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**What play therapists do within the therapeutic relationship of**

**humanistic/non-directive play therapy**

Play therapists are increasingly being employed in schools, yet there is confusion among many health, education and social care practitioners about the role of play therapists. This paper explains how play therapists position themselves and what they do through an examination of the therapeutic relationship between the therapist and child. It discusses the core conditions of congruence, acceptance and empathy with reference to recent research. Play therapists vary their practice in terms of verbal or non-verbal interaction, the tools in their playroom and how they physically place themselves. This paper argues for placing an emphasis on the non-verbal mirroring of the child, the incorporation of expressive media such as paint, clay and sand into the play room and the positioning of the therapist within the play space.

Key words: play therapy, children, emotional well-being, therapeutic relationship

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**Introduction**

Children’s health and wellbeing not only affects their educational performance and achievement whilst they are children (WHO, 2011; Zins et al, 2004), but it can influence their health, wellbeing and achievement throughout their lives (DH, 2010). There is a growing interest in preventing, early detecting and intervening in health problems before they cause long-term difficulties (Allen, 2011; DH, 2011). Primary schools are increasingly employing play therapists in addition to, or instead of school counsellors, in order to support the mental, emotional and social health and wellbeing of the children.

Play therapists usually set up their playroom within a classroom or vacant office, and see children once per week for between 30 minutes to 40 minutes over a period of time from six weeks to an academic year or more. Clack et al (2010) found that there is much confusion among practitioners in health, education, social care and child care about what play therapists do, and that their role is often confused with other play-based interventions such as play work. As a rough guide, Play Therapy UK (2011) suggests that, in terms of the level of severity, play and play work are suitable for slight problems, play therapy for moderate to severe problems, and child psychotherapy/psychology or psychiatry for complex and severe problems. In terms of number, play and play work are suitable for single problems, and play therapy or child psychotherapy/psychology or psychiatry are recommended for multiple problems. So common reasons for a play therapy referral include social or academic underachievement; disturbed sleep; parents who have separated or divorced; problems making friends; getting into quarrels, bullying or being bullied; being withdrawn; trauma, including physical, emotional or sexual abuse; loss or bereavement; attachment difficulties; eating disorders; inappropriate emotional responses and elective mutism (West, 1996; PTUK, 2011). Thomas (2008) found that, according to teachers’ ratings, 68% of 1851 children had improved after play therapy, as measured by a reduction in total difficulties comprising dimensions of conduct, peer relationships, emotions and hyperacivity, using the Strengths and Difficulties Questionnaire.

Fuller accounts of play therapy are covered very well in several good books (West, 1996; Wilson and Ryan, 2005; Landreth, 2002; Schaefer and Kaduson 2008 ), but this paper will examine how play therapists position themselves and what they do within the playroom in order to maximise the therapeutic benefits for the children with whom they are working. It focuses specifically on the therapeutic relationship because this lies at the very heart of the process and is core to understanding how play therapy works. It seeks to show that whilst therapists agree on many aspects of practice, there are some differences of opinion about the verbal or non-verbal exchanges, the tools in their playroom and how they physically place themselves in the room.

**The therapeutic relationship**

 It is well established that the quality of the relationship between the therapist and the client is a very strong predictor of the outcome of the work (Shirk and Saiz, 1992; Shirk and Karver, 2003; Karver et al, 2006). Within children's therapy Shirk and Saiz (1992) suggest that the therapeutic relationship has been viewed as a means to an end as well as a means in itself. For example Anna Freud saw the ‘therapeutic alliance’ as enabling the child to accept the therapist as someone who could help him to change, Shirk and Saiz (1992) empirically demonstrated that a positive affective therapeutic relationship was essential for children to fully engage in therapeutic tasks, and Axline (1969) saw the therapeutic relationship as offering the conditions within which a child could psychologically grow and change themselves.

