Child-Centered Play Therapy (CCPT): Theory, Research, and Practice

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Abstract. Beginning with the groundbreaking work of Virginia Axline in the 1940s, nondirective/child-centered/person-centered play therapy has been recognized as a developmentally responsive therapeutic intervention for children that utilizes play, children's natural means of expression. Child-centered play therapy (CCPT), the term used in North America, is founded on the belief that, just as adults, children possess within themselves the ability to make meaning of their experiences and solve their own problems. This article provides an overview of the theory and practice of child-centered play therapy (CCPT), including research to support its effectiveness.

Keywords: play therapy, child-centered, nondirective, person-centered theory, child therapy

Kindzentrierte Spieltherapie (CCPT): Theorie, Forschung, Praxis
Seit der bahnbrechenden Arbeit von Virginia Axline in den 1940-er Jahren ist die nicht-direktive/kindzentrierte/personzentrierte Spieltherapie als ein therapeutisches Verfahren anerkannt, das bei Kindern die Entwicklung fördert. Es ist ein Verfahren, welches das Spiel, das natürliche Ausdrucksmittel von Kindern, nutzt. Child-centered play therapy (CCPT), der in Amerika verwendete Begriff, beruht auf der Überzeugung, dass Kinder genau wie Erwachsene die Fähigkeit besitzen, ihren Erfahrungen Bedeutung zu geben und ihre eigenen Probleme zu lösen. Dieser Artikel liefert einen Überblick zur Theorie und Praxis Kindzentrierter Spieltherapie einschliesslich der Forschung, die ihre Effektivität aufzeigt.

Terapia de Juego Centrada en el Niño (TJCN): Teoría, Investigación y Práctica
Comenzando con el trabajo innovador de Virginia Axline en los años 40, la terapia de juego no directiva/centrada en el niño/centrada en la persona, ha sido reconocida como una intervención terapéutica para

Author Note. Child-Centered Play Therapy (CCPT), based on person-centered theory, is the term used in North America. The terms nondirective play therapy, client-centered play therapy, person-centered child therapy are used elsewhere in the United Kingdom and Europe to describe this approach. Because the authors practice in the USA following the principles and procedures of CCPT (Landreth, 2002), the term CCPT will be used throughout. Literature reviewed was limited to English language publications.

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niños que responde al desarrollo y utiliza el juego, medio natural de expresión de los niños. La terapia de juego centrada en el niño (TJCN), el término utilizado en América del Norte, se basa en la creencia de que, al igual que los adultos, los niños poseen dentro de ellos mismos la capacidad de extraer significado de sus experiencias y resolver sus propios problemas. Este artículo brinda una visión general de la teoría y práctica de la terapia de juego centrada en el niño (TJCN), e incluye investigaciones que apoyan su eficacia.

La Thérapie par le Jeu Centrée sur l'Enfant : Théorie, Recherche et Pratique
Depuis le travail fondamental de Virginia Axline dans les années 1940, la thérapie par le jeu non-directive/centrée sur l'enfant/centrée sur la personne est reconnue comme un type d'intervention thérapeutique qui utilise le jeu, en tenant compte du développement de l'enfant, et comme moyen d'expression naturel pour les enfants. La thérapie par le jeu centrée sur l'enfant, (child-centered play therapy, CCPT), terme utilisé en Amérique du Nord, est fondée sur la croyance suivante. Comme pour l'adulte, l'enfant possède en lui-même la capacité de donner sens à ses expériences et de résoudre ses propres problèmes. Cet article fournit une vision de l'ensemble de la théorie et de la pratique de la thérapie par le jeu centrée sur l'enfant, ainsi que la recherche qui prouve son efficacité.

