

# Limits and Relationship in Child-Centered Play Therapy: Two Case Studies

Jeff L. Cochran, Nancy H. Cochran, and Ashley Cholette

University of Tennessee

William J. Nordling

Institute for the Psychological Sciences

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*This article presents case studies exploring two boys' uses of limit testing as a therapeutic tool in child-centered play therapy (CCPT). Both boys were referred for behavior that was abnormally disruptive for their age and setting, which was kindergarten in an elementary school that serves a very high poverty community and is accustomed to handling misbehavior. Data evidencing progress is provided as a reference point, while analysis is focused on conceptualization and mechanisms of change related to each child's use of limit testing in CCPT. The authors suggest that each boy used limit testing in CCPT to try out the therapeutic relationship as a stand-in for other relationships, to rethink relational expectations inside and outside of therapy, revisit unmet needs and meanings of early experiences, and change self-concept in ways that affected positive behavioral change.*

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**Keywords:** child-centered play therapy, limit testing in play therapy, at-risk, self-concept, mechanisms of change in play therapy

Limits are a normally occurring and essential part of play therapy (Cochran, Nordling, & Cochran, 2010; Guerney, 2001; Landreth, 2002). Limits cannot be avoided, as for examples: every session must end, which is a limit; if toys are intentionally broken, children's opportunities to express are diminished; and of course children cannot be allowed to hurt themselves or others in play therapy (Cochran, et al., 2010). As Moustakas (1959) clearly stated, "Without limits there could be no therapy" (p. 10). Yet Axline (1969) guided therapists to establish "only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship" (p. 73). As a result the balance in effective and empathic limit setting can be complex. Landreth (2002) explains that limit setting can be seen as one of the most problematic aspects of play therapy for most therapists (Landreth, 2002).

We concur that limits are necessary and complex, but also see children's use of

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This article was published Online First September 5, 2011.

Jeff L. Cochran and Nancy H. Cochran, Department of Educational Psychology and Counseling, University of Tennessee; Ashley Cholette, University of Tennessee; William J. Nordling, Department of Psychology, Institute for Psychological Sciences, Arlington, VA.

Correspondence concerning this article should be addressed to Jeff L. Cochran, Department of Educational Psychology and Counseling, University of Tennessee, 535 Bailey Educational Complex, Knoxville, TN 37996-3452. E-mail: jcochr11@utk.edu

limits in child-centered play therapy (CCPT) as at times central to the child's work. In some cases, it may be as Bixler (1947) concluded, "limits are therapy" (p. 1).

The current study provides an in-depth analysis of two clients' use of limits in their individual play therapy sessions. Their case examples are part of a larger and ongoing study of CCPT outcomes for children with abnormally disruptive behavior in urban, high poverty elementary schools. Their cases were selected for individual analysis due to their unusually heavy use of limits. The study provides outcome data for each client as reference points, but focuses on conceptualization of each child's use of limits and apparent mechanisms of change.

## **METHOD**

### **Setting**

Both clients were served in a large, urban, Title I, high poverty elementary school. The school has over 700 students, a free or reduced meal rate over 90%, a 40% mobility rate, and apparently many of its students come with significant challenges as only 29% were proficient or advanced in reading and only 35% in math.

### **Clients**

Both clients were boys referred by teachers and school administrators in the fall of their kindergarten year. Both were seen as having severe and persistent patterns of defiant and aggressive behaviors markedly different from peers. Both referrals were initiated by experienced kindergarten teachers who had implemented behavioral interventions prior to referral. Both were referred to the office for discipline (1–3 times per month), plus received less formal office support in the form of brief visits with school administrators or with the time-out resource teacher. Both had been suspended an average of once per month. Especially considering the need for suspensions early in their kindergarten years, the school administration was highly concerned that they were running out of helpful interventions.

According to school staff and teacher reports, both boys were living in chaotic, stressful situations, in poor neighborhoods, with little parental oversight. Both were sons of single mothers who described their son's problems as continuing from preschool and reported feeling overwhelmed and not knowing how to control or help their sons. According to mothers' reports, one boy's father was incarcerated and the other boy's father had been charged with domestic violence and lived out of state. Both boys had experienced abrupt changes, trauma, and stress early in their development. Neither mother was able to follow-up on repeated invitations to work with counselors or other school staff on changes at home to help their sons.