The child’s participation in the therapeutic relationship is especially vital as it is he that needs to change. For a play therapist to accept a referral she needs to be sure that the child is able to benefit from therapy at that time. Timing is important because if the cause of the child’s distress is currently on-going the child will be feeling a lack of control and will be entirely focused on survival, but if the cause has moved to the past the child is able to focus his work on gaining empowerment over the emotional issues left by the crisis (Norton and Norton, 2008). How the child approaches the therapist depends on his earliest experiences of relationships, his self concept, his own self awareness of a need to change and broader socio-contextual variables (Shirk and Saiz, 1992). The latter acknowledges that the therapeutic relationship operates within ongoing peer and family relationships. The theory of socialization argues that children are shaped in a ‘top down’ way by the agencies of family, peers, school and so forth (Giddens, 2006), but this has been recently challenged by models such as Bronfenbrenner and Ceci’s (1994) bioecological model and transactional models (Oates and Stevenson, 2005 ), which suggest that children are in dynamic, ever-evolving relationships characterised by their ability to influence their family, peers and others, as well as being influenced by them. Reviews of research evidence show that the most important influence on a therapeutic outcome is not the therapeutic relationship (30%), but the characteristics of the client and wider extra-therapeutic factors (40%). These are followed by the client’s expectancy or placebo effects (15%) and techniques that are unique to specific therapies (15%) (Asay and Lambert, 1999). So, while we examine the role of the therapist within the playroom, as if through a microscope, it is important to remember that the therapist will be constantly influenced by the child and that, for both, the therapeutic relationship sits within a number of other influential characteristics, inter-personal relationships and a wider social context.

Ryan and Wilson (2000 ) describe how the therapist needs to prepare herself for entering into the therapeutic relationship by emptying her mind from her world, in order to give the child her full attentiveness. She needs to consider the child’s age and situation, and be ready to view the child as a unique person in a fresh way. She needs to be consciously aware of transference. In psychodynamic terms, this is the transferring of emotions and ideas from previous relationships, perhaps about children who have similar referral profiles, into this new relationship (Dryden, 1989). In scientific terms, memory is stored within specific neuronal patterns within the brain, and present perceptions are concurrently influenced by this existing neuronal architecture (Cozolino, 2006). It is unavoidable, but if the therapist is aware of this, she can self-reflect and distinguish what is past from what is present. She also needs to recognise any heightened anxiety arising from any previous negative experience, lack of confidence or inexperience, because anxiety will interfere with her brain’s capacity to accept incoming information and to think clearly (Cozolino, 2006). From the very start, her openness to the child, and her curiosity in the child, is vital to the development of a therapeutic relationship.

**Humanistic/non-directive approach and the core conditions**

Carl Rogers, the father of client-centred counselling, was influenced by humanistic psychology, which holds that people have within them an innate strong tendency to grow and develop towards their maximum potential, which Maslow (1943) called self actualisation . Rogers’ approach to counselling was non-directive and focused on creating the conditions under which this innate growth can occur. Bratton et al (2005) carried out a meta-analysis of 93 studies of play therapy undertaken with children, spanning 1953 to 2000, to find out what factors were associated with positive outcomes. They compared humanistic/non-directive approaches with non humanistic ones which included behavioural, cognitive and directive interventions such as board games. With the reservation that the former was represented by six times as many studies as the latter, they found that humanistic approaches were more effective.

 In 1957 Carl Rogers proposed that constructive therapeutic change could be achieved through six necessary and sufficient conditions: two people being in psychological contact, the client is vulnerable or anxious, the therapist is congruent, the therapist experiences unconditional positive regard for the client, the therapist experiences an empathic understanding of the client’s frame of reference and the therapist succeeds, to a minimal degree, in communicating to the client her empathic understanding and her unconditional positive regard. These conditions became known as the ‘core conditions’: congruence, acceptance and empathy, which lie at the heart of the therapeutic relationship. As these core conditions have since been shown repeatedly to be the most important *therapist*-related variables associated with positive outcomes of therapy, they are also frequently adopted by therapists who work within non-humanistic models of therapy (Asay and Lambert, 1999; Heard and Lake, 1997; Karver et al, 2006). Children who have received high levels of these core conditions from their play therapist are able to provide more positive statements about themselves compared to those who received lower levels of these core conditions (Siegel, 1972).

**Congruence**

Congruence means that the therapist is genuine and sincere about believing in the client’s innate potential to self-direct and achieve insight into their own problems. This is not merely an intellectual belief but a full feeling that is true with their whole being (Rogers, 1946; 1957; 1991), for children particularly are very sensitive to picking up on any inconsistencies in a therapist’s attitudes or behaviour (Axline, 1969). Both Landreth (2002) and Rogers (1946) discuss the process of developing a successful therapeutic relationship in terms of the therapist needing to undo or discard prior understandings. Rogers was bringing the new concept of client-centredness into a therapeutic era where the psychoanalytical therapists had ascended to being crowned ‘king of the mind’, so he urged them to remove their illusion of superior expertise and place trust in the client’s abilities to heal themselves. Similarly Landreth (2002) appears to make the assumption that potential play therapists might need to disregard some traditional adult-centred views of children that do not consider that children are psychologically capable and full of sufficient potential to help themselves. Truly respecting the child means treating them with sincerity and honesty, and not hurrying them (Axline, 1969). A therapist might start by setting out boundaries and then handing over the power to the child. Kneeling or sitting at the child’s level, she might say,

“This is your time. We play within the playroom space. We are kind to everything in the playroom and we are kind to each other. Otherwise, you can do anything you want to do in this playroom, or you can choose to do nothing. It is your choice.”

