CHILD-CENTERED PLAY THERAPY

Virginia Axline, first a student under Carl Rogers and then a colleague of his, translated the philosophy and principles of Rogers's nondirective counseling approach (i.e., belief in the individual's natural strivings for growth and the individual's capacity for self-direction) to work with children in her definitive play therapy text, Play Therapy: The Inner Dynamics of Childhood, in 1947. Rogers's approach was later referred to as client-centered therapy, and today as person-centered therapy. The person-centered (or, with children, child-centered) approach makes no effort to control or change the child and is based on the theory that the child's behavior is at all times caused by the drive for complete self-realization. To understand the child-centered play therapy approach it is necessary to first understand the meaning of play in children's lives.

THE LANGUAGE OF PLAY

The elementary school counselor uses play therapy with children because play is the child's symbolic language of self-expression, and for children to play out their experiences and feelings is the most natural, dynamic, and self-healing process in which children can engage. Play is serious business (White, 1960) and a process through which children build up their confidence in dealing with their environment. Self-directed play provides children with an opportunity to be fully themselves (Bruner, 1986). In play therapy nothing is held back; all parts of the self are experienced because self-directed play is safe. Only through engaging in the process of play in an accepting, caring relationship can children express and use the totality of their personalities.

Because children's language development lags behind their cognitive development, they communicate their awareness of what is happening in their world through their play. The use of toys enables them to transfer anxieties, fears, fantasies, and guilt to objects rather than people. In the process, children are safe from their own feelings and reactions because play enables children to distance themselves from traumatic events and experiences. Therefore, children are not overwhelmed by their own actions because the act takes place in fantasy. By acting out through play a frightening or traumatic experience or situation symbolically, and perhaps changing or reversing the outcome in the play activity, children move toward an inner resolution, and then they are better able to cope with or adjust to problems.

In a relationship characterized by understanding and acceptance, the play process also allows children to consider new possibilities not possible in reality, thus greatly expanding
the expression of self. In the safety of the play therapy experience, children explore the unfamiliar and develop a knowing that is both experiential-feeling and cognitive. It can then be said that through the process of play therapy, the unfamiliar becomes familiar, and children express outwardly through play what has taken place inwardly. A major function of play in play therapy is the changing of what may be unmanageable in reality to manageable situations through symbolic representation, which provides children opportunities for learning to cope by engaging in self-directed exploration. Axline (1947) viewed this process as one in which the child plays out feelings, thus bringing the feelings to the surface, getting them out in the open, facing them, and learning to either control them or abandon them. It would seem then that play allows children to express themselves in a way that reduces tension and anxiety, and thus allows them to gain control of their lives.

Because toys are used by children like words and play is their language, children below the age of 11 years experience great difficulty expressing their emotional world by verbal means. Therefore, elementary school counselors must leave their typical verbally bound approach to communication and must go to the child's level of communication by using play therapy. Only through the process of play can the counselor gently touch the emotional world of the vulnerable child.

A VIEW OF CHILDREN

The child-centered play therapist appreciates the unique dynamic potential of each child. The play therapist cannot make children grow faster in any significant emotional developmental area by his or her efforts, as well-intentioned or skillfully manipulated as those efforts may be. That simply is not possible. The child-centered play therapist believes in and trusts the child's intrinsic motivation toward adjustment, mental health, independence, autonomy, and self-actualization, and, therefore, allows the child to move at a pace of growth determined by the child's unique, forward-moving pace. Elementary school counselors often experience pressure from teachers, administrators, and parents to change children or their behavior. Consequently, the counselor may search for something more to do in play therapy, or the counselor may probe into areas he or she thinks the child should talk about, as though that would somehow magically bring about the desired change.