Ludoterapia Centrada na Criança (LTCC): Teoria, Investigação e Prática
Tendo tido início com o trabalho inovador de Virginia Axline na década de 1940, a ludoterapia não directiva centrada na criança/na pessoa foi reconhecida como uma intervenção terapêutica responsiva em termos do desenvolvimento da criança, recorrendo ao jogo, o seu meio natural de expressão. A Ludoterapia centrada na criança (LTCC), designação usada na América do Norte, encontra sustentação na crença de que, tal como os adultos, também as crianças possuem no seu interior a capacidade para atribuirem significado às suas experiências e para resolverem os seus problemas. Este artigo fornece uma visão geral da teoria e da prática da Ludoterapia centrada na criança (LTCC), incluindo investigação que suporta a sua eficácia.

子ども中心遊戯療法(CCPT)に関する研究、理論、実践の紹介
1940年代のアクスラインの素晴らしい実践を皮切りに、非指示的／子ども中心／人間中心の遊戯療法が子どもに対する治療的な介入方法として認められてきた。それは、子どもの発達に応じた介入方法であり、遊びという子どもにとって自然な自己表現の方法を活用する療法である。子ども中心遊戯療法(CCPT)とは、主に北米において使用されている用語であり、子どもも大人と同様に、自身の経験を意味を紡ぎ出し、問題を解決できる力を有しているという信条に基づいている。この論文では、子ども中心遊戯療法(CCPT)の理論および実践を概観し、このアプローチの有効性を示す研究を紹介する。

Identifying early mental health interventions tailored to the unique maturational needs of children is a growing concern in the United States (New Freedom Commission on Mental Health, 2003; U.S. Public Health Service, 2000) and in other countries (Wilson & Ryan, 2002). For over six decades play therapy has been in use as a developmentally responsive approach to treating a wide range of children's presenting concerns (Bratton & Ray, 2000) and more recently, acknowledged as an effective treatment modality (Bratton, Ray, Rhine, & Jones, 2005). The use of play in therapy is based on the principle that children are best understood from a developmental perspective (Wilson & Ryan, 2005), and from a CCPT perspective, is necessary in order for the therapist to create optimal therapeutic conditions for the child.

RATIONALE FOR PLAY THERAPY

Play is fundamental to children's emotional, social and cognitive growth (Piaget, 1962) by offering the ability to fully express concrete and symbolic experiences encountered by the child. Uniquely human, the pretend play of children represents their efforts to make sense of their experiences (Irwin, 1983). Landreth (2002) further emphasized that children use play as their natural form of communication with fellow children and adults. Within the context of play, children are able to express themselves, using the play materials, much in the same way adults use words (Landreth, 2002). Play allows children to communicate to self and others, learn, master new tasks, practice adult responsibilities, make meaning of their experiences, and possibly work through traumatic events (Gil & Drewes, 2005). Through play therapy, the therapist is allowed the opportunity to enter into the child's experience as it is played out.

HISTORY AND DEVELOPMENT

Historical use of play therapy was rooted in psychoanalytic schools of thought. Anna Freud (1928) and Melanie Klein (1932) have been traditionally acknowledged as the developers of play therapy. In order to apply analytical approaches to their work with children, they used play to replace verbalized free association. In David Levy's (1939) 'Release Therapy' and Gove Hambidge's (1955) structured techniques, the therapist took a more directive role, using the toys and play materials to stimulate catharsis.

However, child-centered play therapy (CCPT) emerged from the person-centered philosophy of Carl Rogers (1942). Rogers' belief that each person's drive for self-actualization gives the capacity for positive self-growth extended not only to adults, but to children. Virginia Axline (1947), a student of Rogers, used her belief in children's ability to self-heal and solve their own problems to apply nondirective techniques to play therapy. Her research and writing in the 1940s and 1950s positioned play therapy as a viable treatment modality for children and paved the way for additional developments in the field. Clark Moustakas (1953), Haim Ginott (1961), Louise Guerney (2000) and Garry Landreth (2002) built on Axline's (1947) work and popularized what has come to be known as child-centered play therapy (CCPT) in North America. The terms "nondirective play therapy" or "person-centered/client-centered play therapy" are more commonly used in the United Kingdom, Germany and other parts of Europe (Goetze & Jaede, 1974; West, 1996; Wilson & Ryan, 2005) and are used to explain the same underlying belief systems and basic procedures used in CCPT.