 It is a process of discovering, respecting, valuing and giving power to the child. The attention that a child receives from their therapist, and the materials which are made available to the children in the playroom, contribute to making the child feel valued (Carroll, 2002).

**Acceptance**

Rogers’ (1946; 1957; 1991) second core condition was acceptance. Axline (1969) explains that in order for a child to be able to fulfil their innate drive towards self actualization, they need to be able to freely express their self concept. Children’s positive self concept is undermined if their painful feelings are not recognised by others as being normal and acceptable (Roberts, 2006). So the therapist needs to be accepting and permissive towards the child so that he can drop his natural defensiveness, feel understood and so be free to communicate. This requires that the therapist’s whole personality is disciplined towards a consistent, sensitive appreciation of her client (Rogers, 1947), as Axline explains,

“Not until she fully realizes the significance of what it really means to be completely accepting of another person, and has sufficient understanding of all the implications of this term, is she able to be permissive so that the child can be himself, can express himself fully, and she can accept him without passing judgement.” (Axline, 1969 p.64)

When a play therapist tells a child that he can do what he wants within the playroom, she is symbolically saying that he can be who he wants to be (West, 1996). When she tells him that he can choose what to do or choose what a toy can be, she is strengthening the child’s self concept that he is someone who can make choices (Landreth, 2002). Carroll (2002) interviewed 14 children, aged nine to 14, about their experiences of play therapy and their relationship with their therapist. All felt warmly towards their therapists, describing how they were made to feel both physically and emotionally comfortable, but as the author notes, the children might not have found it easy to voice negative views. Eight said that just ‘being with’ the therapist was helpful in itself, and seven children valued the confidentiality offered by the therapist. Eight described their therapist as kind and friendly and two noted that the therapist was unlikely to get upset or angry. These findings demonstrate that children value feeling accepted.

**Empathy, starting with attunement**

Rogers (1946; 1957) describes empathy, the third core condition, as like stepping into the client’s shoes so that the therapist can understand the feelings and spirit of his world. Kelly and Odenwalt (2008) explain that it is through empathy with the child that the therapist can provide validation of him, and from this he can feel safely related to the therapist. The relationship provides the child with the experience of trusting another which he can then take into other relationships. In other words, the therapeutic relationship between therapist and child replicates what Winnicott (1971) described as the transitional space between a mother and her child. It also tries to replicate what Bowlby (1988) described as a secure attachment between mother and child. When a child feels securely attached to a caregiver, he is able to develop an inner sense of control, can wait and think, express feelings and self soothe (Gerhardt, 2004). He has confidence that the caregiver, or therapist, will respond to his feelings, and he is able to empathise with her feelings too. This experience creates a positive internal working model of himself and his abilities within relationships, which means that he will go on to anticipate positive experiences of future relationships (Benedict, 2008).

Initially, the therapist needs to anticipate a new client’s anxiety associated with feeling unsafe. According to Maslow (1943), a child would not be able to progress to fulfilling his needs for love, affection or self esteem unless he first feels safe. This resonates with trust versus mistrust being the first psychosocial crisis that a baby faces (Erikson, 1965). The play therapist needs to provide a physical place of safety, and as such provide a predictable play room, one that does not change, along with play room rules which provide limitations/boundaries designed keep the child and the therapist safe (West, 1996; Landreth, 2002; Wilson and Ryan, 2005). The physical containment complements the psychological containment of the therapeutic relationship (Benedict, 2008).

The therapist replicates the types of interpersonal communications which have been found to promote wellbeing in infants. Infants are born with mirror neurons which, when activated, trigger resonance (automatic/imitative) behaviour which allows the baby to attune to the emotional state of their mother (Cozolino 2006). Schore (2001) explains these as resonating exchanges of affect synchrony (affect attunement), meaning that they match and reflect one another, and they sympathetically vibrate. One augments and enlarges the other to become, what Holmes (2008) describes as, contingent (following), marked (exaggerated) responses. The infant reacts with delight and reciprocally the mother is motivated to continue (Schore, 2001). The mother is regulating her baby’s intense feelings, and gradually the baby learns to self regulate and build emotional resilience to stress and anxiety (Gerhardt, 2004). More specifically the mother’s facial responses will provide feedback to the baby about how the baby is perceived by his mother, from which he will begin to develop his own self concept (Winnicott,1971; Sunderland, 2003; Hughes, 2008). Her accepting face encourages the baby to develop a concept of himself as loveable and acceptable. These communications provide the early building blocks for empathy with another and for all emotional relationships with others throughout life.

