You like that dark pink colour… tiny pink flowers… you're pleased with that….Oh, you are disappointed at how that turned out." Lily looks over at the therapist's painting and says, "That's good". The therapist responds, "You're noticing my painting".

From her very first meeting with Lily, the therapist has demonstrated unconditional acceptance and positive regard. Lily experiences the therapist as someone who, rather than trying to get her to change, allows her to be, whoever she feels like at any given moment, in a psychologically safe context. Lily finds out that the therapist does not praise her with "That's very good," or "Well done", or even "That's a beautiful picture". Instead she says unusual things such as, "You are pleased with that," and "… trying really hard to get it how you want it to be". These comments are made in an appropriate tone of voice, reflecting Lily's feelings rather than a scale of values about "good" or "bad" results, "nice" or "nasty" play themes. It is a little disconcerting for Lily not to receive overt praise, but she comes to realise that she does not have to please the therapist, put on a show of "being good", nor suppress her feelings under a bright smile. Paradoxically, this acceptance by the therapist – her unconditional positive regard – actually allows a natural progress toward healthy and adaptive expression of feelings, self-control and self-responsibility.

Example 3 – Empathic responses

Without speaking Martin picks up the toy motorbike *[the Play Therapist knows from previous sessions that Martin uses this toy to express his feelings and ideas about himself]*.

Martin drives the motorbike in wide arcs over the table top, sometimes crashing it into other cars. The therapist comments on the action, describing what the bike is doing and ascribing possible feelings and thoughts to the bike: "He likes going very fast. He crashes into the black car – but he keeps going!" Martin's expression is gleeful but changes and freezes as the bike teeters on the edge of the table. The therapist says, "He just stopped himself! That was close!" Martin nods slightly and repeats this play with small variations twice more *[the therapist knows that this means that this small sequence is communicating something of importance to the child]*. She varies her comments, on the third repeat saying warmly, "He stops himself going over the edge; he's learned how to do that". Martin sighs and smiles while glancing briefly at the therapist. He moves away and starts a new play sequence on the floor involving dinosaurs.

The excerpt illustrates how Martin is allowed to express his feelings about himself and how the therapist responds empathically as he plays silently, keeping in mind what she already knows about him. She knows, for instance, that he mostly wants to keep on the move, easily gets restless, and acts on impulses that get him into trouble at home and school. He has been like this, since he was around 2 years old and not grown out of it. He feels bad about himself, he feels angry because "it's not fair" and he feels scared when he faces the abyss of grownups not being able to control him or themselves when things get really bad. He subconsciously projects these feelings into the little motorbike. The Play Therapist keeps all her comments within the play metaphor: the motorbike has these feelings of power, anger, fear and dawning self-control. She does not try to get Martin to talk about himself, although she listens and accepts if he does. However, the play therapist accepts equally whether he talks about the motorbike, or indeed if he keeps silent. He has been developing play sequences of this sort over several weeks, and he can repeat and modify them as many times as he needs to. The therapist may also note that Martin plays out related sequences involving themes of "in control/out of control" and "powerful/powerless". So the play therapist interprets or analyses the play, and forms working hypotheses about what drives the themes of his play. She may share these interpretations and hypotheses with Martin's father, a single parent, in the review of play therapy coming up in a couple of weeks. Nevertheless, Martin is allowed to keep the psychological safety and distance inherent in his symbolic play. This also allows him to play out his worst fears, nightmarish scenarios, and fantasy outcomes that may eventually include "happy endings".

Example 4 – Empathic and congruent responses

Lily makes loud noises with the simple whistles and percussion instruments but looks anxious. The play therapist says, "… looking a bit worried. It is OK for children to be noisy in here". Lily smiles between sharp blasts on a whistle. The therapist says something like, "Blowing it very loudly - you like doing that." Lily hands another whistle to the therapist and begins making shrill sounds with hers. The therapist listens and responds in a "duet", at first making similar shrill sounds. Then noticing how Lily's sounds are like shrieks and wails, and noticing her own inner sense of wanting to shut out the distress, she uses her whistle and her facial expressions to convey sadness.