Is it possible for the play therapist to teach children about themselves? Can the wisdom of the play therapist be used to lead children into areas of more productive behavioral change? Gibran's (1923) Prophet addressed this issue and said, "No man can reveal to you aught but that which already lies asleep in the dawning of your own knowledge. . . . For the wisdom
of one man lends not its wings to another man" (p. 32). The play therapist is not a person who tries to make things happen, for that is not an option within the possibilities that exist in reality. To create within the child inner knowledge is simply not possible. Whatever is important or necessary for children's growth already exists in children. The play therapist's role or responsibility is not to reshape children's lives or get them to change in some predetermined way to fit the perceptual expectations of concerned adults. Change is already occurring. The living of life is never a static occurrence; it is a process of relentless learning and renewal, of continuous and dynamic chance. Pasternak was reacting to the efforts of some people to produce change in others when he said:

When I hear people speak of reshaping life it makes me lose my self-control and I fall into despair. Reshaping life! People who can say that have never understood a thing about life--they have never felt it's breath, it's heartbeat, however much they may have seen or done. They look on it as a lump of raw material that needs to be processed by them, to be ennobled by their touch. But life is never a material, a substance to be molded . . . . Life is constantly renewing and remaking and changing and transfiguring itself. (Salisbury, 1958, p. 22)

As the child reacts to his or her changing world of experience, the child does so as an organized whole so that a change in any one part results in changes in other parts. Therefore, a continuous dynamic intrapersonal interaction occurs in which the child, as a total system, is striving toward actualizing the self. This active process moves toward becoming a more positively functioning person, toward improvement, independence, maturity, and enhancement of self. The child's behavior in this process is goal directed in an effort to satisfy personal needs as experienced in the unique phenomenal field which for that child constitutes reality. Personal needs, then, influence the child's perception of reality. Therefore, the child's perception of reality is what must be understood if the child and his or her behavior are to be understood. Thus, the play therapist avoids judging the child's behavior and works hard to try to understand the internal frame of reference of the child. The play therapist trusts the child to take the play therapy experience into those emotional areas the child needs to explore. This dynamic variable is central to the child-centered approach.

**THERAPEUTIC CONDITIONS FOR GROWTH**

The child-centered philosophy of play therapy is just that: an encompassing philosophy for living one's life in relationships with children. Child-centered play therapy is not a cloak of techniques to put on upon entering the playroom, but a way of being based on a deep commitment to certain beliefs about children and their innate capacity for growth.
Child-centered play therapy is a complete therapeutic system, not just the application of a few rapport-building techniques. The nature of the interaction between the play therapist and the child in the child-centered approach was clarified by Axline (1947) in her eight basic principles that serve as a guide for therapeutic contact with the child. These principles, in revised and extended form, are:

1. The play therapist is genuinely interested in the child and develops a warm, caring relationship.
2. The play therapist experiences unqualified acceptance of the child and does not wish that the child were different in some way.
3. The play therapist creates a feeling of safety and permissiveness in the relationship so the child feels free to explore and express him- or herself completely.
4. The play therapist is always sensitive to the child’s feelings and gently reflects those feelings in such a manner that the child develops self-understanding.
5. The play therapist believes deeply in the child’s capacity to act responsibly, unwaveringly respects the child’s ability to solve personal problems, and allows the child to do so.
6. The play therapist trusts the child’s inner direction, allows the child to lead in all areas of the relationship, and resists any urge to direct the child’s play or conversation.
7. The play therapist appreciates the gradual nature of the therapeutic process and does not attempt to hurry the process.
8. The play therapist establishes only those therapeutic limits that help the child accept personal and appropriate relationship responsibility.

In this approach, the child and not the problem is the point of focus. When the focus is on the child’s problem, the play therapist may lose sight of the child. Diagnosis is not necessary because this is not a prescriptive approach. The therapist does not vary the approach to meet demands based on a specific referral problem. The relationship that develops and the creative forces this relationship releases in the child generate the process of change and growth for the child. It is not preparation for change. Whatever develops in the child was already there. The therapist does not create anything. The therapist only helps to release what already exists in the child. In this process, the child is responsible for self and is quite capable of exercising that responsibility through self-direction, resulting in more positive behavior. In child-centered play therapy, the relationship, not the use of toys or interpretation of behavior, is the key to growth. Therefore, the relationship is always focused on the present, living experience (Landreth, 1991).
The child-centered play therapist enters the relationship with an openness to emotionally immerse him- or herself so experientially into the child's life (as shared at that moment) that the play therapist will see what the child sees and hear what the child hears, not what the play therapist thinks the child should hear or wishes were true for the child. The play therapist experiences a deep yearning to make contact with the inner person of the child and to feel what the child feels without any dependency on verbal expression.