So in order for the therapist to create an empathic relationship with the child, she needs to mirror his actions, so that the mirror neurons in the brains of both are activated and the therapist can become attuned to the emotional state of the child. This is why she needs to enter the relationship with a clear head. The mirror neurons of one create a mental representation of the thoughts, feelings, needs and motivations of the other (Cozolino, 2006). The therapist receives what Cozolino (2006) describes as a visceral-emotional template of what the child is experiencing. He explains that, for the child, this emotional resonance has been found to be associated with the child being able to better regulate his own emotions, to discuss them and to describe his inner experiences to others. For the therapist, this neurological activity combines with the visual-spacial, cognitive and abstract neuronal activity going on in her brain in order to place the inner information from the child into a context. This means that the therapist imagines the inner world of the child whilst also being aware of her own inner world. Out of this comes a hypothesis about the child. Cozolino (2006) says that this goes to the core of the therapeutic relationship.

A therapist’s non-verbal close observation of a child, or her mirroring of the child’s actions within a nourishing silence, is supported by the research of Shirk and Saiz (1992). They compared children’s affective experience of psychodynamic therapy with that of each child’s own therapist using Therapeutic Alliance Scales. There was a greater convergence between the ratings of the two when examining the affective quality of the therapeutic relationship, compared to the ratings for when they were just collaborating on tasks. This means that when a therapist thinks that she is emotionally connected to the child, the child thinks so too. Bradbury and McCoard (1997), writing about sandplay therapy, explain this connection in terms of the unconscious forces of therapist and client becoming aligned. Souter-Anderson (2010) explains the same phenomenon scientifically in the context of working with clay. She says that when a therapist begins to mirror the child’s use of clay, the mirror neurons of both are activated, and the result is an emotional attunement which allows the therapist to become very close to the feelings and processes of the child. This attunement releases opioids and oxytocin which produce feelings of wellbeing. The physical mirroring of dance and movement therapy is thought to work in the same way (Berrol 2006). It seems likely that the same physiological process occurs when a therapist mirrors the child’s use of other substances such as paint, collage materials or sand, or when the therapist mirrors the child’s motor movements. This evidence would logically suggest that when a play therapist only observes or if she is distracted from focusing entirely on the child, for example writing notes during a play therapy session which many report doing (Axline, 1969; West, 1996; Wilson and Ryan, 2005), the attunement is probably weakened or interrupted and the child will be aware of it.

**Empathy to bring about therapeutic change**

Heard and Lake (1997) suggest that although attunement provides the necessary ground work, it is not sufficient to bring about therapeutic change on its own. Hughes (2008a) explains,

“emotional communication that combines nonverbal attunement and reflective dialogue and is followed by relationship repair when necessary, is the central therapeutic activity.” (p.2)

A number of therapists have emphasised the importance of verbal emotional regulation in the form of giving the child verbal empathic responses, which demonstrate an acceptance of the child’s feelings which, in turn, lessens their intensity and makes them more manageable (Axline, 1969; Landreth, 2002). Verbally reflecting the child’s feelings back to him helps him to ‘see’, ‘own’ and ‘gain insight’ so that he is able to ‘accept’ his own feelings (Axline, 1969; Oaklander, 1988; Heard and Lake, 1997; Landreth, 2002; Wilson and Ryan, 2005; Holmes, 2008). Landreth (2002) advocates that the play therapist should trust her intuition, perhaps listening to her mirror neurons, and use direct ‘you’ statements for example, “You feel angry about that.” He argues that ‘you’ recognises the person of the child and that *they* own the activity or feeling. West (1996) explains how play therapists utilize counselling skills comprising close listening and attending, the skills of reflection, paraphrasing, summarising, amplifying and occasional confrontation, skills of primary empathy and advanced empathy. Play therapists are cautioned against using interpretation without great care, and of the importance of reflecting back to the child using the same metaphor that the child has used (Axline, 1969; West, 1996; Wilson and Ryan, 2005). These arguments are supported by Green’s (2010) research with children who had experienced play therapy in the context of a school counselling service. The children explained that these types of verbal exchanges helped them to release difficult feelings.