The therapist begins by making verbal empathic reflections about Lily's feelings and thoughts. Her responses in the duet fulfil the same function by non-verbal means. The therapist also knows that Lily's family broke up; that her mother, whom Lily sees alternate weekends, is clinically depressed; that her grandmother died two years ago. Realizing that Lily is likely to be expressing underlying anger and distress by making a lot of noise and using some of her bigger muscles, the therapist is likely to add, at some point if not the first

time, “Maybe some angry feelings, “ and may give permission with “It is OK to be angry in here.” The therapist’s use of empathy goes beyond mere description. In this sequence, she also uses her own congruent feelings. Recognising her own growing feeling of sadness, she is experiencing something of Lily’s grief. Underneath the pleasure of the play there is anger, and beneath that, deep sadness and loss. The therapist uses all her knowledge about the child plus what is happening in that moment to give voice to Lily’s inner emotional world. Of course, the therapist may misunderstand what is happening or miss-time her comment. Lily is likely to tell her if this is so, either verbally or non-verbally, for example, by saying, “No” and/or turning away.

Example 5 – Therapeutic Limit-Setting

Martin picks up the small wooden hammer and taps the pegs into the holes on a toy designed for preschoolers. As the therapist comments he hammers harder and harder on the pegs, then starts on the doll house. The therapist states the limit: “Martin, you feel angry and powerful, but remember, one of the things you may not do is to damage or break things. But you may hammer on this pillow.”

The therapist is using the skill of therapeutic limit-setting. She follows a three-step process of naming the feelings, reminding him of the limit on behaviour, and redirecting behaviour i.e. suggesting an acceptable alternative (Landreth 2002]. Martin knows that, in play therapy, he can express anger - that huge feeling which erupts into behaviour that gets him in trouble at home and school. Once the feeling has been named and expressed via safe behaviour it subsides, bringing a sense of relief and a glimmer of a sense of self-control. In addition, if he bangs something so hard that it breaks (or the therapist thinks it might break) he gets a clear message in a formula he soon comes to recognise. The therapist will not allow him to hurt himself or her, or to damage the room or the toys deliberately. She however keeps the messages simple and clear, not stating a rule or limit until it is needed (Landreth 2002). Note that the therapist avoids the use of “No” and “Don’t”. Her choice of words helps to sidestep habitual oppositional responses. Personal choice and self-responsibility are implicitly offered.

Some children do cause damage or break a limit before the therapist can verbally intervene. Suppose, for instance, that Martin carries on hammering the doll house and damages it. The therapist states the limit again adding a warning of the consequence. The consequence may be that “the hammer will be put away for today, or even, “your play therapy session will end, and we will have to leave straightaway”. The therapist is firm but calm, and continues to reflect his feelings appropriately. If he persists, she enforces the consequence, reminding Martin that, “because you chose to go on hammering the doll house, you chose to leave.” The therapist is not being punitive or angry when she enforces a limit in this way. She gives the child the choice of how to behave. Most children quickly learn about limits, and because they want to stay in the play therapy room, they choose to regulate their behaviour. Martin learns to take responsibility for his own behaviour, and he experiences the benefits of self-control. The therapist does not have to spell out the lesson: he learns it as a result of his direct experience.

Limits are also necessary to keep the child and the therapist physically safe, and to provide physical, emotional and psychological safety for the child: it is important that a child’s previous experiences of shame, guilt, punishment and/ or injury are not repeated or mirrored in the therapy room by the therapist’s reactions.

Axline (1989) notes that limits are necessary to anchor the session in reality: the child is not permitted to act out feelings using any behaviour at all but only those that are safe. The time boundaries (described under example 1 above) also limit the play safely, bringing the session to an end at a fixed point. The therapist's use of time warnings to structure the session helps children to regulate their behaviour and feelings so as to be able to return to "real life" as they leave the protected space that is the play therapy room.