### **Treatment**

Treatment was provided in 30-min sessions, scheduled twice weekly. The therapist was an advanced graduate student in mental health counseling during the

first months, then a counselor beginning her work toward licensure in the remaining months. She had completed one course in CCPT and an internship that included CCPT. She is the third author of this study.

As the words counselor and therapist may often be interchangeable, we refer to her as “therapist” in this study, fitting with the name of the approach. The therapist received weekly supervision on sight. Her supervisor is the second author in this study and has extensive knowledge and understanding of CCPT. In supervision, at about the time these clients started, the therapist was working on her limit setting and relational consistency skills.

The treatment is CCPT (Axline, 1947; Axline, 1969; Landreth, 2002), in the variant developed by Louise Guernsey (Cochran, Nordling & Cochran, 2010; Guernsey, 1983; Guernsey, 2001) and promoted and taught through the National Institute for Relationship Enhancement (NIRE). The child’s free self-expression and the therapist’s empathy for and acceptance of his experience are paramount in the approach. The treatment model includes necessary structural limits that keep self-expression safe and anchored to reality. The limit-setting procedure within the approach can be referred to as, “the empathy sandwich” (Cochran, Nordling & Cochran, 2010, p. 132). This approach sandwiches the limit that has become necessary between (a) the therapist’s empathic acknowledgment of the child’s apparent motivation for engaging in the behavior, and (b) the therapist’s empathic response to the child’s reaction to the limit. Limits are stated in a firm, yet warm and nonthreatening manner. Limits are worded to be specific in order to only restrict the smallest number of behaviors necessary. If a child were to persist toward a known and stated limit (e.g., “one of the things you may not do is throw the ball toward my face”) he would be informed with wording like the following:

*Responding empathically to the child’s intent:* “You want to know what happens when you throw the ball at my face . . .” or (if child is obviously enjoying this activity) . . . “you like to throw the ball at my face . . .” or (if the child obviously angry at the therapist) . . . “you’re mad and want to throw that ball right at my face!”

*Stating the consequence of proceeding with the limited behavior:* “(Child’s name) . . . throwing the ball at my face is one of the things you may not do. If you throw the ball at my face again, our special play time will end for today.”

*Responding empathically to the child’s next response after the stated limit or asserting the consequence, if necessary:* [The child has moved on to another activity] “You have a new idea. You have decided to play with the army guys” or [Child repeats the previously limited behavior and throws the ball at the therapist’s face. The therapist picks up the ball and get’s child’s attention by calmly saying his name] “(Child’s name), you threw the ball at my face again. That is what you want to do, but that is one of the things you may not do. Our special play time is over for today [heading toward the door]. We will have special play time again on Thursday.”

It should be noted that it is *very rare* that children in the model engage this consequence. A calm, but firm tone of voice, and acceptance conveyed through facial expression and open body posture when the initial limit is stated are often enough to help even the most limit testing child know that “you still have control and a choice . . . however, this is one thing you may not do in special playtime.” The therapist remains empathic, accepting, and sensitive to the child’s reactions and feelings during a necessary ending time, but also firmly maintains that “special playtime is over for today.”

The Guerney/NIRE approach to CCPT provides guidance for therapist participation in children's play and a stage model for understanding children's process in CCPT (Cochran, Cochran, Nordling, McAdam, & Miller, 2010a; Cochran, Nordling, & Cochran, 2010; Guerney, 2001; Nordling & Guerney, 1999). Therapist participation provides for rich relational work. Recognizing the stages of a child's work provides a lens through which to view children's internal therapeutic process in play therapy, a process which is not as readily apparent as in "talk therapy" with adults.

Briefly, the typical stages of CCPT can be described as the following:

*Warm-up:* therapeutic relationship is formed, including an understanding of the child and therapist's roles, the unique potential of the playroom, and a feeling of safety that facilitates free expression. In this stage children work to discern just who this person of the therapist is to them, what is allowable in this relationship, what will be OK and what will not be OK in the playroom.

*Aggressive Stage:* children work on issues related to exerting power and control, and often express deep seated aggressive tendencies or thoughts through characters and actions in role-play.

*Regressive Stage:* children explore issues related to attachment and nurturance, and often play in younger seeming ways than would be expected for the child's chronological age; themes of protection, and giving and receiving nurturance predominate.