However for many children, direct communication through speech can be very daunting. A child’s inability or reluctance to use words might be related to their cognitive developmental level (Oates and Grayson, 2004), a fear of revealing something they think they should not, or an overwhelming incapacity to put their experience into words (Homeyer and DeFrance, 2005). It seems contradictory that the same play therapists who argue that play is a child’s natural language, his natural medium of expression, and the play materials are his words, simultaneously emphasize the importance of an affective/reflective *verbal* dialogue (Axline, 1969; Landreth, 2002). Evolutionary neuroscience shows that a child’s thoughts, feelings, instincts and memories are stored in all parts of the brain within neuronal networks and not specifically in words or language (Cozolino, 2006). Stern (1998) explains that,

“Until recently, it was thought that infants needed developed language or symbols not only to represent events but also to be able to associate these representations. It now seems that nonverbal, even global, experiences can also be remembered and represented without being transposed into words ... a non verbal event ... consists of ... how it smells, looks, feels, and so on. The smell of one experience can remind one of the smell of a past experience, and in doing so, can re-evoke the whole past experience. Symbols or words are not needed.” (p.124)

This scientific evidence, along with our understanding that the activation of mirror neurons and the resulting attunement do not require words, supports those who advocate that verbal reflections should be kept to a minimum (Thomas and Jephcott, 2011). Furthermore Norton and Norton (2008) explain how verbalisation can disempower the child. They write,

“A verbal response directly to the child, even though it is responding to affect, does so in such a manner as to bring the disguised content into consciousness and pushes the child to acknowledge the event in a conscious, cognitive manner. In this way, the child loses control over presentation of the affect. While the verbal response may be completely accurate, the child must struggle to accept or reject its impact. When the child controls the experience, he or she gains mastery over the emotionality at his or her own pace.” (p.52)

Play therapy is described as one of the expressive therapies (Malchiodi, 2005) and a play therapist will often utilize expressive media such as drama, sandplay, art, puppets, music and clay in her work (West, 1996; Wilson and Ryan, 2005). This model of play therapy is described as being ‘evolutionary’ in contrast to the traditional North American model of play therapy which uses toys alone (Thomas and Jephcott, 2011). Green (2010) found that the children in his study reported that sandplay, art/drawing and drama/role play had helped them to express the feelings that they would have had difficulty expressing verbally. West (1996) explains that a shy child is able to speak more fluently through a puppet than directly to the therapist. He will project aspects of himself into the puppet thereby revealing his inner world. This is a form of projective identification, a theory proposed by Melanie Klein, whereby a child may put strong feelings, about which he might not be aware, into the puppet’s persona (Hough, 2002). Similarly, a child projects something about himself when he imposes a role onto a therapist and together they act out a story. So the selection of materials in a playroom needs to lend itself to imaginative or symbolic play (neuronal network engagement) (West, 1996). For example a child’s play with toy food can reveal something about his nurturing experience, fighting with play swords might symbolise that the child feels a need to defend himself, and cars can reveal something about the child’s ego which might be stalled, crashed or speeding along. The plastic arts, comprising painting, drawing, clay, sand and water, provide the child with a means of expression through form and colour. Norton and Norton (2008) describe these processes as children transforming their emotional inner energy into metaphorical and symbolic representations of their inner worlds. Malchiodi (2005) cites McNiff’s work in describing the child’s imagination as being like the engine that drives his discovery, his momentum towards corrective solutions, and finally, it brings about change.

Expression through media and toys does not require words and it is not unusual for children to reveal their *pre*verbal world in their play (West, 1996), because *all* of the child’s lifetime experience is imprinted in the connections of their neurons (Cozolino, 2006). Play therapists consider the symbolism of the child’s individual play choices within the context of their whole play over a number of sessions, and tentatively consider the meaning that might be associated with the sequence presented. In the same way that Rogers (1946) explained that empathy necessitates the therapist concentrating in the moment of what is happening for the client as he explores areas that are coming into consciousness, the play shows the emergence of matter from the unconscious to the conscious (Turner, 2005 ; Wilson and Ryan, 2005; West, 1996; Souter-Anderson, 2010). In contrast to Heard and Lake (1997) some play therapists, including Landreth (2002), believe that children’s expression through these expressive modalities have as much value as verbal reflection about any experience, and in themselves can provide sufficient process for change. Other therapists believe that they are much more important than verbal reflection and provide the essential toolkit for the therapist working within the therapeutic relationship (Norton and Norton, 2008; Thomas and Jephcott, 2011).