The attitude experienced and projected by the play therapist is a desire to experience with the child as fully as is humanly possible what the child experiences at the moment in the shared relationship. The play therapist is so fully committed to being with the child that he or she experiences no attempt to evaluate or question the child's thoughts or expressions. That would interfere with the child's experiencing responsibility for leading the relationship. Questions intended to verify a hypothesis or to lead the child to talk about a specific topic are a therapeutic mistake and usually result in the child's feeling defensive, or believing that the counselor does not understand.

The intentionality of the play therapist to see, hear, feel, and experience with the child in a nonevaluative relationship is communicated to the child at all times through the following four messages the play therapist lives out in the relationship:

- **I AM HERE.** Nothing will distract me. I will be fully present physically, mentally, and emotionally. I am here for the child.
- **I HEAR YOU.** I will listen fully with my ears and eyes to everything about the child, what is expressed and what is not expressed. I want to hear the child completely.
- **I UNDERSTAND YOU.** I want the child to know I understand what he or she is communicating, feeling, experiencing, and playing, and will work hard to communicate that understanding to the child.
- **I CARE ABOUT YOU.** I really do care about this little person, and I want the child to know that. If I am successful in communicating fully the first three messages, the child will know I care (Landreth, 1991).

In child-centered play therapy, the therapist is highly interactive verbally and is so actively responsive to the child that the child feels at all times as though the therapist is a part of whatever the child is engaged in at the moment, even though the therapist may not be physically participating. The play therapist is never an observer but is always an emotional and verbal participant.
Some elementary school counselors do not have a permanent place to call their own. Being a congenial group, they are often guests invited in to use an office or room delegated to someone else. This should not present a problem in implementing a play therapy program, but it does mean adjustments will be necessary. Play therapy sessions can be held in the corner of the cafeteria, a storage closet, a workroom, the nurse’s office, the library, or the corner of an unused regular classroom. Of course, appropriate concern for confidentiality must be exercised in these settings. Although many elementary school counselors are assigned to several schools, where there is a will, there does seem to be a way. I once supervised an elementary school counselor who served five schools and had seven 30-minute play therapy sessions in each school. She used a different setting (i.e., a book-room, a classroom, and so on) in each school. In sharp contrast are the elementary schools in Irving, Texas, a suburb of Dallas, where each school has a counselor and a play therapy room.

Although desirable, a fully equipped playroom is not essential for children to express themselves. What is important is that children have ready access to play materials selected for the purpose of encouraging expression. All toys and materials do not automatically encourage children’s expression or exploration of their needs, feelings, and experiences. Therefore, toys should be selected, not collected. Play therapy is not used as a way to pass the time or to get ready to do something else. The purpose is not to engage the child’s hands while trying to elicit some verbal expression from the child’s mouth. Consequently, careful attention should be given to selecting play materials that aid in the following:

- Exploration of real life experiences
- Expression of a wide range of feelings
- Testing of limits
- Expressive and exploratory play
- Exploration and expression without verbalization
- Success without prescribed structure

Mechanical or complex toys would not fit these objectives and so are avoided. Play materials that require the counselor’s assistance to manipulate are inappropriate. Many children in need of play therapy have poor self-concepts and are overly dependent. Play materials should not reinforce such problems.

In a modified play therapy setting, consideration will need to be given to the size and portability of materials, because the counselor may need to carry the materials from school to school or may need to store them in an out-of-the-way place. The following toys and materials are considered to be the minimal requirements for conducting a play therapy
session and are recommended because they encourage a wide range of expressions and can easily be transported in a tote bag:

- Crayons (8-count box)
- Newsprint
- Blunt scissors
- Nursing bottle (plastic)
- Rubber knife
- Doll
- Clay or Play-doh
- Dart gun
- Handcuffs
- Toy soldiers (20-count size is sufficient)
- Two play dishes and cups (plastic or tin)
- Spoons (avoid forks because of sharp points)
- Small airplane
- Small car
- Lone Ranger-type mask
- Nerf ball (a rubber ball bounces too much)
- Bendable Gumby (nondescript figure)
- Popsicle sticks
- Pipe cleaners
- Cotton rope
- Telephone
- Aggressive hand puppet (alligator, wolf, or dragon)
- Bendable doll family
- Doll house furniture (at least bedroom, kitchen, and bathroom)
- Small cardboard box with rooms marked on the bottom (cut door in one side and window in another; doubles as storage container for toys)
- Transparent tape
- Costume jewelry (Landreth, 1991)

If storage space is available, an inflatable vinyl punching bag would be a special asset. A dishpan-size plastic container with an inch of sand in the bottom also would be useful in a more permanent setting. Rice could be used in place of the sand if cleanup is a problem.

Therapeutic Limit Setting
Limit setting is absolutely crucial in promoting the therapeutic dimensions of the child-centered play therapy relationship. Children do not feel safe, valued, or accepted in a completely permissive relationship. The child-centered play therapy approach is not a passive relationship in which the play therapist's attitude is one of detached resignation to anything the child wants to do. A part of the structure provided by the play therapist is that of therapeutic limit setting, which provides the child an opportunity to exercise self-control and experience self-responsibility. A climate of permissiveness is more important than the actual existence of permissiveness.

In therapeutic limit setting, the child's desire to break the limit is always the primary focus of attention because we are dealing with intrinsic variables related to motivation, perception of self, independence, need for acceptance, and the working out of a relationship with a significant person. Therefore, all feelings, desires, and wishes of the child are accepted, but not all behaviors are allowed. The child-centered play therapist has an unwavering belief that children will choose positive cooperative behavior when provided with conditions of acceptance of self. This attitude of belief in the child and the child's feelings at the moment are key variables in the process of change and are more important than the child's behavior.

Because play therapy is viewed as a learning experience for children, limits are not set until they are needed because that is the optimum learning moment. Providing a list of limits at the beginning of the first session establishes a negative atmosphere, may convey a lack of trust in the child, and would only give some children ideas! Other general principles are that limits should be minimal, specific, total rather than conditional, and enforceable. "You can't hit me hard" would be a conditional limit and sets up the basis for an argument about whether or not a hit was hard. The statement is also not acceptable because the child does not know what behavior is prohibited. "I'm not for hitting" would be a total limit. The child knows exactly what is not allowed. The limits necessary for facilitating a therapeutic relationship and a thorough explanation for setting the limits are included in Play Therapy: The Art of the Relationship (Landreth, 1991). Because of space limitations, they are summarized here as follows:

1. **Limits help ensure the physical and emotional security of children.** The physical safety of children is ensured and behaviors for which they may later feel guilty, such as pouring paint on the therapist, are prohibited.
2. **Limits protect the physical well-being of the therapist and promote acceptance of the child.** Allowing a child to persist in throwing a barrage of wooden blocks at the therapist would very likely stimulate some feelings of rejection in even the most experienced therapist.
3. Limits facilitate the development of decision making, self-control, and self-responsibility. "You can't paint on the wall" is an authority statement and places responsibility for controlling the behavior on the play therapist. "The wall is not for painting on. The paper on the easel is for painting" indicates a permissible way to express self and presents the child with a choice: to act on the original impulse or to express self through alternative behavior.

4. Limits anchor the session to reality and emphasize the here and now. When the play therapist states a limit, the experience is quickly changed from fantasy to the reality of a relationship with an adult in which certain behaviors are unacceptable, as is true in the world outside the playroom.

5. Limits promote consistency in the playroom environment. Consistent limits, unwaveringly enforced, help to make the play therapy relationship predictable and thus increase the child's feeling of emotional security.

6. Limits preserve the professional, ethical, and socially acceptable relationship. Therapeutic limit setting enables the child to express behaviors and accompanying feelings symbolically and allows the therapist to be an objective but involved participant, thus preserving the professional and ethical therapeutic relationship.