*Mastery:* children work on issues related to competence and self-mastery, and work on integrating the gains of earlier stages into their personality. Play is age appropriate, and nonconflictual. This stage signals readiness to begin to end play therapy.

## Design and Analysis Procedures

### *Protection of Client Identity*

To protect client identity, the boys are given pseudonyms in this report. Additionally, some playroom behaviors that are key to understanding the child's process, but possibly identifying, have been changed by inserting parallel behaviors that the authors considered quite true to the child's process without risking identification. All study procedures, including parental permissions and data collection, are approved by the Institutional Review Board of the first author's university.

### *Panel Consensus*

The authors formed an expert panel in order to conceptualize each client and his use of CCPT. The process leading to categorizing play into stages, conceptualizing clients and mechanisms of change included the following. The first author interviewed the therapist regarding stages, conceptualization of each client and progress. The first author then drafted a report of the interview with follow-up questions for the therapist to confirm or correct from her understanding. Differ-

ences in understanding (there were very few), were discussed until a comfortable consensus was reached. The second author/therapist's supervisor during the treatment year then reviewed this work, adding her input which was discussed with the first author until consensus was reached. The fourth author, who also has extensive knowledge of CCPT then reviewed the results of this work and offered his input regarding classification of play behaviors into stages, client conceptualization, and likely mechanisms of change. Finally, the therapist/third author was given the results of the panel changes to approve as accurate from her perspective. As a panel, we have over 65 years combined experience conceptualizing client difficulties, planning and assessing treatment, and particular expertise in the using the Guernsey stage model. The authors hold advanced degrees, licenses, and certifications in counseling, psychology, child-centered play therapy, and child-centered play therapy supervision.

### *Outcome Data Sources*

There are three sources of outcome data: school administration reports of the child's behavior, therapist and supervisor observations, and teacher ratings through the Teacher Report Form (TRF) of the Child Behavior Check List (Achenbach & Rescorla, 2001). The TRF includes 118 items that ask teachers to rate the presence of behavioral symptoms on a 3-point scale of frequency. The TRF enables score reports of Total, Internalizing and Externalizing Composites, and eight syndrome scales: Anxious/Depressed, Withdrawn/Depressed, and Somatic Complaints make up the Internalizing Composite; Aggressive Behavior and Rule-Breaking make up the Externalizing Composite; and Social Problems, Thought Problems, Attention Problems contribute to the Total, but neither composite.

Test-retest reliability for the TRF was established at correlations of .90 for Total Score and .91 and .92 for the Internalizing and Externalizing Composites. The internal consistency of problem area scales was supported by alpha coefficients of .78-.97.

Standard errors of measurement (SEM) are provided by referred versus non-referred norm groups. SEM allows the determination of confidence intervals at 90%, which allow statements of significance of score changes to those confidence levels (i.e., that we can be 90% sure that the score difference is actual behavior change vs. errors in measurement or normally occurring variation). Strong validity evidence for TRF scores has been established through multiple studies across decades (Achenbach & Rescorla, 2001).

## **CASE RESULTS AND DISCUSSION FOR STEPHON**

### **Overview**

Stephon had 28 sessions from mid November through April. He had teacher ratings pretreatment, after 21 sessions, and at the end of the school year/following his 28th session.

### External Measures of Change

From pre- to midtreatment teacher ratings, Stephon's scores in Total as well as Attention Problems and Anxious Depressed syndrome scales worsened significantly. At posttreatment (year-end) teacher ratings, his Total score was significantly improved from pretreatment. His Externalizing Composite score improved more than twice the confidence interval for significance. His Internalizing Composite score was back to his low pretreatment level. His Rule-Breaking score improved beyond the confidence interval for significance. His Aggressive Behavior and Attention Problems scores improved more than twice the confidence interval for significance. See Table 1.

Stephon had eight office referrals and two suspensions prior to treatment. From the beginning of treatment through the end of the school year, he had only one office referral and suspension, which happened about one month into treatment. Early in treatment it appeared clear to his therapist that his teacher and peers dreaded his being in class. By the end of treatment, they appeared to enjoy and welcome him.

From his teacher's written comments, her primary concerns and reasons for referral were "tantrums" and "disregard for all rules." TRF items marked with the highest rating, "Very True" included: "Defiant, talks back to staff," "Disobedient at school," "Temper tantrums or hot temper," "Doesn't seem to feel guilty after misbehaving," and "Breaks school rules." At his end of treatment rating, each of these items was marked only as "Somewhat or Sometimes True."