Another major development in the field of CCPT was training parents and other significant caregivers in the principles and procedures of CCPT to use with their own children (Guerney, 1964). Bernard and Louise Guerney developed this innovative approach in the early 1960s based on their belief that by training and supervising parents to use CCPT skills in special play times with their children, the potential for long-term change was enhanced. The use of filial

therapy approaches by clinicians has grown rapidly over the past two decades, in large part due to Landreth's (2002) development of a condensed 10-session model, more recently termed Child Parent Relationship Therapy (CPRT, Landreth & Bratton, 2006). CPRT's strong research base and its use of a manualized treatment protocol (Bratton, Landreth, Kellam, & Blackard, 2006) have contributed to the growing acceptance and use of filial therapy as an effective treatment modality for children presenting with a wide range of problems.

Wilson and Ryan (2005) commended recent changes within the British Department of Health that support the use of interventions that focus on children and work with families, such as play therapy and filial therapy. In the United States, the president's New Freedom Commission on Mental Health (2003) recommended the promotion of screening, assessing and providing services for the mental health of young children. The Commission also proposed the need for empirically based mental health interventions for children and adults. Bratton et al. (2005) suggested that play therapy/filial therapy is empirically validated as an effective intervention for children. Bratton et al. further reported that humanistic play therapy approaches, including nondirective and child-centered play therapy, showed the largest treatment effects. West proposed that child-centered play therapy reaches beyond "white, Western, middle-class" populations to provide an intervention that is multicultural in nature (West, 1996, p. 195). For the purposes of this article, the term "Child-Centered Play Therapy" (CCPT) will be employed as it is regionally known in the United States.

CURRENT RESEARCH

As in most psychotherapy research, play therapy studies are limited by small sample size, which leads to a lack of generalizability of results (Ray, Bratton, Rhine, & Jones, 2001). Because the necessity of large sample sizes hinders research practicality, psychotherapy has relied on meta-analytic reviews of research to address the effectiveness of interventions. LeBlanc and Ritchie (1999) published the initial results of their meta-analysis of play therapy outcomes summarizing the results of 42 controlled studies, with an effect size of .66 standard deviations. The researchers further detailed their study in a later publication citing that benefits of play therapy appear to increase with the inclusion of parents (LeBlanc & Ritchie, 2001). Using Cohen's (1988) guidelines for interpretation, an effect size of .66 denotes a moderate treatment effect, similar to effect sizes found in other child psychotherapy meta-analyses (Casey & Berman, 1985, *ES* = .71; Weisz, Weiss, Han, Granger, & Morton, 1995, *ES* = .71).

Bratton et al. (2005) conducted the largest meta-analysis on play therapy outcome research. This meta-analysis included the review of 180 documents that appeared to measure the effectiveness of play therapy dated 1942 to 2000. Based on stringent criteria for inclusion designating use of a controlled research design, sufficient data for computing effect size, and the identification by the author of a labeled "play therapy" intervention, 93 studies were included in the final calculation of effect size. The overall effect size was calculated at .80 standard deviations interpreted as a large treatment effect, indicating that children receiving

play therapy interventions performed .80 standard deviations above children who did not receive play therapy. Bratton et al. (2005) coded specific characteristics of play therapy that impacted or had no impact on play therapy outcome. Effect sizes for humanistic (*ES* = .92) and nonhumanistic play therapy (*ES* = .71) interventions were considered to be effective regardless of theoretical approach. However, the effect size reported for humanistic approaches, including child-centered and nondirective play therapy, was in the large effect category while nonhumanistic was in the moderate category. This difference in effect may be attributed to a larger number of calculated humanistic studies (*n* = 73) compared to nonhumanistic studies (*n* = 12). Results also indicated that play therapy had a moderate to large beneficial effect for internalizing, externalizing and combined problem types.