West (1996) explains that sometimes children choose to play alone and sometimes they involve the play therapist. Axline (1969) gives the impression of always sitting to the side of the playroom observing. Wilson and Ryan (2005) and Landreth (2002) refer to the therapist finding a place in the room where she can sit. Both Landreth (2002) and West (1996) write about sitting and watching unless being invited into the play by the child, and Landreth (2002) is emphatic that the play space belongs to the child. The rationale is because joining the child in the play space is interpreted as being an intrusion into the child’s personal space, and for children who have been abused and had their personal boundaries crossed without consent, respecting their space is part of providing the safe psychological and physical secure-base for therapy (Wilson and Ryan, 2005). However this pre-supposes that the play space initially belonged to the child. If the play space is introduced as a place within which the child and the therapist play together, it seems unlikely that the metaphor of feeling intruded upon stands.

Landreth (2002) says, “Sitting and watching without responding to the child can result in the child feeling watched and may increase the child’s anxiety” (p. 212). So rather than changing the ‘sitting and watching’, his solution is for the therapist to continually verbalise what is going on, in order to maintain a strong connection with the child, such as saying, “You’re putting the doll to bed,” in the form of ‘tracking responses’. Like Hughes (2008; 2008a) he emphases the importance of the therapist matching the child’s affect, and argues for the importance of touching on the child’s feeling whenever possible. This approach, based strongly on voice, tone, words and facial expression, in order to ‘mirror the affect’ (Axline, 1969), does not include the ‘non- invited’ mirroring of *non- verbal* movements that seem to contribute so much to attunement. These activities appear in the literature about dynamic play therapy (Harvey, 2006), experiential play therapy (Norton and Norton, 2006) and theraplay, which is an interactive and directive form of play therapy which has demonstrated positive outcomes (Wettig, Franke and Fjordbak, 2008), where the therapist sits on the floor in the play space engaging with the child from the start (Jernberg and Booth, 2001). Corsaro (2003) carefully observed pre-school children’s behaviour in pre-school settings over many years and saw very little solitary play. He concludes that children are social, they want to play with others. It seems that when a play therapist places herself in the area of play, observes carefully and starts to mirror the child’s play, she is replicating the ‘*non-verbal* entry’ access strategy that Corsaro observed among children when they want to play with another. He writes,

“Debbie merely places herself in the area of play ... Debbie keeps watching the play, but now physically circles the sand box ...Debbie ... carefully makes note of what the other kids are doing. With this information she is able to enter the area and do something in line with the other kids’ play (that is, pick up a teapot).” (Corsaro, 2003 p.42)

 It seems that being with the child in the play space from the start might be a more natural and more effective way to initiate attunement and empathy compared to sitting to one side, talking and waiting to be invited.

Having discussed the three core conditions, it is clear that the core condition of empathy is difficult to accomplish. It requires effort, concentration and discipline, as the therapist constantly strives towards a clearer awareness of the child’s feelings and private world through intense observation, listening, mirroring, attunement, facilitation of the child’s expression and gradual analysis of the process. It is not surprising therefore that when a therapist is fatigued or stressed, their skills of providing empathy are the first to suffer (Asay and Lambert, 1999).

**Conclusion**

This paper has sought to clarify what play therapists do and how they position themselves in order that other professionals might better understand their work. It has demonstrated that a play therapist working within a humanistic/non-directive approach works from the premise that the child has the inner resources and power to heal himself. She creates a therapeutic relationship between herself and the child in order to facilitate the child’s psychological growth. In order to do this, the core competencies of congruence, acceptance and empathy need to be present in the personal qualities of the play therapist. For example both Play Therapy UK (2010) and British Association of Play Therapists (2011) describe play therapists as needing to be congruent by having sincerity, honesty, integrity and humility; acceptance through showing respect for people’s needs, rights and dignity, not patronising or coercing and showing appropriate esteem to others; and empathy by being able to, “... communicate understanding of another person’s experience from that person’s perspective” (PTUK, 2010 p.8). Play therapy always includes the facilitation of a child’s play in order to accept and empathise with his inner world and experiences, but individual therapists vary in terms of their emphasis on verbal or non-verbal interaction, the tools of their playroom and how they physically place themselves in relation to the child in the room. It has been argued that non verbal mirroring of the child is associated with the achievement of attunement, a child’s inner world might be more easily revealed through being enabled to work with a range of expressive media, and that both are best supported by the play therapist engaging with the child in the play space.

**References**

Allen, G. (2011). *Early Intervention: The Next Steps. An Independent Report to Her Majesty’s Government.* London: H.M. Government.

Asay, T.P. & Lambert, M.J. (1999). The empirical case of for the common factors in therapy. In

M.Hubble, B.L. Duncan & S.D. Miller (Eds.) *The Heart and Soul of Change. What works in Therapy* (pp.23-47). Washington: American Psychological Association.

Axline, V. (1969). *Play Therapy* (Revised ed.) New York: Ballantine Books.