### Progress Through Stages

#### *Stephon's Limit Testing Warm-Up Stage*

Stephon was high energy and quick to test limits from his first minutes in the playroom. He seemed to be checking for what might not be OK with his therapist.

**Table 1.** Stephon's TRF Scores

Score area	Pre-treatment Ratings	2nd rating, after 1st 21 ½ hr. sessions	Final ratings, after last 9 sessions
Total	70	85*	47*
Ext. Composite	30	32	15**
Rule-Breaking	7	6	3*
Aggressive Behavior	23	26	12**
Int. Composite	2	9	4
Anxious/Depressed	2	6*	4
W/drawn/Depressed	0	2	0
Somatic Complaints	0	1	0
Non-Com. Scales			
Social Problems	3	2	2
Thought Problems	1	1	1
Attention Problems	33	39*	22**

\* Denotes change from Pre-Treatment scores beyond the 90% confidence interval created from the standard error of measurement for referred children ages 6-18. \*\* Denotes change from Pre-Treatment to Final scores more than two times the amount of this confidence interval.

When exuberantly wrestling the giant stuffed dinosaur, he would look to see how she reacted to the violent pounding he gave it. Seeing her response of acceptance, he attacked with increased vigor, switching from wrestling by hand to pummeling with objects from around the room. Soon the thrown objects began to veer close to the therapist and a first limit was set.

As therapy continued, Stephon seemed to bump up against limits through his naturally vigorous, aggressive play (e.g., great battles with the dinosaur or against unseen enemies, crashing cars and other objects). At other times, his limit testing seemed more intentional, as if he were absorbed in his play, then suddenly thought, "Hey, I wonder what she will do if I . . .?"

It became his tendency to test a limit, realize the parameter, and rapidly pursue other possible limits, until ultimately returning to and becoming absorbed in more sustained and focused play. For example, during one battle with the stuffed dinosaur, he spontaneously blurted out a few cuss words. Seeing no negative response to this, he more obviously tried a few more. Meeting no resistance here, he moved to the art table and immediately tested the limit of purposely trying to break the tips off markers. After a limit was set here, he moved quickly to painting, and tested the limit of trying to paint on the walls. After a limit was set here, he returned to battling the dinosaur and became absorbed in that work again.

Stephon's limit testing pattern continued for about 11 sessions. His second session had to end early due to his persistence with a limited behavior. He continued to seemingly "choose to end" sessions this way for the next 10 sessions; however, the early endings due to repeating a limited behavior were typically within the last 5 minutes of his sessions. The first few times he was picked up for his next scheduled session after having to end the previous session early, he appeared surprised to have another session. As therapy sessions progressed, he seemed to gain more confidence that ending special play time early would be his only consequence, and that nothing in his therapist's acceptance and willingness to continue with him would change.

### *Aggressive Stage Play*

Stephon's heavily aggressive stage play began while he was still warming up, exploring the limits of the playroom and his relationship with his therapist. While he shifted away from limit testing, his work with limits continued, though less intensely and without the need to end sessions early.

His most clearly aggressive stage sessions featured competition against his therapist. As he invented games, the rules he set guaranteed that he would win and get to rudely celebrate his victory (for other examples of similar behavior, see Cochran, Cochran, Nordling, McAdam & Miller, 2010b). At other times, in more aggressive-regressive stage play, he had them both "tag team" the giant dinosaur, taking turns, at his direction, putting the dinosaur in painful TV type wrestling holds. As this play theme developed further, he began the more purely regressive stage play with themes of rescue and nurturing. He and his therapist would take turns "being rescued" in a role-play wherein the dinosaur would begin to inflict



intense pain on one of them, and the other would “swoop in” to rescue the trapped partner from the dinosaur’s deadly grasp.

### *Regressive Stage Play*

Stephon’s main regressive stage play began within his aggressive-regressive stage role-plays. He would pause within his more aggressive role-plays and go to the school desk to draw while instructing his therapist how and what to draw with him. During these more subdued moments, he often talked like he was much younger than his age, sometimes in “baby talk” and inadvertently referring to his therapist as “mommy.”