The field of play therapy has a history of over 60 years of continuous research which indicates that play therapy most likely has the longest history of research of any psychological intervention. Over the last two decades, since 1990, approximately 38 (29 published) research studies on the impact of play therapy, excluding filial therapy research, have been conducted. The majority of these studies identified the treatment as child-centered or similar humanistic play therapy approach. The most recent studies, from the past decade, have demonstrated the positive impact of play therapy on general behavioral problems (Raman & Kapur, 1999; Shashi, Kapur, & Subbakrishna, 1999); externalizing behavioral problems (Flahive & Ray, 2007; Garza & Bratton, 2005; Karcher & Lewis, 2002; Kot, Landreth, & Giordano, 1998; Ray, Schottelkorb, & Tsai, 2007; Schumann, 2004); internalizing problems (Packman & Bratton, 2003); self-efficacy (Fall, Balvanz, Johnson, & Nelson, 1999); self-concept (Kot et al., 1998; Post, 1999); anxiety (Baggerly, 2004; Shen, 2002); relationship stress (Ray, 2007); depression (Baggerly, 2004); speech problems (Danger & Landreth, 2005); and diabetes treatment compliance (Jones & Landreth, 2002).

Research investigating effects of filial therapy/CPRT has grown tremendously over the past two decades and further contributes to the evidence for the effectiveness of child-centered approaches. During that time span, approximately 36 studies (21 published) were conducted to examine the effects of treatment on children's behavior problems, on parent/caregiver factors such as caregiver empathy and acceptance, and on parent–child relationship stress. Landreth and Bratton (2006) provided a comprehensive review of the research, noting that the majority of studies utilized a pre-post control group design and found statistically significant improvement for children and caregivers participating in CPRT/filial therapy. The empirical evidence for this approach suggests that teaching caregivers child-centered play therapy skills to use with their children is an effective treatment modality.

Although a few of the aforementioned play therapy/filial therapy studies are quasi-experimental in nature, many meet the current rigor required of experimental research designs to determine intervention efficacy. Meta-analytic and independent study research indicates that child-centered play therapy can be considered an empirically supported treatment intervention.

CHILD-CENTERED PLAY THERAPY IN PRACTICE

Child-centered play therapy (CCPT) aims to create an environment that allows the child to experience self-direction, integration, and growth (Bratton, Ray, & Landreth, 2008). According to Raskin and Rogers (2005), an atmosphere of genuineness, unconditional positive regard and empathy facilitates positive change on the part of the client.

Like adults, children require an outlet for emotional expression. However, it is difficult for them to express their experiences and feelings through words alone. CCPT provides children with an opportunity to express such feelings as anger, fear, anxiety, and happiness through the toys and materials they choose, and frees them from the restriction associated with discussing the details of an event. Through the child's activity, the therapist is able to enter into the child's experience and access related feelings as they emerge. The specific play behaviors allow the therapist to gain insight into the child's underlying needs and perceptions. If, for example, the child was referred to the therapist for aggressive behavior toward a younger brother, the child's play may reveal conflicted feelings toward the sibling and an underlying need for more nurturing attention from parents. The therapist can then provide suitable responses to facilitate the child's safe expression of feelings within the boundaries of the playroom, as well as provide adjunct services to parents to help them better understand and respond to their child's needs.

CCPT is based on Axline's (1947) eight guiding principles. These basic tenets place emphasis on enhancing the therapeutic relationship and therefore align with the philosophy of person-centered theory. Axline noted that the therapist should (a) develop a warm, friendly relationship with the child; (b) accept the child exactly as he is; (c) facilitate an atmosphere of permissiveness so that the child is free to express self; (d) recognize and reflect the child's feelings in order to help him gain insight into his behavior; (e) honor the child's inherent capacity to solve his own problems; (f) allow the child to direct the therapy; (g) understand that therapy is a gradual process and should not be hurried; and (h) establish only those limits necessary to ground the child in the world of reality and make the child aware of his responsibility within the therapeutic relationship.

