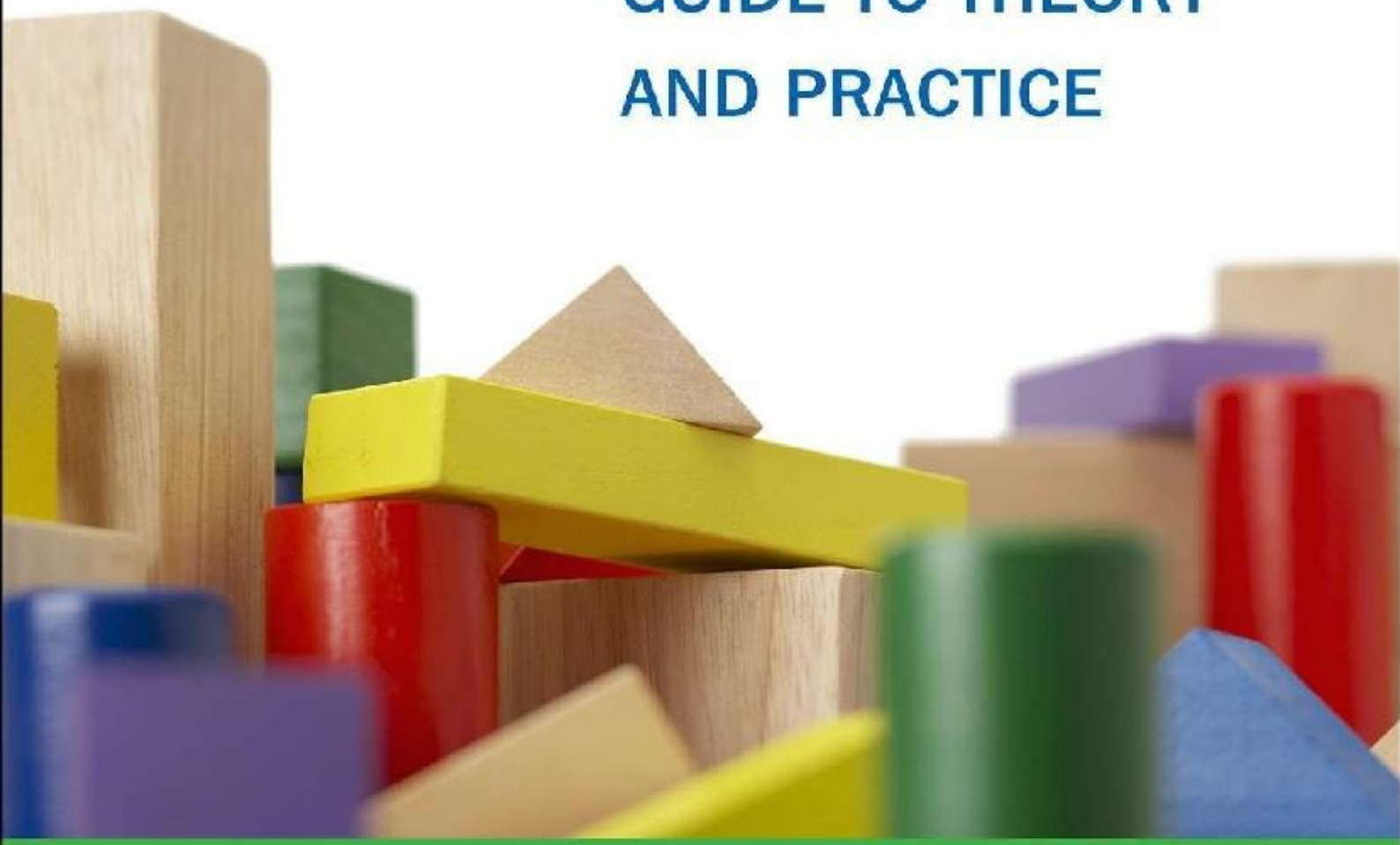
Play Therapy

A COMPREHENSIVE GUIDE TO THEORY AND PRACTICE



EDITED BY
David A. Crenshaw & Anne L. Stewart

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Foreword by Stuart Brown

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About the Editors

David A. Crenshaw, PhD, ABPP, RPT-S, is Clinical Director of the Children's Home of Poughkeepsie, New York. He is a Board Certified Clinical Psychologist by the American Board of Professional Psychology, a Fellow of the American Psychological Association and of its Division of Child and Adolescent Psychology, and a Registered Play Therapist–Supervisor by the Association for Play Therapy. Dr. Crenshaw is Past President of the Hudson Valley Psychological Association, which honored him with its Lifetime Achievement Award, and of the New York Association for Play Therapy. He served on the editorial board of the *International Journal of Play Therapy*; taught graduate play therapy courses at Johns Hopkins University; and has published numerous journal articles, book chapters, and books on child therapy, child abuse and trauma, and resilience in children. Dr. Crenshaw is a frequent presenter at statewide and national conferences on play therapy.

Anne L. Stewart, PhD, RPT-S, is Professor of Graduate Psychology at James Madison University, where she teaches, supervises, and conducts play therapy each week. She has written and presented internationally about crisis intervention, attachment, supervision, military families, improvisation, and resilience. She is Founder and President of the Virginia Association for Play Therapy, Chair of the National Foundation for Play Therapy, and an editorial board member of the *International Journal of Play Therapy*. Dr. Stewart is a recipient of the Distinguished Service Award from the Association for Play Therapy and the Outstanding Faculty Award from the State Council of Higher Education for Virginia.

Contributors

Jeffrey S. Ashby, PhD, ABPP, College of Education, Georgia State University, Atlanta, Georgia

Bonnie Badenoch, PhD, LMFT, Nurturing the Heart, Vancouver, Washington