British Association of Play Therapy *Ethical basis for Good Practice in Play Therapy*. Retrieved March 1st, 2011, from BAPT Web site: http://www.bapt.info/ethicalbasis.htm

Berrol, C.F. (2006). Neuroscience meets dance/movement therapy: mirror neurons, the therapeutic process and empathy. *The Arts in Psychotherapy*, 33, 302-315.

Benedict, H.E. (2008). Object relations play therapy. In C.E. Schaefer & H.G.Kaduson (Eds.), *Contemporary Play Therapy. Theory, Research and Practice (pp. 3-27).* New York: The Guildford Press.

Bradway, K. & McCoard, B. (1997). *Sandplay – Silent Workshop of the Psyche*. London: Routledge.

Bratton, S., Ray, D., Rhine, T. and Jones, L. (2005). The efficacy of play therapy with children: a meta-analytic review of treatment outcomes. *Professional Psychology: Research and Practice*, 36 (4), 376-390.

Bowlby, J. (1988). *A Secure Base*. London: Rout ledge.

Bronfenbrenner, U. & Ceci, S.J. (1994). Nature-nurture reconceptualised in developmental perspective: a bioecological model. *Psychological Review*, 101(4), 568-586.

Carroll, J. (2002). Play therapy: the children’s views. *Child and Family Social Work,* 7, 177-187.

Clack, G., Crowley, K., Waycott, L., Prince, J. & Birdsey, N. (2010).Childcare practitioners’ knowledge and perceptions of play therapy. *British Journal of Play Therapy*, 6, 19-34.

Corsaro, W.A. (2003). *We’re Friends Right? Inside Kids’ Culture*. Washington DC: Joseph Henry Press.

Cozolino, L. (2006). *The Neuroscience of Human Relationships.* New York: W.W.Norton.

## Department of Health (2010). *Healthy lives, Healthy people. Our Strategy for Public Health in England*. London: Department of Health.

## Department of Health (2011). *No Health without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of all Ages*. London: Department of Health.

Dryden, W. (1989). The Therapeutic Alliance as an Integrating Framework. In W.Dryden (Ed.) *Key Issues for Counselling in Action (*pp.1-15)*.* London: Sage.

Erikson, E.H. (1965). *Childhood and Society*. Vintage UK.

Gerhardt, S. (2004). *Why Love Matters. How Affection shapes a Baby’s Brain*. Hove: Routledge.

Giddens, A. (2006). *Sociology*. London: Polity Press.

Green, E. (2010). Children’s perceptions of play therapy. In J.N.Baggerly, D.C. Ray, & S.C. Bratton (eds) *Child Centered Play Therapy Research (249-266)*. New Jersey: John Wiley & Sons.

Harvey, S. (2006). Dynamic play therapy. In C.E. Schaefer & H.G. Kaduson (Eds.) *Contemporary Play Therapy. Theory, Research, and Practice (pp.55-81)*. London: The Guildford Press.

Heard, D. & Lake, B. (1997). *The* *Challenge of Attachment for Care-giving*. London: Rout ledge.

Homeyer, L.E. & DeFrance, E. (2005). Play therapy. In C.A. Malchiodi (Ed). (2005) *Expressive Therapies* (pp.141-161). London: The Guildford Press.

Hough, M (2002). *A Practical Approach to Counselling*. Harlow: Pearson Education Ltd.

Hughes, D. (2008). *Building the Bonds of Attachment. Awakening Love in Deeply Troubled Children* (2nd Ed.). London: Jason Aronson.

Hughes, D. (2008a). The discovering of one’s strengths and vulnerabilities within a safe relationship. Paper given at *Awakening and addressing Attachment Needs in Troubled Kids, Teens and Adults* conference, Centre for Child Mental Health, London. 17th May.

Jernberg, A.M. & Booth, P.B. (2001). *Theraplay. Helping Parents and Children build better Relationships through Attachment-based Play (*2nd ed). San Francisco: Jossey-Bass.

Karver, M.S,. Handelsman, J.B., Fields, S. & Bickman, L. (2006). Meta-analysis of therapeutic relationship variables in youth and family therapy: the evidence for different relationship variables in the child and adolescent treatment outcome literature. *Clinical Psychology Review*, 26, 50-76.

Kelly, M.M. & Odenwalt, H.C. (2008). Treatment of sexually abused children. In C.E. Schaefer, &

H.G. Kaduson (Eds.), *Contemporary Play Therapy. Theory, Research and Practice* (pp.186-211).New York: The Guildford Press.