The process of change

Just as in person-centered therapy with adults, CCPT emphasizes the therapist–client relationship as the conduit for positive change. Therapists who employ CCPT believe that it is the child's experience in the framework of the therapeutic alliance that is the most significant factor in determining sustainable change. The therapist therefore aims to create an atmosphere of understanding, safety and acceptance. Through play and the symbolism of the toys, the child is free to communicate all feelings, thoughts and needs and move toward emotional and behavioral health. CCPT acknowledges that learning, growth and lasting change stem from within the child; hence, the focus is on the child not the problem. A major goal is to enhance the child's self-knowledge and self-acceptance. According to Landreth (2002), during CCPT, children learn (a) to respect themselves; (b) that their feelings are acceptable; (c) to express their feelings responsibly; (d) to assume responsibility for themselves; (e) to be creative and resourceful in facing problems; (f) self-control and self-direction; (g) to accept themselves;

and (h) to make choices and be responsible for their choices. Axline (1947) proposed that through the process of play therapy, the child is allowed the freedom to play out thoughts and feelings and either learn to bring them under control or abandon them altogether.

In the following, the authors describe the practice of CCPT based on their own practice and experience training and supervising play therapists — from beginning the relationship with the child to involving parents in the therapeutic process.

Beginning the relationship

In child-centered play therapy (CCPT) the therapist aims to maintain consistent respect and regard for the child. This process of facilitating a secure therapeutic bond begins during the first interaction with the child in the waiting room. At this time, the therapist focuses attention on the child and communicates his/her importance. The therapist crouches down to the child's level, maintains eye contact and greets the child. After introducing herself, the therapist may, say "we can go to the playroom now. Your dad [or the person who brought the child] will be here when we come back from the playroom." The therapist then introduces the child to the playroom in a manner that communicates permissiveness, minimal limits, and that the child is free to choose: "Kira, this is our playroom, and in here, you can play with the toys in many of the ways that you like."

Playroom and play materials

Landreth (2002) suggested the dimensions of the playroom should be approximately12 by 15 feet, although an open space of any size may be used. This is especially the case in schools where there is usually no dedicated space for a playroom. In this case, the therapist may create a portable playroom with a selection of toys. No matter what play area is used, the therapist should be intentional about the play materials and toys. Landreth suggested that toys should be carefully selected rather than collected, and provided a complete list of toys and materials for fully equipping a child-centered playroom.

The criteria for selection of toys and play materials should include (a) their contribution to the objective of play therapy, and (b) the degree to which they align with the rationale for play therapy. The therapist should also ensure that the toys represent the cultural experiences of children. Landreth (2002) suggests that play therapists choose toys that facilitate (a) a positive relationship with the child; (b) the expression of a wide range of feelings; (c) the exploration of real experiences; (d) testing of limits; (e) a positive image; (f) self-understanding; and (g) the opportunity to redirect behavior that is unacceptable to others.

Types of toys that may be chosen for the playroom include (a) nurturing toys (baby dolls, kitchen items, medical kit); (b) aggressive toys (handcuffs, punching bag, toy soldiers, aggressive puppets); (c) toys related to normal social experiences (family house and people, cash register, police); (d) communication toys (foam ball and bat, telephone); and (e) mastery toys (chalk board, Velcro darts, school supplies, blocks). An inflatable punching toy can be used if the room allows. Mechanical toys and highly structured materials should be avoided because they may hinder rather than facilitate children's expressions.

Therapeutic skills

There are specific nonverbal and verbal skills that are considered to be essential in CCPT. The degree to which these are used within the play therapy session will depend on the immediate needs of the child as determined by the therapist. Since children's words are expressed through the toys and play materials, play therapy is highly dependent on nonverbal skills. These include leaning, being physically directed toward the child, showing genuine interest and matching the child's affect throughout the play session.

The therapist should use responses that are consistent with the child's developmental level. For younger children lengthy responses tend to confuse the child and communicate a lack of understanding on the part of the therapist. The tone and rate of therapist response conveys understanding of the child by matching the level of intensity and degree of interaction of the child. If, for example, the child is quiet, the therapist should pace her comments to avoid overwhelming the child.

The following essential CCPT skills are expected to be demonstrated in most play therapy sessions: (a) reflecting nonverbal behavior (tracking); (b) reflecting verbal content; (c) reflecting feeling; (d) facilitating decision making and returning responsibility; (e) facilitating creativity and spontaneity; (f) esteem building and encouraging; (g) facilitating relationship; and (h) limit-setting (Landreth, 2002; Ray, 2006).