Steven Baron, PsyD, private practice, Bellmore, New York

Helen E. Benedict, PhD, RPT-S, Department of Psychology and Neuroscience, Baylor University, Waco, Texas

Phyllis B. Booth, MA, LPC, LMFT, RPT-S, The Theraplay Institute, Chicago, Illinois

Sue C. Bratton, PhD, LPC, RPT-S, Center for Play Therapy, University of North Texas, Denton, Texas

Stuart Brown, MD, National Institute for Play, Carmel Valley, California

Heather McTaggart Bryan, LPC, RPT, Gil Institute for Trauma Recovery and Education, Fairfax, Virginia

Angela M. Cavett, PhD, LP, RPT-S, Beacon Behavioral Health Services and Training Center, West Fargo, North Dakota

Peggy L. Ceballos, PhD, LPC, RPT-S, Department of Counseling, University of North Carolina at Charlotte, Charlotte, North Carolina

Kathleen McKinney Clark, MA, LPC, private practice, Alpharetta, Georgia

David A. Crenshaw, PhD, ABPP, RPT-S, Children's Home of Poughkeepsie, Poughkeepsie, New York

Greg Czyszczon, EdS, LPC, Harrisonburg Center for Relational Health, Harrisonburg, Virginia

Eric Dafoe, MA, Center for Play Therapy, University of North Texas, Denton, Texas

Lennis G. Echterling, PhD, Department of Graduate Psychology, James Madison University, Harrisonburg, Virginia

Tracie Faa-Thompson, MSW, Turn About Pegasus, Northumberland, United Kingdom

Diane Frey, PhD, RPT-S, Department of Counseling, Wright State University, and private practice, Dayton, Ohio

Brijin Johnson Gardner, MSW, LSCSW, RPT-S, Operation Breakthrough, Parkville, Missouri

Eliana Gil, PhD, LMFT, RPT-S, ATR, Gil Institute for Trauma Recovery and Education, Fairfax, Virginia

Myriam Goldin, LCSW, RPT-S, Gil Institute for Trauma Recovery and Education, Fairfax, Virginia

Louise F. Guerney, PhD, RPT-S, National Institute of Relationship Enhancement, Bethesda, Maryland

Christopher Hill, MS, MA, Clinical and School Psychology Doctoral Program, James Madison University, Harrisonburg, Virginia

Kevin B. Hull, PhD, LPC, Hull and Associates, Lakeland, Florida

Heidi Gerard Kaduson, PhD, RPT-S, Play Therapy Training Institute, Monroe Township, New Jersey