The role of parents and caregivers

The role of the parent or caregiver is very important, for without their involvement the work can become, or be seen as, an attempt to "fix the child" without reference to the context in which the child lives. So the Play Therapist must take a systemic approach in many respects, considering the home first and foremost, but also the educational and social contexts. Before the therapist even meets the child she will want to ascertain whether the child is "safe enough", whether there is at least one person in his life who can be sufficiently emotionally available to support the therapeutic process. This is not always easy to assess, whether the therapist is making use of the assessments done previously by other professionals or conducting her own assessment. However, the "rule of thumb" is that the function of play therapy is to help a child after the abuse or trauma has stopped and when the child cannot adjust to "normal" life. If therapy took place while a child was known to be experiencing abuse or neglect, or at risk of these, the therapist would be colluding in the abuse, in the sense that the implicit expectation would be that the child should adapt to the abusive circumstances, rather than that adults should safeguard the child. Play therapy is not a substitute for safeguarding. The role of the Play Therapist, therefore, is sometimes to refuse to work with a child until circumstances have changed and the child is in a relatively stable and safe context. The therapist would want to discuss with other agencies what support and help the child would need in such circumstances.

Parents/caregivers may initially be unsure about play therapy. It is considered good practice for the therapist meets with parents at the outset to discuss and explain the treatment and their part in it, which goes beyond that of bringing the child to a weekly session (Wilson and Ryan 2005). Anecdotally, a parent's emotional availability may be said to be the key to the success of the intervention. The centrality of the parent's role is certainly acknowledged (Landreth 2001; McGuire and McGuire 2001; Wilson and Ryan 2005). The parent who can engage in collaborative, reflective discussions with the therapist in their regular review meetings is more likely to see change, and more likely to support change, than one who is able to itemise the child's misdeeds but little else. The therapist-child relationship cannot and should not replace the parent-child relationship. This viewpoint would be supported by attachment theory. The therapist will not describe the child's play sessions to the parent in detail but will give feedback based on the themes that have emerged and other things they have noticed about the child. The way the child expects the therapist to behave, for instance, gives clues about the child's predominant attachment style. Play Therapists can involve parents/caregivers in a number of ways. Landreth (2001) and McGuire & McGuire D (2001) describe some of these. The Play Therapist may have the parent in the session as a participant observer while the child "settles" or on a longer term basis that may lead to joint sessions. Some Play Therapists will give brief feedback to a parent after every session while others will do so at longer intervals and in more depth. The parents may receive some parenting advice, ideas about new strategies to try out at home, play-based tasks, and recommended reading. Filial Play Therapy, which involves the parent being even more involved, is discussed briefly later in this article.

As part of the systemic, ecological approach to understanding and helping the child, the Play Therapist will, in many cases, liaise with schools, social care and other agencies. As with other mental health and social care professions, multi-agency working is at the heart of good practice.

Therapeutic play

Professionals other than Play Therapists may use the therapeutic power of play in a range of settings. This is also sometimes referred to as "play therapy". McMahon (2009) explores the interfaces and distinctions between play therapy and the use of therapeutic play.

Play has an intrinsic potential to be therapeutic, most especially if it is a shared experience between a child and an empathic, accepting and trustworthy adult. There are many well-documented ways of working utilising play to assist with physical disabilities, learning disabilities, learning difficulties, mental health disorders, emotional and social problems. A very wide range of play-based techniques are used by professionals with different levels of training and a variety of theoretical models including other child psychotherapists, occupational therapists, speech and language therapists, teachers, social workers, play workers, and hospital play specialists. In addition, a professional Play Therapist may also employ play-based techniques for assessment of children and families prior to treatment (Gil 2006; Rye and Jaeger 2007). Play therapists who are trained in more than one model may incorporate a range of techniques and approaches into their work (Kaduson and Schaefer 2003; Reddy, Files-Hall, Schaefer 2005) while others will prefer to keep exclusively or almost exclusively to a child-centred, non-directive model.