Reflecting nonverbal behavior (tracking)

This skill involves the therapist's careful verbal observation of the child's play behavior. For example, if the child goes to the sand tray and begins to place stones in a row in the sand, the therapist may say "you are lining those up one by one." This therapeutic skill communicates to the child that the therapist is interested and accepting of the child's actions. It also helps the therapist immerse himself or herself into the child's world.

Reflecting content

In play therapy, this skill is the equivalent of reflecting content in talk therapy. This involves paraphrasing what the child says during the play session. For example, the play therapist may say "you know a lot about your friend Mara" or "you and Mara like a lot of the same things" (after the child shares various details about her friend Mara). According to Landreth (2002), reflecting content helps to validate children's perceptions of their experiences thereby facilitating self-understanding.

Reflecting feeling

This skill recognizes the feelings of the child and is a key relationship-building tool that helps the child to know that the therapist is present, observing and in tune with the feelings and needs of the child. A child may play with the ring toss, succeed on his/her first attempt and smile broadly and exclaim, "Yes!" Here the therapist may reflect the feeling expressed by saying "you are excited — you got it on your first try!"

Facilitating decision making and returning responsibility

From a child's perspective, adults have all the answers, so there is no need to try. The rule of thumb in play therapy is to never do for a child what the child can do for himself or herself (Landreth, 2002). Responses that facilitate decision making or return responsibility help children experience themselves as able and empowered. Examples of responses that facilitate decision making and returning responsibility are "in here you get to decide what toys to play with" or "in here that's up to you" (when a child asks the play therapist what he should play with first).

Facilitating creativity and spontaneity

Play therapy also enables children to see themselves as creative beings. When a play therapist conveys acceptance, encouragement and permissiveness, the child is given the freedom to express his/her uniqueness and spontaneity. This autonomy allows the child to develop flexibility in thoughts and actions. Therapeutic responses that facilitate creativity include "you can use any color you like" (when a child asks the therapist what color he should use) or "you have lots of ideas about what you want to make" (when the child describes various craft projects she would like to make).

Esteem building and encouraging

This skill recognizes the effort and energy of the child and therefore enhances his/her sense of self. Esteem-building statements help children experience themselves as capable. Examples of esteem-building and encouraging responses are "you're trying lots of different things" and "you're really working hard on that." Encouragement may also serve to give permission to a child who may be hesitant to play freely. For example, a child may slowly enter the playroom and look around uncertainly before picking up a toy. At this point, the therapist may say "you decided to take a look at that one to see if you want to play with it."

Facilitating relationship

Since the therapeutic alliance potentially represents all intimate relationships, the therapist makes an effort to respond to the child when he/she addresses the therapeutic relationship. Relational responses model effective communication and reflect the therapist's care for the child. Responses that facilitate the relationship include "you wanted me to see that" (when a child picks up a puppet and shows it to the therapist) and "you enjoy our special time in the playroom" (when a child states that he likes coming to the playroom with the therapist). Relationship responses should always make reference to both the child and the therapist.

Limit setting

Landreth (2002) suggested a method of limit setting intended to help the child develop self-direction and self-responsibility. This A-C-T model involves (a) acknowledging the feeling; (b) communicating the limit; and (c) targeting an alternative. The permissive nature of the play sessions encourages minimal limits aimed at the safety of the therapist, the child and the playroom toys and materials. Using the A-C-T model, a child may scoop some sand in his/

her hands and begin to walk toward the dollhouse with the sand. The therapist may then say "you would like to take some sand over to the dollhouse, (empathy statement which acknowledges feelings/intent) but the sand is for staying in the sand tray (communicating the limit). You may bring the dolls to the sand tray (targeting an acceptable alternative).

Involving parents in the therapeutic process

Before the first play session, the play therapist meets with the parent(s) without the child present. The length of the session and the information requested/shared by the therapist will depend on the theoretical and personal philosophy of the therapist. The main goal of this first meeting is for the therapist to connect to the parents, focus on their concerns and emphasize the importance of their role in their child's therapy.