Sueann Kenney-Noziska, MSW, LISW, LCSW, RPT-S, Play Therapy Corner, Las Cruces, New Mexico

Theresa Kestly, PhD, RPT-S, Sandtray Training Institute of New Mexico, Corrales, New Mexico

Elizabeth Konrath, LPC, RPT, Gil Institute for Trauma Recovery and Education, Fairfax, Virginia

Terry Kottman, PhD, LMFT, RPT-S, The Encouragement Zone, Cedar Falls, Iowa

Garry L. Landreth, EdD, LPC, RPT-S, Center for Play Therapy, University of North Texas, Denton, Texas

J. P. Lilly, MS, LSCW, RPT-S, private practice, Provo, Utah

Liana Lowenstein, MSW, RSW, CPT-S, private practice, Toronto, Ontario, Canada

Dianne Koontz Lowman, EdD, Harrisonburg Center for Relational Health, Harrisonburg, Virginia

Lauren E. Maltby, PhD, Department of Psychiatry, Harbor–UCLA Medical Center, Torrance, California

Joyce C. Mills, PhD, RPT-S, The Story Play Center, Scottsdale, Arizona

Claudio Mochi, RP, RPT-S, Association of Play Therapy of Italy, Rome, Italy

John B. Mordock, PhD, ABPP, private practice, Poughkeepsie, New York

Kristie Opiola, MA, Center for Play Therapy, University of North Texas, Denton, Texas

Sarah C. Patton, PsyD, Psychology Service, North Florida/South Georgia Veterans Health System, Gainesville, Florida

Mary Anne Peabody, EdD, LCSW, RPT-S, Social and Behavioral Sciences Program, Lewiston–Auburn College, University of Southern Maine, Brunswick, Maine

Phyllis Post, PhD, LPC-S, NCSC, RPT-S, Department of Counseling, Special Education, and Child Development, University of North Carolina at Charlotte, Charlotte, North Carolina

Dee C. Ray, PhD, LPC-S, RPT-S, Department of Counseling and Higher Education, University of North Texas, Denton, Texas

Scott Riviere, MS, LPC, RPT-S, Kids Interactive Discovery Zone (K.I.D.Z.), Lake Charles, Louisiana

John W. Seymour, PhD, LMFT, RPT-S, Department of Counseling and Student Personnel, Minnesota State University, Mankato, Mankato, Minnesota

Jennifer Shaw, PsyD, Gil Institute for Trauma Recovery and Education, Fairfax, Virginia

Angela I. Sheely-Moore, PhD, NCC, Department of Counseling and Educational Leadership, Montclair State University, Montclair, New Jersey

Janine Shelby, PhD, RPT-S, Department of Psychiatry, Harbor–UCLA Medical Center, Torrance, California

William Steele, PsyD, MSW, National Institute for Trauma and Loss in Children, Clinton Township, Michigan

Anne L. Stewart, PhD, RPT-S, Department of Graduate Psychology, James Madison University, Harrisonburg, Virginia

Debbie C. Sturm, PhD, LPC, Department of Graduate Psychology, James Madison University, Harrisonburg, Virginia

Kathleen S. Tillman, PhD, Department of Counseling Psychology and Community Services, University of North Dakota, Grand Forks, North Dakota

Jessica Anne Umhoefer, PsyD, NCSP, Department of Graduate Psychology, James Madison University, Harrisonburg, Virginia; Fairfax County Public Schools, Alexandria, Virginia

Risë VanFleet, PhD, RPT-S, CDBC, The Playful Pooch Program, Family Enhancement and Play Therapy Center, Boiling Springs, Pennsylvania

William Whelan, PsyD, Virginia Child and Family Attachment Center, University of Virginia, Charlottesville, Virginia

Marlo L.-R. Winstead, LSCSW, LCSW, RPT-S, Department of Social Work, University of Kansas, Kansas City, Kansas

Foreword

Accessing the richness of *Play Therapy: A Comprehensive Guide to Theory and Practice* allows the reader-practitioner to dive deeply into the transformative power of play itself. Each chapter acknowledges play as a force of nature, captured in its essence and refined through the comprehensive skill, broad scholarship, and multiple foci of accomplished authors and editors. The result of this immersion is inspiration and deepened professional identity for the practitioner, and healing mercies for those who become safe and playful through its applications. Guided, chapter by chapter, through this volume's varied and verdant landscapes, the reader emerges with a treasure of theoretical and philosophical grounding plus solid clinical guidance for greater professional excellence. No small accomplishment.