### *Stephon’s Beginning Of Mastery Stage*

Altogether, Stephon had about 12 half hour sessions in aggressive-regressive stage play before beginning to show signs of mastery stage play. From his regressive stage time drawing at the desk, Stephon shifted to creating games at the desk where he again manipulated the rules to make sure he won, but he also gave the therapist a chance to “win.” He demonstrated his mastery of school skills to his therapist, “Look I can write my first and last name now.” He began to persist in efforts to complete pictures that represented ideas that he had in mind, and to self-express. He often showed pride in what he had made.

The end of his school year prompted an arbitrary countdown (i.e., before he was well established in mastery stage play; see Cochran et al., 2010 for examples of how to handle such a countdown). Stephon shifted back, but with much less intensity, toward some of his aggressive play themes in countdown. His therapist noted that this late aggressive theme play seemed to coincide with days that she knew there was disruption in the classroom or school environment.

## **Non-Therapy Factors That May Have Affected Change**

Stephon’s teacher was on maternity leave for six weeks within the four months from his first to his second ratings. Also during this time he was pulled out of class for parts of the day into a specialized class of students with similar behavioral difficulties. These transitions coincided with particularly aggressive play and a high need to test limits in therapy. School officials saw the pull-out as necessary, but not helpful and possibly detrimental to Stephon’s progress.

## **Conceptualization and Mechanisms of Change**

### *Rethinking Relational Expectations: Testing Rejection by Testing Limits—Reducing Excessive Worry of Rejection*

Stephon often appeared approach-avoidant in relating to his therapist. It seemed that while he longed for closeness, he expected to be rejected. At times he



seemed to be “looking for landmines” in his attempts to identify all off limit behaviors, and then “exploding the mines” as if to confirm for himself just what would happen. After repetitive testing, he seemed able let go of excessive worry over rejection. It may be that he generalized this new expectation to other adults, decreasing his need to test limits and increasing his ability to tolerate limits in the classroom, as evidenced by his significant improvements in teacher ratings in Total, Externalizing Composite, Rule-Breaking, and Aggressive Behavior scores. In addition, his highly significant progress in his Attention Problems score may suggest that his attention problems, which were predominated by the hyperactivity-impulsivity versus the inattention domain of the scale (e.g., inability to sit still, fidgeting, talking out of turn) resulted from a fearful hypervigilance that was reduced through changing relational expectations in CCPT.

### *Revisiting Unmet Needs and The Meanings of Those Experiences*

Having concluded that his therapist was a safe person to fully express himself with and that he did not need excessive worry over rejection, Stephon seemed to return to earlier times in his development. He first expressed his most aggressive self with needs for power and control, and then he expressed his feelings of being small and vulnerable, as if deciding whether these feelings were also tolerable and acceptable. This work in CCPT seemed to allow him to test out new ways of asking for help and nurturing from his therapist and other caring adults.

### **Notes on Stephon’s Course of Progress**

We find it interesting that Stephon’s teacher ratings became worse before they improved. It could be that he was reacting to the transitions he had experienced during her maternity leave at the time she completed her second rating. It also may be that his externalizing behavior increased during his more intense work in his CCPT. His pattern of worse ratings before much better ratings underscores the need to remain steady in CCPT, at least so long as internal progress through typical stages suggests that externally evident progress can be expected to follow. This pattern also underscores the need to inform caregivers that it can require significant work and before seeing external progress.

We do not see his path to progress as particularly long—30 half hour sessions or 15 session hours. We also note that while he continued to misbehave during his first months of CCPT, his reductions in office referrals and suspensions suggest improvement soon after therapy began as he became better able to stop himself from escalating to behavioral extremes requiring office discipline and suspension.

We see his extensive limit testing as due to two factors. At the time he started with his therapist, she was addressing her development of unconditional positive regard toward accepting both “positive” and “negative” child self-expressions while setting necessary limits to remain congruent. In our experience, this is often a struggle for beginning child-centered play therapists. But while her development

may explain some of his extensive limit testing, we think that Stephon's limit testing was also the work that he needed to do.

## CASE RESULTS AND DISCUSSION FOR ARMAND

### Overview

Armand had a four month waiting period before he could be scheduled for CCPT. His treatment period was 2.5 months. While his counseling was scheduled for twice weekly half hour sessions, he only had 10 such sessions as his teacher often insisted that meetings be rescheduled once he began to succeed in classroom behavior.