During the first parent consultation, the therapist informs the parents about play therapy and what to expect from the overall process. This includes a description of the playroom, the role of play in a child's life and how the toys and play materials facilitate the child's self-expression. The therapist may also want to ask about special circumstances that may affect the play therapy process. For example, some children may have difficulty separating from their parents, even for short periods of time. Such information will enable the therapist to discuss with the parents possible courses of action to take if the child clings to them.

The initial parent consultation also gives the therapist the opportunity to stress the importance of confidentiality. In the U.S., most states do not recognize the child's right to confidentiality; however, the therapist should emphasize the importance of providing children with a safe space where they feel free to express themselves. In this way, although the therapist may note general behavioral themes/patterns, specific play behaviors and words will not be directly disclosed to the parents. Based on this premise, parents will not observe play sessions so that children will be free to express feelings, thoughts, needs, and actions. During the first parent consultation, the therapist will also emphasize the importance of consistent participation in play therapy, noting the potential of irregular attendance to interfere with the therapeutic process.

The play therapist will also note the need for a final play session in the event that parents decide to prematurely end play therapy. An abrupt end to therapy without the support of the play therapist may cause undue discomfort for the child, particularly if there was a strong connection to the therapist. A final session allows the therapist the opportunity for closure, while enabling the child to experience a positive end to a significant relationship.

Consistent with the person-centered approach, the play therapist approaches parents with empathy, genuineness, and unconditional positive regard. The goal is to connect to parents so that they view the therapist as trustworthy and understanding. This first meeting often sets the stage for the degree of investment that parents have in the play therapy process. The first consultation is therefore not a time for education and instruction, which have the potential to overwhelm parents.

An important part of play therapy is consistent contact with parents for regular follow-up consultations. A minimum of once per month meetings (approximately 30 minutes each) allows the play therapist to continue to build a relationship with the parents, provide

support, determine additional needs and check in on the child's experiences/progress at home and school.

A major component of these follow-up consultations is the discussion of play themes demonstrated by the child during play sessions. These discussions help to maintain parents' involvement in play therapy while facilitating a better understanding of their child. The play therapist may, for example, help parents to make connections between the child's play behavior and their behavior at home/school. A child who has difficulty following limits at home may make attempts to break limits in the playroom as well. The therapist may use this knowledge/experience to help parents develop effective limit-setting skills (e.g., A-C-T model). Bratton, Landreth, Kellam, and Blackard (2006) describe common skills that therapists can teach parents. In addition to limit setting, these include encouragement, reflection of feeling, choice giving, returning responsibility to the child, and problem-solving techniques.

Consistent parent consultations encourage parents' continued participation in play therapy, help develop parenting skills and build a healthy alliance between the parents and the therapist. As part of initial assessment and ongoing consultation, child-centered therapists will be evaluating parents' and children's readiness to participate in filial therapy, with a goal in mind to transfer play therapy skills into the hands of parents when clinical judgment dictates.

Multicultural applications of play therapy

Person-centered approaches have been criticized for being individualistic in nature (Kirschenbaum, 2004) and therefore potentially inappropriate for more communalistic cultures. However, in child-centered play therapy (CCPT), the child is viewed as a holistic organism with a unique experience of his/her world and the innate capacity for self-direction. As such, the therapist does not have preconceived notions of the child's reality. A culturally responsive play therapist will be aware of possible culture-specific variables that inform and impact the child's experience. This awareness should facilitate a desire to learn about the child's unique familial and cultural values. This involves an acceptance of the individual child as well as salient group norms. Since the toys will be used by the child to symbolically represent his/her social and cultural reality, the play materials should also reflect cultural diversity.