The diverse inclusions in Part I, Play Therapy Theories and Approaches, provide a personal narrative and professional identity for the play therapist—a necessary anchor in a windswept theoretical sea. What has evolved within responsible therapeutic domains allows varied approaches and numerous theoretical foundations—client-centered, Jungian, psychoanalytic, Adlerian, cognitive-behavioral, or attachment-based—to become united by their reliance on play. The experience of play itself is the transformative magic, but it does require grounding on the part of the therapist.

Let's look more fully at the shared source of healing in the chapters: play. What is it that most profoundly *engages* us with ourselves and the world?

Play.

It takes us out of time's arrow, allows us to exist in a separate "state" of being from all others, and when it occurs, is a self-organizing phenomenon driven by intrinsic motivation, with myriad patterns and forms, but still a process of *being* and *doing* something just for its own sake. And the prerequisites for discovering or rediscovering its bounties when it has been missed or lost are in-depth professional wisdom and diagnostic and clinical skill. By guiding a client into experiencing it more fully, play grants gifts that endure well beyond the immediate experience itself—one boon from this truly comprehensive guide.

What is the world without healthy authentic play? Or a better question might be, what is it that healthy play bestows, that its absence or deprivation reveals as missing? The capacity for joy, freedom to explore the possible, detection and enactment of one's

unique talents, safety in intimacy, and an optimistic hopeful approach to life and the future are among play's blessings and benefits. Bringing these life-giving qualities through play therapy in the settings and play-needy conditions described in Part II, Clinical Applications of Play Therapy, provides avenues for clients to become *fully human*. Without access to play, this human birthright is just not possible to enjoy. Fulfilling this deficit has direct personal emotional rewards that enliven the practitioner's professional identity and help to assure a more balanced life for therapist and client alike—another boon from the bounty of this guide.

For the well-versed player, life in all its challenges can be experienced as a complex playground. For the play deprived, life is too often seen as a battleground. Becoming more fully grounded in providing this foundational humanitarian outreach gives greater meaning and purpose to a noble professional life. And what is perhaps unique to the play therapist-practitioner is that this "work" is fun—yes, *fun*! So the benefits for professional and client are legion.

A broad overview of play behavior in animals and humans, tracing its evolutionary trajectories and supported by a flood of recent neuroscientific play-based discoveries, reveals play behavior as a fundamental survival drive. Housed in subcortical circuitry, the universally innate biological roots that drive play behavior require environmentally appropriate signaling (the many languages of play) to activate and sustain this primal drive. The elaboration and continuing crafting of body and mind, though most urgently needed in childhood, nonetheless persist throughout the human life cycle.

In order for professionals to serve as role models and mentors, they must be authentic players in their own personal lives. So skill in learning and living through life's complexities—the subtlety of play signaling, the free access within oneself, the bodily and gestural dance of nonverbal play languages—adds veracity and emotional grounding that transcend linear cognitive limitations. Yes, it is possible to bring personally crafted lived-out-in-life art into the science of play therapeutics. This art needs to be practiced and honed in life beyond the clinical playroom.

In Part III, Research and Practice Guidelines in Play Therapy, esteemed authors focus on what it takes to practice competently, joyfully, and in an attuned manner. A unique contribution of this book is its evident appreciation for the science and art of play and the emergent field of epigenesis. In studies indicating that environmental playfulness (at least in playful rats) turns on latent prefrontal cortical genes awaiting the right signal, animal play researchers are demonstrating in playful laboratory animals what human clinicians surmise is occurring in effective and transformative play therapy settings—namely, that new cerebral connections that "help craft the social brain" are specifically sparked into action by active play experiences. Clinicians sense that bringing play into *action* creates new cerebral "maps" with emotional regulation as an adjunctive benefit. This new animal-based knowledge is adding more and more depth and importance to affirming play as a lifetime necessity for adaptability and individual flexibility.