7. Limits protect the play therapy materials and room. The playroom is not a place of limitless freedom where the child can do anything. The toys and materials are not for destroying. Nevertheless, there should be some items that are for smashing or breaking. Egg cartons seem to fit this purpose quite well. Therapeutic limit setting follows three specific steps, usually in the following order:

   a. Acknowledge the child's feelings, wishes, and wants: "You are

   b. Communicate the limit: "The doll house is not for hitting with the hammer."

   c. Target acceptable alternatives: "The log is for hitting with the hammer."

If a child persists in breaking a limit, Step 4 can be removal from the room or placing the item off limits for the remainder of the session. "If you choose to continue to try to hit the doll house with the hammer, you choose to (leave the playroom, not play with the hammer) for today."

**RESEARCH ON CHILD-CENTERED PLAY THERAPY**

The popular myth of child-centered play therapy being a slow process requiring a long-term commitment is unfounded. Crow (1989), an elementary school counselor, had ten 30-minute individual child-centered play therapy sessions with 12 first-grade students
who had been retained because of low achievement in reading and found that their self-concepts were significantly improved as compared to a matched control group.

Recently I trained 16 incarcerated fathers to use child-centered play therapy procedures in filial therapy sessions with their children. The fathers had special 30-minute play sessions once a week on visitation day for 10 weeks. These children's self-concepts improved significantly as compared to a control group of incarcerated fathers and their children. These results should be especially encouraging to elementary school counselors who strive daily to help children develop more positive self-concepts, because they recognize poor self-esteem as a basic cause of many academic and social problems in elementary school-age children.

Over 40 years ago, Bills (1950) investigated the effects of nondirective play therapy on poorly adjusted slow readers and found that after six individual and three group play therapy sessions, students in the play therapy group showed significant gains in their reading ability when compared to a control group.

Barlow, Strother, and Landreth (1985) reported on the case of a 4-year-old child whose emotional reactions were so severe that she had, over a period of several months, pulled all her hair out and was completely bald. By the end of the eighth play therapy session, previously reported behavioral symptoms had disappeared and her hair had grown back, a dramatic picture of the effectiveness of child-centered play therapy.

I have experienced dramatic changes in the behaviors of traumatized and emotionally disturbed children by the fifth and sixth sessions of play therapy. In one case, the mother of a 5-year-old boy who was reacting to his parent's divorce reported dramatic changes in her son's behavior (i.e., less aggressive and angry) by the sixth session. In another case, a 6-year-old boy who had spent 2 years denying the permanency of his grandfather's death was able to express awareness and acceptance of his grandfather's death during the fifth play therapy session.

Child-centered play therapy has also been demonstrated to be effective in ameliorating elective mutism (Barlow, Strother, & Landreth, 1986), increasing academic performance in learning-disabled children (Axline, 1949; Guerney, 1983b), correcting speech problems (Axline & Rogers, 1945; Dupent, Landsman, & Valentine, 1953), improving social and emotional adjustment (Axline, 1948; Cox, 1953; Dorfman, 1958; Moustakas, 1951), and helping children accept their sex (Guerney, 1983a).

CASE ILLUSTRATION
The following partial transcript of Paul's second play therapy session (Landreth, 1991) is illustrative of the child-centered play therapist's approach and the way in which children use the freedom and security of the relationship to symbolically express themselves through play. When Paul was 4 years old, his grandfather died. Two months after his grandfather's death, Paul insisted his mother take him to the cemetery to visit "Paw Paw." At the cemetery, Paul ran over to the grave site, got down on his hands and knees and began to talk to Paw Paw through a hole in the flat headstone, evidently intended for a flower vase. After talking to Paw Paw for several minutes, Paul was ready to go home. Two weeks later Paul insisted his mother take him to the cemetery again to talk to Paw Paw. This became the pattern for the next 2 years, every other week an hour drive to the cemetery to talk to Paw Paw. For the next two years, Paul struggled with an obsessive fear of death and his ambivalence about the permanency of death. The following transcript is from Paul's second play therapy session:

Paul: Hey, does this work? You put it in there? (Examines T.V. and figures out where a piece goes.)

Counselor: There, you figured it out.

Paul: Does it move? (Tries to make picture screen move.)

Counselor: I guess you're wondering, does this thing really work like a real one?