Strupp (1993) suggested that therapists who want to transfer therapeutic interventions from one culture to another tend to place emphasis on the relationship. Since CCPT is a relationship-based therapy, it has been viewed as suitable for use with diverse cultural groups. Ramirez (1999) noted that in CCPT, the therapist attempts to see the child's perspective without imposing their own views on the child. According to Glover (2001), since CCPT is grounded in acceptance and respect, it is an appropriate intervention for use with diverse groups. There has been limited research on the multicultural application of CCPT but those studies that have been conducted provide support for its effectiveness (e.g., Garza & Bratton, 2005; Shen, 2002). Garza and Bratton found that CCPT was effective in treating behavioral problems in Hispanic children, while Shen studied the impact of CCPT on Chinese children who survived an earthquake and found a significant reduction in anxiety and suicide risk. An additional study by Baggerly and Parker (2005) presented anecdotal evidence from CCPT

sessions with African American boys and provided suggestions for incorporating the African worldview into CCPT.

To date, cross-cultural applications of filial therapy/Child Parent Relationship Therapy (CPRT) have received more attention in the literature than play therapy. Filial therapy's focus on the family and parent–child relationship may make it especially suitable for application among diverse cultural groups (Strupp, 1993). Studies have examined the effectiveness of filial therapy with diverse parent populations including: Germans (Grskovic & Goetze, 2008); Native Americans (Glover & Landreth, 2000); Israelis (Kidron, 2004); immigrant Chinese (Chau & Landreth, 1997; Yuen, Landreth, & Baggerly, 2002); immigrant Koreans (Lee & Landreth, 2003); Koreans (Jang, 2000); Latinos (Ceballos, 2008), African Americans (Sheely, 2008; Solis, Meyers, & Varjas, 2004); and a Jamaican (Edwards, Ladner, & White, 2007). The findings of these studies reflect decreased parental stress (Ceballos, 2008; Chau & Landreth, 1997; Sheely, 2008); a reduction in perceived problem behaviors of children (Ceballos, 2008; Sheely, 2008; Yuen, Landreth, & Baggerly, 2002); parents' increased acceptance of their children (Jang, 2000); increase in parental empathy (Glover & Landreth, 2000); and increased awareness and analysis of parenting practices (Edwards, Ladner & White, 2007; Solis, Meyers, & Varjas, 2004).

In summary, while more research is needed, the utility of child-centered play therapy has been demonstrated cross-culturally. Furthermore, the use of culture-specific approaches show regard for the cultural framework of the client and therefore align with the respect consistent with a child-centered approach.

CONCLUSION

Over the past century, play therapy has evolved to include a range of theoretical approaches and treatment interventions/techniques that are grounded in the therapeutic powers of play, however child-centered/nondirective approaches continue to be the most used by practitioners (Lambert, LeBlanc, Mullen, et al., 2005) and the most widely researched (Bratton et al., 2005). This article has focused on the theory, research and practice of child-centered play therapy (CCPT). Play therapy research dates back to 1942 and includes recent meta-analyses that demonstrate its effectiveness as a treatment modality for children. Just as in person-centered therapy with adults, CCPT emphasizes the primacy of the therapist–client relationship as the conduit of sustainable therapeutic change. According to Axline (1947) and Landreth (2002), the therapist develops a warm, friendly relationship with the child, accepts the child as he/she is, creates an atmosphere of permissiveness, recognizes and reflects the child's feelings, acknowledges the child's capacity to solve problems, does not direct the child's actions, sees therapy as a gradual process, and establishes minimal limits. Through the symbolism of the toys, the child is free to communicate all feelings, thoughts, and needs and move toward emotional and behavioral health. In order to enhance the effectiveness of play therapy, the child-centered therapist sees the child within the context of a support system, and thus works with parents to help them increase in their understanding of their child and become more

invested in the play therapy process. Filial therapy, an extension of CCPT, involves caregivers fully in their children's therapy by teaching them CCPT principles to use in special play sessions with their own children.

In summary, child-centered play therapy has a long history of use and a strong research base to support its utility with children presenting with a myriad of difficulties. CCPT is unique in that its principles and procedures have been shown effective when applied by mental health professionals and shown equally effective when practiced by caregivers under the supervision of a mental health professional trained in play therapy. Its broad appeal and usefulness as a treatment modality is further evidenced by its successful application with diverse populations of children.

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