There is plenty of nourishment in this volume to establish it as a fresh and necessary revelatory "bible" of play therapy, guiding the therapist to new and more effective personal and professional rewards.

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PART I

Play Therapy Theories and Approaches

INTRODUCTION

Long before Virginia Axline wrote the book *Dibbs: In Search of Self* (1964), which captured the imagination of aspiring and practicing play therapists around the world, play therapy was practiced within the four walls of child psychoanalysts' offices in Europe and the United States. Among the early child analysts was Freud's daughter, Anna Freud, and some of this rich history is contained in John B. Mordock's chapter on psychodynamic play therapy (Chapter 5). Axline's book was one of the influential works that led to the differentiation of play therapy as a separate field of its own, with its own practitioners, but, of course, within the larger context of child therapy and child therapists—some of whom, particularly those who chose not to work with preschool children, did not view themselves as practicing play therapy. Many child psychiatrists to this day receive little or no training in play therapy. Virginia Axline, Clark Moustakas, and Garry Landreth (see Dee C. Ray and Garry L. Landreth, Chapter 1) developed child-centered play therapy (CCPT) based on the person-centered theory of Carl Rogers. The University of North Texas, where Garry Landreth taught for many years, is still the largest training center for play therapists in the world, with emphasis placed on CCPT.

The object relations (attachment-based) approach to play therapy is eloquently presented and detailed by Sarah C. Patton and Helen E. Benedict in Chapter 2. Helen Benedict is one of the most respected scholars and researchers in the play therapy field, most deservedly so. Terry Kottman and Jeffrey S. Ashby, in Chapter 3, present the tenets and key features of Adlerian play therapy. Although he describes himself as the "mechanic" of Jungian theory, J. P. Lilly shares a quite readable but masterful exposition of Jungian analytical play therapy (Chapter 4). Angela M. Cavett presents cognitive-behavioral play therapy in a scholarly but reader-friendly style (Chapter 6). These key theories with deep historical roots are followed by a diverse group of play therapy approaches.

The integrative approach to play therapy that, in our mind, is akin to the prescriptive approach made well known by Charles Schaefer is well illustrated by Eliana Gil and her colleagues at the Gil Institute for Trauma Recovery and Education

in Chapter 7. Chapters by leaders in the play field follow on attachment-based play therapy in Chapter 8 (William Whelan and Anne L. Stewart); filial play therapy in Chapter 9 (Sue Bratton); Theraplay in Chapter 10 (Phyllis B. Booth and Marlo L.-R. Winstead); sandtray therapy in Chapter 11 (Theresa Kestly); StoryPlay therapy in Chapter 12 (Joyce C. Mills); family play therapy in Chapter 13 (Greg Czyszczon, Scott Riviere, Diane Koontz Lowman, and Anne L. Stewart); and in Chapter 14 an exciting chapter on a relatively new play therapy approach: animal-assisted play therapy (Risë VanFleet and Tracie Faa-Thompson).

The play therapy field continues to benefit from the strong foundation constructed by innovative thinkers, inspiring leaders who further developed theories and approaches to work with hurting children. A new generation of play therapists, some whose work appears in this book, continues to think deeply and creatively about the healing process with children and families.

REFERENCE

Axline, V. (1964). *Dibbs: In search of self*. Boston: Houghton Mifflin.

CHAPTER 1

Child-Centered Play Therapy

Dee C. Ray
Garry L. Landreth

The relationship is the therapy; it is not preparation for therapy or behavioral change.

—Garry L. Landreth (2012, p. 82)

Child-centered play therapy (CCPT) is predicated on the belief that the relationship between therapist and child is the primary healing factor for children who are experiencing difficulties arising from contextual, developmental, and internal struggles. CCPT recognizes play as the child's developmentally appropriate language, a common principle among most schools of play therapy. However, CCPT is set apart from other play therapy approaches by its focus on the relationship and environment as sources to health and functioning. Landreth (2012) defined play therapy as "a dynamic interpersonal relationship between a child (or person of any age) and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child (or person of any age) to fully express and explore self (feelings, thoughts, experiences, and behaviors) through play, the child's natural medium of communication, for optimal growth and development" (p. 11). It is through the therapist's understanding and acceptance of the child's world, as well as the child's receptivity of these factors, that unleashes the child's potential to move toward self-enhancing ways of being.