Emergence of play therapy as a therapeutic modality

The task of fully describing the history of play therapy is beyond the scope of this article. A fuller account of the history of play therapy and the emergence of distinct play therapy modalities can be found in Landreth (2002). A mere outline is offered here. Play therapy began to emerge in the first half of the 20th century as therapists and theorists such as Anna Freud, Margaret Lowenfeld and Melanie Klein developed their ideas about how to gain insight into a child's inner emotional world through play. But it was the work of Virginia Axline (1989) that saw child-centred play therapy emerged as a new modality distinct from that of the existing child psychotherapies. Axline drew on the work of Carl Rogers' (1951) client-centred therapy; formulating eight principles that are remain at the heart of child-centred play therapies today. Her book "Dibs: In Search of Self" (1964) is still widely read. Modern child-centred play therapy draws on research and theory in other relevant fields and has its own theoretical framework and research base. Because play therapy takes a developmental perspective it is especially important that practitioners are familiar with theoretical frameworks based on research in both typical and atypical child development. The classic theories of Piaget, Erikson and Vyogtski underpin the work of the therapist. Attachment theory is also of prime importance and can provide a basis for understanding not only the origins of the child's current difficulties but also his current presenting problems. Attachment theory was first developed by Bowlby (1973, 1979, 1980, 1982). Although a wealth of research and literature has followed his original work, his writings still have much to say. Others have built on his work and developed their own models of how attachment relationships influence the ways in which people respond to each other throughout life, not just in infancy. Crittenden's (2003 Crittenden and Claussen) Dynamic Maturational Model, and Heard and Lake's (1997) theory of companionable caregiving are two distinctive examples of theoretical attachment frameworks upon which a Play Therapist might draw in

her work with children and their parents/caregivers. It is also important to keep abreast of research in fields such as neuroscience and sensory integration, in order to understand the neurodevelopmental and physiological bases of human behaviour (Cozolino 2006; Gerhardt 2004).

Filial Play Therapy – working directly with the parent

There are several different parent-child therapy models in use. One of the best-researched child-centred modalities is Filial Play Therapy, also called Filial Therapy (Guerney B 1964; Guerney LF 2003; VanFleet 2005) which can be used with single families or groups. Landreth and Bratton (2006) have developed a 10 week model for group interventions based on Filial Therapy called Child-Parent Relationship Therapy (CPR-T). Filial Therapy is a very flexible modality. The parent conducts the play sessions instead of the therapist. The role of the therapist is part Play Therapist, part trainer/coach and part clinical supervisor. After a careful assessment of the family, often using play-based methods, the Play Therapist trains the parents/caregivers in the basic skills for conducting a short child-centred play session with the child. If possible every child in the home has a "special time" once a week, which may or may not be a Filial play session. Filial Therapy has the potential to become a whole family intervention, but even when it is not, it often brings great benefit to the troubled child-parent relationship. The child, who may have already seen several professionals, does not have to form yet another relationship but can work directly with one of the most important people in his life. The parent/carer brings his or her own expert knowledge of the child to the play sessions and can sometimes provide more direct insight into the play than the therapist. The therapist has the advantage of seeing parent-child interactions directly. In her feedback to parents the therapist is able to give encouragement mixed with a little direction to improve the skill levels. Parent and therapist can reflect together on emerging themes in the child's play.

Evidence base for Play Therapy

There is a substantial body of literature on child-centred play therapy and other modalities. Filial Play Therapy/Filial Therapy has always had a particularly strong evidence base: Bernard and Louise Guerney (Guerney 1964)) began the first group as a research project. LeBlanc and Ritchie's (1999) meta-analysis of 42 studies revealed a moderate positive treatment effect (0.66). Ray, Bratton, Rhine and Jones' (2001) meta-analytic review encompasses 94 experimental play therapy studies carried out over six decades. It revealed a large positive effect, specifically 0.73 for the general play therapies and 1.06 for the filial therapies. Reddy, Files-Hall, Schaefer (2005) have contributions from a number of sources that detail empirical research into a range of play-based interventions including Filial Therapy.

Conclusion

Play therapy continues to develop in child-centred and other modalities, as a range of effective interventions for helping troubled children and adults. At the heart of "traditional" child-centred play therapy is the child, with his or her unique set of genes, life experiences, thoughts, fantasies, sensory and physical sensations, coping strategies, and ecological niche. All these and more can be expressed in the child's play. In play therapy, the child experiences an adult who aims to enter his world alongside him. The process they share over the weeks, months or years will also be unique. The adults surrounding the child will usually gain more understanding of the child, through the therapist's work. Many times, play therapy will also result in positive and healthy changes in the child's way of responding to the world.

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