### External Measures of Change

From pre- to postwaiting periods, Armand's TRF scores worsened in some areas and stayed the same in others. In his posttreatment ratings, this pattern reversed toward progress. See Table 2.

Armand was removed from class and suspended for aggressive behavior six times prior to beginning CCPT. He had one such office referral in March when treatment was just beginning and one in May, very near the end of the school year.

Early in treatment, his therapist noted that his peers seemed afraid of him. His teacher seemed worn-down by his unpredictable behavior, and stiffened toward him with each reentry. By the end of treatment, his teacher and peers were ready to welcome him as he arrived back to class. It was difficult to schedule his final sessions, as his teacher focused on helping him catch-up critical skills once his progress made this possible.

Quotes from his teacher's written comments prior to and after treatment suggest reasons for referral and moderate progress. When asked what concerns her most before treatment, her comments began, "Anger—very explosive; doing well

**Table 2.** Armand's TRF Scores

Score area	Pre-waiting period scores	Post-waiting period scores	Post-treatment scores
Total	55	78* worse	71
Ext. Composite	36	36	26* better
Rule-Breaking	7	7	4* better
Aggr. Beh.	29	29	22* better
Int. Composite	8	14* worse	18
Anx./Depr.	4	5	11* worse
W/drawn/Dep.	4	9* worse	6
Somatic Complaints	0	0	1
Non-Com. Scales			
Social Probs.	4	6	3* better
Thought Probs.	1	0	0
Attn Problems	18	21	22

\* Denotes change beyond the 90% confidence interval created from the standard error of measurement for referred children ages 6–18.

one minute then throwing things and crying the next minute (literally).” Her response to the same question posttreatment seems more moderate, describing him as, “easily frustrated, [having a] bad temper, [not] conforming well when schedules change, so much a perfectionist that he can’t get things done—then becomes more frustrated, argumentative.” TRF items marked with the highest rating, “Very True,” pretreatment included: “Physically attacks people,” “Explosive and unpredictable behavior,” and “Feels others are out to get him.” At his end of treatment, each of these items was rated as only “Somewhat True” or “Not True.”

## Progress Through Stages

### *Warm-Up Stage*

Armand’s readiness to engage the toys seemed quick, even for his age. He went excitedly through the toys telling what he had at home and what he did not. If he wasn’t smiling through this period, it was only because he was in deep concentration trying out a particular idea. He appeared overjoyed to have someone trust in his ability to be self-directed. He encountered his first limits (e.g., toys stay in the playroom/cannot be taken from the playroom) during this rapid exploration time by asking if he could keep some of the toys he particularly liked.

Armand’s persistent play theme of cleaning up and trying to please the therapist developed in these early sessions. While rapidly exploring the toys in his first session, he found a little dust pan and broom. He went right to work cleaning. He soon found the spray bottle with water and towels and set to work cleaning surfaces. For 7–8 sessions, he spent most of each session cleaning and organizing the toys or drawing pictures. During each task he frequently checked for approval, “Is that good?” “Is that clean?” or after drawing a picture at the art table, “Do you like it?” “Did I do a good job?”

His therapist responded to these questions with empathy for what was being expressed, “You aren’t sure yet if that is good,” “You want it to be just right,” “You want to know if it pleases me,” and/or asserting the structure of the importance of *his* decisions in special play time, “In special play time, you can decide when it is just the way you like it” or “In special play time, it is more important what you think is good.”

### *Aggressive-Regressive Stage*

Armand’s cleaning theme developed into overt limit testing. In his 7–8 sessions focused on cleaning, he seemed to learn that pleasing his therapist was not required for acceptance. He came to use “cleaning” to test just how messy he could make things. He seemed to work to test the patience of his therapist. At times he sprayed areas so much that materials (paper art materials, cloth materials) would become soaked, or sprayed the linoleum floor by the door so much that it would not be safe to walk on. Armand’s cleaning/mess making came to have a more purely regressive stage tone of a mischievous, limit-testing 2–3 year-old than a 6-year old. Reasonable limits

with empathy were needed to contain the “mess” when too unsafe or too destructive of materials, and these limits were accepted by Armand.

### *Countdown, Disrupted Ending, Signs of Mastery*

His countdown began due to nearing the end of the school year on his eighth session. He was intended to have five more sessions at that time, allowing him to complete 13. However, his therapist was only able to complete two more due to scheduling restrictions from his teacher and end of the year school events.