Landreth, G. (2002). *Play Therapy: The Art of the Relationship*. Hove: Brunner: Rout ledge.

Malchiodi, C.A. (Ed.) (2005). *Expressive Therapies*. London: The Guildford Press.

Maslow, A. (1943). A theory of human motivation. *Psychological Review*, 50, 370-396.

Norton, C.C. & Norton, B.E. (2008). Experiential play therapy. In C.E. Schaefer & H.G. Kaduson (Eds.), *Contemporary Play Therapy. Theory, Research and Practice* (pp. 28-54)New York: The Guildford Press.

Oaklander, V. (1988). *Windows to our Children*. Maine: The Gestalt Journal Press.

Oates, J. & Grayson, A. (Eds.) (2004). *Cognitive and Language Development in Children*. Milton Keynes: The Open University.

Oates, J. & Stevenson, J. (2005). Temperament and development. In J.Oates, C.Wood & A.Grayson (Eds.) *Psychological Development and Early Childhood* (pp.167-210)Oxford: Blackwell/Open University.

Play Therapy United Kingdom (PTUK) (2010). *Ethical Framework for Play Therapy and Filial Play and Profession Conduct Procedure*. PTUK Ltd.

Play Therapy United Kingdom *The UK Society for Play and Creative Arts Therapies*. Available at [http://www.playtherapy.org.uk/index.html. Accessed march 30th 2011](http://www.playtherapy.org.uk/index.html.%20Accessed%20march%2030th%202011).

Roberts, R. (2006). *Self-esteem and Early Learning* (3rd ed.). London: Paul Chapman.

Rogers, C. (1946). Significant aspects of client-centred therapy. *American Psychologist*, 1, 415-422.

Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21 (2), 95-103.

Rogers, C. (1991). *Client-Centred Therapy*. London: Constable.

Ryan, V. & Wilson, K. (2000) *Case Studies in Non-directive Play Therapy*. London: Jessica Kingsley.

Schore, A. (2001) The effects of a secure attachment relationship on right brain development, affect regulation and infant mental health. *Infant Mental Health Journal*, 22,7-66.

Schaefer, C.E. & Kaduson, H.G. (Eds.) (2008). *Contemporary Play Therapy. Theory, Research and Practice.* New York: The Guildford Press.

Shirk, S.R. & Saiz, C. (1992). Clinical, empirical, and developmental perspectives on the therapeutic relationship in child psychotherapy. *Development and Psychopathology*, 4, 713-728.

Shirk, S.R. & Karver, M. (2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: a meta-analytic review. *Journal of Consulting and Clinical Psychology*, 71 (3), 452-464.

Siegel, C.L. (1972). Changes in play therapy behaviours over time as a function of differing levels of therapist-offered conditions. *Journal of Clinical Psychology*, 28,235-236.

Souter-Anderson, L. (2010) *Touching Clay, Touching What?* Dorset: Archive Publishing.

Stern, D. (1998). *Diary of a Baby*. New York: Basic Books.

Sunderland, M. (2003). *Helping Children with Low Self Esteem*. Milton Keynes: Speechmark publishing.

Thomas, J. (2008) Practice based research – latest clinical outcomes. *Play for Life*, Autumn, 12-21.

Thomas, J. & Jephcott, M. (2011). Book Review: Child Centred Play Therapy. *Play for Life*, Winter, 41-43.

Turner, B. (2005). *The Handbook of Sandplay Therapy.* California: Temenos Press.

West, J. (1996). *Child Centred Play Therapy (*2nd ed.). London: Arnold.

Wettig,H.H.G., Franke, U. & Fjordbak, B.S. (2008). Evaluating the effectiveness of theraplay. In C.E. Schaefer & H.G. Kaduson (Eds.) *Contemporary Play Therapy. Theory, Research, and Practice* (pp.103-135). London: The Guildford Press.

Wilson, K. & Ryan, V. (2005). *Play Therapy. A Non-Directive Approach for Children and Adolescents.* London: Bailliere Tindall/Elsevier.

Winnicott, D. (1971). *Playing and Reality*. London: Rout ledge.

World Health Organization (2011). *The Impact of Health and Health Behaviours on Educational Outcomes in High-Income Countries: A Review of the Evidence*. Copenhagen: World Health Organization Regional Office for Europe.

Zins, J., Bloodworth, M.R., Weissberg, R.P. & Walberg, H.J. et al (2004). The scientific base linking social and emotional learning to school success. In J. Zins, R.P. Weissberg, M.C. Wang, H.J. Walberg

 (Eds.) *Building Academic Success on Social and Emotional Learning. What does the Research say?* London: Teachers College Press (pp.3-22).