CCPT was developed in the 1940s, distinguishing it as one of the longest-standing mental health interventions used today. Virginia Axline (1947) operationalized person-centered theory (Rogers, 1951) through the structure of CCPT, offering a method of working with children that was consistent with person-centered principles. Axline referred to this approach as *nondirective play therapy*, which was later termed *child-centered play therapy* by therapists in the United States. In the years since the introduction of CCPT, 62 outcome studies have explored its effectiveness, presenting evidence that CCPT is a viable and effective intervention for children (Ray, 2011). Currently, CCPT is recognized as the most widely practiced approach to play therapy

in the United States (Lambert et al., 2005), and the approach has earned a strong international reputation (see West, 1996; Wilson, Kendrick, & Ryan, 1992). CCPT is operationalized in several volumes of literature, all in agreement on its basic tenets and structure (Axline, 1947; Cochran, Nordling, & Cochran, 2010; Landreth, 2012; Ray, 2011; VanFleet, Sywulak, & Sniscak, 2010).

THEORETICAL CONSTRUCTS

Person-centered theory, upon which CCPT is based, was elegantly presented by Carl Rogers (1951, pp. 481–533) in 19 propositions, summarized in nine points below.

The person is viewed as:

1. Being the best determiner of a personal reality. The person's perceptual field is "reality."
2. Behaving as an organized whole.
3. Striving toward independence, maturity, and enhancement of self.
4. Behaving in a goal-directed manner in an effort to satisfy needs.
5. Being behaviorally influenced by feelings that affect rationality.
6. Behaving in ways that are consistent with the self-concept.
7. Not owning behavior that is inconsistent with the self-concept.
8. Responding to threat by becoming behaviorally rigid.
9. Admitting into awareness experiences that are inconsistent with the self if the self is free from threat.

Through these propositions, Rogers sought to explain the self-actualizing nature of the person and personality development; the roles of emotions, thoughts, and behaviors; and the development, or lack thereof, of self-enhancing ways of being. These propositions provide the rationale for the use of CCPT and serve as a guide for play therapists in understanding and facilitating the change process in children (Ray, Sullivan, & Carlson, 2012). The propositions emphasize that each person is the center of his or her own perceived phenomenological field, meaning that each person's perception of experience represents reality for that individual. Personal phenomenological experience, which encompasses the perception and integration of experiences from the phenomenological field into perceptions of self, guides the growth and development of the self. All organisms seek to actualize, maintain, and enhance the self.

A child's construct of self arises through interactions with others in the perceptual field throughout development. As interactions take place, a child comes to evaluate self-worth based on the perceived expectations and acceptance of others. These perceived conditions of worth are eventually integrated into the developing self, so that subsequent experiences represent the child's internalized representations of how he or she is valued. Thus, the personal valuing process may or may not contribute to optimal

growth, depending on how internalized representations of experiences of being valued relate to the self-construct. Behavior is directly consistent with the view of self and the valuing process, whether or not it is within the awareness of the person. Behavior is seen as an attempt to maintain the organism and fulfill needs, depending on the perceived expectations of the environment, and the emotion accompanying behavior is seen as dependent on the perceived need for behavior. Hence, a person will behave and emotionally respond in a way that is consistent with the view of self, even if the view of self does not facilitate the optimal growth of the individual (Ray et al., 2012).

The self-structure is formed and continues to develop in relation to the child's experiences with others and the environment. Functionality is enhanced when a child integrates these experiences congruently with the self. Experiences that are incongruent with the self and denied integration can be perceived as threats to self, even if those experiences are potentially enhancing to the organism. When provided with a nonthreatening environment, a person can examine experiences in a nonjudgmental way and integrate them into a self-structure that is respectful of the intrinsic direction of the organism. Because of the self-actualizing and relational nature of the person, a congruent self-structure results in a person's desire and ability to enhance relationships with others.