Paul: It didn't move. Daddy bought a new television, didn't he? Mr. Dad, for them.

Counselor: Dad brought it home for them.

Paul: To watch, to watch. The kids saw the new truck Daddy bought. Daddy . . . the kids didn't know it yet. They start running.

Counselor: Oh, he sort of surprised them.

Paul: The kids didn't see nothing like it, didn't they?

Counselor: So it was a special surprise.

Paul: Dad's gonna, he's gonna have to take it back someday.

Counselor: So Dad can't keep it.
Paul: (Puts the dolls in the truck.) They're gonna have a ride. Where's the baby? Oh. Get in there. (Puts doll family in scooter truck.) They're gonna have fun, aren't they?

Counselor: So they're all going together in that new truck to have fun.

Paul: (Pushes the truck slowly around the doll house, makes motor noise, stays very close to doll house.) They're almost home, aren't they?

Counselor: They're coming back.

Paul: Time for them to get out. (Takes dolls out and puts in the house.) Oh, the kids say "Oowh, Oowh!"

Counselor: They didn't want to.

Paul: They didn't want to go home. They liked their ride, didn't they?

Counselor: They were having lots of fun.

Paul: Guess what? He might buy a tractor. He gets to go to work.

Counselor: So, he bought a T.V. and then a truck, and he might even buy a tractor.

Paul: They might move.

Counselor: Hmmm. They might move.

Paul: (Begins loading furniture into scooter car.) Yeah, but poor mom can't cook anymore (as he loads kitchen stove.) She was hungry. The dad was hungry. You know something, they can move that bathroom.

Counselor: Uh huh. They can move just about everything in that house.

Paul: In the truck. Oh God! And they moved, didn't they?

Counselor: Moved everything out of the house.

Paul: Yeah. They decided to live here again. (Puts furniture back in doll house.)

Counselor: So they moved out and then decided to move back in.

Paul: Know why? They were missing some more cartoons.
Counselor: So they wanted to get back and watch some.

Paul: Know what Dad has to do. (Moves to the sandbox with father doll.)

Counselor: You can tell me what he's gonna do.

Paul: Ok. He's gonna . . . he died.

Counselor: Oh, Daddy died.

Paul: Yeah. So they're gonna bury him in the sand. (Scoops out hole in sand and begins to bury father doll.)

Counselor: He died and now he's getting buried right there.

Paul: I know. I guess they have to have a new Daddy, right? (Continues covering doll with sand.)

Counselor: So if that daddy died, they'll need to get another one.

Paul: Oooh. He's all buried.

Counselor: Now he can't be seen.

Paul: There's where he's at. (Places funnel upside down on top of grave with spout pointing up, just like the headstone in the cemetery.) The kids came to see him. The baby's still asleep. (Goes to doll house, gets boy and girl dolls.)

Counselor: Hmmm, so they're going to go and see where he is buried.

Paul: (Places boy doll's head at funnel end.) They heard something. Uhhhhhh. (Sound coming from grave.)

Counselor: They heard something where Daddy is buried.

Paul: Yeah. And guess what. They are going to unbury him. (Pulls doll out of sand.) Oh, God! He's alive!

Counselor: So he wasn't really dead. Now he's alive.

Paul: They were surprised at him. (Sounds excited and glad.)
Counselor: They were surprised but happy.

The graphic way children can play out their concerns is evident in this episode as Paul portrayed his fear of loss, by moving and then immediately moving back into the house. His great ambivalence about the permanency of death was dramatically played out in the death, burial, and resurrection of the father doll.

**SUMMARY**

Child-centered play therapy has a long history of being used effectively in elementary schools and is, perhaps more than any other play therapy approach, truly developmental in nature, because there is no pressure on the child to change. Child-centered play therapy can be used effectively by elementary school counselors to aid change and growth in a variety of developmental problem areas experienced by children. In addition to those areas previously identified through research, child-centered play therapy would be recommended for children experiencing learning disabilities, divorce, lack of self-control, depression, abuse, socially inappropriate behavior, dependency, regressive behavior, physical handicaps, and many other problems.

**REFERENCES**


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