Armand showed limited signs of mastery stage play in countdown. His cleaning once again took on the abilities of his age. He revisited some of his earlier limit testing behaviors, but the tone was more of, “Hey, remember, that was funny when . . .” versus “I’m going to see just how far I can go with this.” He showed signs of beginning direct verbal expression of emotional upset. This kind of direct expression of upset is not the kind of behavior that his therapist would have expected of him early in his sessions. Certainly caring school adults had often asked him what was bothering him, with little response, and often increasing emotional upset.

### **Inconsistent Session Scheduling and Reaction**

Armand’s course of CCPT was affected by missed sessions. Early sessions were missed due to excessive absences. Later sessions were missed due to his teacher’s concern and pressure to make sure Armand gained academic skills necessary to pass to first grade, and therefore her reluctance to send him for sessions when she was finally able to relate to him and teach him in class. Armand noted the missed sessions and complained, especially during his time of limit testing, for example, just before making an excessive mess, “Hey, I didn’t get my time on Tuesday.” Stated with a tone of reproach, “I didn’t get to come.” To such, his therapist responded with empathy and a statement of the structure, “You didn’t get to come on Tuesday. That makes you mad and you don’t like that. I’m not always able to bring you from class as scheduled.”

### **Non-Therapy Factors That May Have Affected Change**

In January, over six weeks prior to beginning treatment, the school brought charges in juvenile court for his excessive unexcused absences. His attendance was not perfect from that point, but improved somewhat.

From early in the school year, Armand was pulled out of class for parts of the day into a small specialized class of students with similar behavioral difficulties. School administrators and his teacher did not see this program as working for him prior to treatment. They noted that he seemed to use misbehavior to stay in the special program. Their worry was that if he did not gain the self-control to stay in the regular classroom, he would spend most of his kindergarten year the special program, missing critical skills that could only be gained in the classroom.

## Conceptualization and Mechanisms of Change

### *Self-Doubt, Nondirectivity, The Struggle to Please, and Self-Responsibility*

Armand seemed to struggle with self-acceptance. His normal reaction to self-doubt seemed to be to avoid risks of failure and rejection by opposing directions from school adults. So CCPT presented him with two challenges: (a) there is very little direction to oppose, and (b) no matter what he did, he could not please or displease his therapist who within safe, reasonable limits offered unconditional positive regard, and turned responsibility of self-evaluation over to Armand.

In the void of very little to oppose, he worked hard to please, perhaps to avoid her rejection or gain acceptance that he expected to be elusive. Exhausting these efforts, he risked pushing the limits and testing her patience. His therapist's consistent, warm acceptance and empathic focus on his experience, including feelings, choices, and ways of being, seemed to leave him with an existential experience of acceptance and choice.

Armand had a very limited time in CCPT and most of this counseling time was taken up with testing the limits of therapeutic relationship. But if from this short course of therapy and extended warm-up, he gained self-acceptance, confidence to face life, and an awareness of choosing for himself, his abbreviated therapy was very effective.

### Notes on Armand's Course of Progress

Considering the differences from his ratings across his waiting period to his treatment period, Armand's work in counseling seems successful within a short period of time. We note that his TRF Total score trended positive during his brief treatment period, but was nonsignificant. It may have been that as his externalizing behavior improved, his teacher noticed more of his anxious behaviors, and so his averaged score does not reflect significant progress. Additionally, as he improved in externalizing behaviors, he was in her class more than he was pulled out for the special class, and therefore she had more opportunities to notice his anxious behaviors. It could also be that his anxiety was higher as he worked on core issues in CCPT. His reduction in office referrals and suspensions, and his therapist's observations of changing teacher and peer relationships, support our impression of overall progress.

Missed sessions due to absences and teacher decisions may have prolonged his relational testing. This underscores the importance of establishing and asserting a clear contract with the teacher. Armand's therapist was a beginner, and though she attempted all scheduled sessions, at times she also struggled to assert his need for consistent therapy. While learning to relate with teachers, she was developing her confidence in CCPT.