Specific to play therapy, it is important to bring these person-centered principles to life when conceptualizing children. We attempt to describe the process in simpler terms. A child is born into the world viewing interactions in a unique and personal way that is apart from reality or others' perceptions. The child will move holistically toward what is most enhancing for the self-organism. A sense of self is established through interactions with significant others and the child's perceptions of those interactions. A child's interactions result in an attitude of self-worth that is influenced by a perceived sense of acceptance by and expectations of others. If a child feels unworthy or unaccepted for certain aspects of self, barriers to self-acceptance arise in turn. Because the organism is holistic in movement, a child's feelings and behaviors will be consistent. More concretely, if a child feels unaccepting of self or unaccepted by others, feelings and behaviors will be more negative and less self-enhancing. In describing maladjustment in children, Axline (1947) wrote: "The individual's behavior is not consistent with the inner concept of the self which the individual has created in his attempt to achieve complete self-realization. The further apart the behavior and the concept, the greater the degree of maladjustment" (p. 14).

This view of development has fundamental implications for the process of CCPT. First, the child can be trusted to move toward self-enhancing ways of being when provided with facilitative relationships and environment. Second, the best way to understand a child's behaviors and emotions is to understand how the child views his or her world. Third, the child's relationships with others within the environment are a crucial influence on the child's view of self and others. And finally, when the therapist can provide, and a child can perceive, an environment and relationship accepting of the child's internal world, the child will move toward self-enhancing integration and functionality.

THERAPEUTIC PROCESS

Because the therapeutic process of CCPT derives from the developmental theory of person-centered propositions, it can be concluded that the therapeutic relationship offered by the therapist is the essential feature of the intervention. The therapist's ability to provide a relationship and environment conducive for the child's growth is the primary concern of therapy. The practice of CCPT is particularly concerned with the removal of any threat to self-structure so that a child can explore experiences that are consistent or inconsistent with self, leading to integration into the revised self-structure (Ray, 2011). The removal of threats is the basis for the key person-centered stance of nondirectivity provided by the therapist to acknowledge the child's right to autonomy and belief in the child's constructive nature (Wilkins, 2010). Nondirectivity is an attitude that promotes the child's self-sufficiency by not guiding his or her goals or therapeutic content. The nondirective therapist is an active, engaged participant in the counseling process.

Landreth (2012) acknowledged that "a powerful force exists within every child that strives continuously for self-actualization. This inherent striving is toward independence, maturity, and self-direction. The child's mind and conscious thoughts are not what direct her behavior to areas of emotional need; rather, it is the child's natural striving toward inner balance that takes the child to where she needs to be" (p. 62). Therapy is focused on the child, not the problem of the child. When provided with a facilitative environment, the child will spontaneously move toward self-enhancement. Therefore, the therapist's role is to support the child in this movement, help remove barriers in the child's contextual world, and be present in the relationship for change to occur.

According to Rogers (1957), certain conditions are necessary to work toward constructive personality change, which he defined as "change in the personality structure of the individual, at both surface and deeper levels, in a direction which clinicians would agree means greater integration, less internal conflict, more energy utilizable for effective living; change in behavior away from behaviors generally regarded as immature and toward behaviors regarded as mature" (p. 95). Rogers identified six necessary and sufficient conditions for therapeutic change: (1) two persons are in psychological contact; (2) the first person (client) is in a state of incongruence; (3) the second person (therapist) is congruent in the relationship; (4) therapist experiences unconditional positive regard for client; (5) therapist experiences an empathic understanding of the client's internal frame of reference and attempts to communicate this experience to the client; and (6) communication to the client of the therapist's empathic understanding and unconditional positive regard is achieved to at least a minimal degree (Rogers, 1957).

Ray (2011) applied the person-centered conditions to CCPT, examining the details of how they are enacted in the play therapy process. In the first condition, the therapist and child must be in psychological contact, or in simpler terms, in a relationship. In this relationship, both the therapist and child must be in each other's awareness,