Ideally, we would more strongly advocate the importance of session consistency. Yet this seems a realistic example of a dilemma for counselors serving children like Armand in schools. If not served in school, he may not have received help until years of learning were lost and negative behavior patterns solidified. His

therapist and her supervisor were aware that Armand had missed valuable learning time due to being pulled out for the specialized classroom placement, due to suspensions, and excessive absences. Nearing the end of the school year, Armand's behavior had improved and the teacher had an enhanced opportunity to reach and teach him. All were faced with the conflict between session consistency to capitalize on gains from CCPT and the pressure to meet demands of the curriculum in order to pass to first grade.

### FIRST GRADE FOLLOW-UP

In Stephon's and Armand's first grade year, our staff formed a CCPT group for children who had made progress in individual CCPT, but also continued to cope with stressful home lives. When approached in October to discuss scheduling, both Stephon's and Armand's teachers responded that while each boy still required redirection and patience, both boys were functioning well in their respective classrooms. Neither had needed time in the specialized class for students with behavioral difficulties. When the rationale for the CCPT group was explained, the teachers agreed that the group was appropriate considering that both boys continued to have social difficulties mainly in transitions, and both had to cope with ongoing difficulties at home. Both were scheduled for CCPT group, but as it became clear that Armand's ongoing difficulties were greater than Stephon's, and at request of the school administration, Armand was scheduled for individual CCPT follow-up once per week, as well as group.

In the group, both boys engaged in the kinds of inter- and intrapersonal conflicts normally expected in group counseling. In our view, it is likely that their behavioral acting out and lack of self-control would have made participation in group CCPT practically impossible the year before. While both boys occasionally tested limits in the group, both also showed an ability to accept limits and move on. Armand had to leave the group early one time due to persisting in a behavior (throwing clay) that had been limited. Stephon occasionally "set a limit" on himself out loud, by saying, "One of the things I may not do is . . ." before trying to break marker tips by pushing down too hard. During one of the first few group meetings, Armand noticed the similarity in limit-setting and excitedly remarked, "This group is a lot like special play time . . . we can do *almost* anything!" In individual CCPT, Armand continued work through the stages of CCPT. Both boys remained in their regular first grade classrooms for the entire year, and did not need to be placed in the specialized classroom for disruptive students. The group leader, who is second author, observed that both boys showed improved emotional regulation and ability to accept limits not only in individual and group CCPT, but also in their classrooms.

### IMPLICATIONS

Two directions of limit testing equal the same acceptance. Trying to please the therapist and testing the limits of her patience is the same relational test. Working hard to please should not garner greater security in a therapeutic relationship in

CCPT and testing the limits of patience should not reduce the security of the relationship.

Stephon and Armand's case studies suggest the power of CCPT, even in relatively short periods with children in quite difficult situations. However, because one cannot generalize from single cases, the greater value is in pointing out aspects of how and why CCPT may help.

Stephon and Armand's use of counseling suggests the role that limits play in CCPT. Effective testing of limits was pivotal to each boy's perception of unconditional positive regard and served as a primary therapeutic tool. The boys seemed to test limits to work out the meanings within their relationships with others, to test out the truth of ingrained ways of thinking, interacting, and behaving. Within the safe parameters of CCPT they appeared to play out questions that an insightful adult client might discuss in counseling. For example, if an adult is often in conflict, he might ponder, "Do I need to defy others and oppose others? Am I able to move beyond this defensiveness and allow myself to *be*, even if it means a greater awareness of my life's difficulties? Can I allow myself to be vulnerable, and ask for help? Can I accept myself in my situation, while also working to improve?"

The difference in the play themes, self-expression, and work of these two boys suggests that striving to please one's therapist can become just as much a challenge to the therapeutic relationship as attempts to misbehave, defy, and drive the therapist away. The possibility that these two boys' novice therapist may have wavered in consistency with unconditional positive regard suggests the importance of therapist self-exploration in this area. Different responses to the type of limit testing, and possible wavering in unconditional positive regard also suggest the importance of the use supervision with advanced CCPT therapists, who are experienced in contemplation and cultivation of the core conditions in themselves with clients.

It is our hope that these case studies will encourage both new and experienced play therapists to redouble their efforts to reach out to troubled children like Stephon and Armand. Limit testing in CCPT brings not only opportunities for the child to self-express within safe parameters, but also for the therapist to develop her strength in unconditional positive regard and deep empathy when faced with a child's limit testing behaviors. We share these boy's stories to help therapists see anew the curative power inherent in limit testing, as well as the opportunities for strengthening the therapist-child relationship.

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