BEHAVIORAL OUTCOMES OF CLIENT-CENTERED PLAY THERAPY

DISSERTATION

Presented to the Graduate Council of the North Texas State University in Partial Fulfillment of the Requirements

For the Degree of

DOCTOR OF EDUCATION

By

Ruby H. Herd, B.S., M. Ed.
Denton, Texas
May, 1969
# TABLE OF CONTENTS

**LIST OF TABLES** ................................................................. v

**Chapter**

**I. INTRODUCTION** .............................................................. 1

- Statement of the Problem
- Hypotheses
- Background and Significance of the Study
- Definition of Terms
- Limitations of the Study
- Chapter Bibliography

**II. REVIEW OF THE LITERATURE** ........................................ 17

- Description and Rationale
- The Therapist in Play Therapy
- The Playroom and the Toys
- The Process and Outcomes of Play Therapy
- Summary
- Chapter Bibliography

**III. METHODS AND PROCEDURES** ........................................ 52

- Subjects
- Description of the Instruments
- Procedures for Collecting Data
- Treatment of Data
- Chapter Bibliography

**IV. STATISTICAL ANALYSIS OF RESULTS** ................................ 71

- Statistical Treatment of the Data
- Null Hypothesis One
- Null Hypothesis Two
- Null Hypothesis Three
- Null Hypothesis Four
- Null Hypothesis Five
- Summary

**V. NON-STATISTICAL INFORMATION** ..................................... 85
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I.</td>
<td>Comparison of Mean Scores on Three Variables</td>
<td>64</td>
</tr>
<tr>
<td>II.</td>
<td>Comparison of Mean Scores on Three Variables</td>
<td>66</td>
</tr>
<tr>
<td>III.</td>
<td>$t$ Values Derived on Pre- and Post-Test Mean Difference Scores between Groups on the Sociometric Measure</td>
<td>72</td>
</tr>
<tr>
<td>IV.</td>
<td>Means and Standard Deviations of Sociometric Measure</td>
<td>73</td>
</tr>
<tr>
<td>V.</td>
<td>$t$ Values Derived on Pre- and Post-Test Mean Difference Scores between Groups on the Vineland Social Maturity Scale</td>
<td>74</td>
</tr>
<tr>
<td>VI.</td>
<td>Means and Standard Deviations of Social Maturity Scores</td>
<td>75</td>
</tr>
<tr>
<td>VII.</td>
<td>$t$ Values Derived on Pre- and Post-Test Mean Difference Scores between Groups on School Grade Points</td>
<td>76</td>
</tr>
<tr>
<td>VIII.</td>
<td>Means and Standard Deviations of School Grade Points</td>
<td>78</td>
</tr>
<tr>
<td>IX.</td>
<td>$t$ Values Derived on Pre- and Post-Test Mean Difference Scores between Groups on the Haggerty-Olson-Wickman Behavior Rating Schedule</td>
<td>79</td>
</tr>
<tr>
<td>X.</td>
<td>Means and Standard Deviations on Behavior Rating Scores</td>
<td>80</td>
</tr>
<tr>
<td>XI.</td>
<td>$t$ Values Derived on Pre- and Post-Test Mean Difference Scores between Groups on the California Test of Personality</td>
<td>81</td>
</tr>
<tr>
<td>XII.</td>
<td>Means and Standard Deviations of Total Personality Adjustment Scores</td>
<td>82</td>
</tr>
</tbody>
</table>
CHAPTER I

INTRODUCTION

In exploring the magic years of early childhood, Selma Fraiberg (12, pp. 22-27) describes the ways that imaginative play make possible the development of mental health. In clinical studies of disturbed children, she found that fears which were beyond the control of the children were almost always the motive force behind aggressive and belligerent behavior. Children who had developed stable defenses which enabled them to cope with their fears worked toward their own mental health through the ability to acquire knowledge, but also through imaginative play. They used their imagination and the people of their imagination to solve their problems and to keep the boundaries between fantasy and reality.

It can be demonstrated that the child's contact with the real world is strengthened by his periodic excursions into fantasy. It becomes easier to tolerate the frustrations of the real world and to accede to the demands of reality if one can restore himself at intervals in a world where the deepest wishes can achieve instant imaginary gratification (12, p. 23).

Children, even in their earliest years, begin to reveal characteristic ways of dealing with life problems. Nelson (26, p. 267) describes play as being the child's work rather than merely fun and games. It is the media through which he
learns, tests, communicates, and expresses his way of life. Not only does he find an outlet for his feelings in play, he may also attempt to change his status with family and friends through experiences which he has first tried out in play situations.

Ginott (15, p. 51) states that the rationale for the use of play in the diagnosis and treatment of disturbed children is the assumption that "... play is the child's symbolic language of self-expression. To a considerable extent, the child's play is his talk and the toys are his words." Children develop character through experiences with persons and situations; it does not come about as a result of words. They internalize their experiences, assimilate them, and make them a part of their personality (16, p. 193).

The use of play as therapy is a comparatively new field in the treatment of behavior disorders in children. Rousseau (17, p. 421) studied the play of children to understand the psychology of the child, but its first use as a means of therapy appears to have grown out of an attempt to apply psychoanalytic theory to children.

Freud appears to have made the first recorded statement about the therapeutic possibilities of play for children. At the time, he was concerned with observations of his patients' needs to re-enact, in words and acts, painful incidents which they had experienced. He concluded that these re-enactments were unconscious variations of the painful incidents and
that the patients were attempting to master these on their own terms.

As Freud was studying this phenomenon, he became aware that it also appeared in the solitary play of children. Here the child was master of his objects, toys, and thus able to arrange them in ways which allowed him to imagine that he was also the master of his life situation as well (14).

Anna Freud (13), in her early work with children, recognized the difficulty of applying Freudian therapy to children. She found that children were rarely able or willing to participate in free-association as a means of bringing repressed experiences out into the open. Believing that they were also unable to form a transference relationship with the therapist, she modified the classical psychoanalytic technique of therapy in her work with children. She used play as a means of winning over a child in order to gain access to his inner thoughts and feelings, primarily as a preliminary to analysis.

Client-centered play therapy appears to have grown out of the concept that it is the relationship between the therapist and the child that brings about change and growth. Rather than diagnostic or as preliminary to therapy, the relationship itself is seen as therapy. Problems are seen not in terms of their historical past, but rather as they exist in the immediate present and in terms of the child's own means of expression. The relationship offers to the child the
opportunity to experience growth under the most favorable conditions (3). Like its adult counterpart, client-centered counseling, client-centered play therapy is based upon the hypotheses that the individual has within himself the capacity for growth and self-direction, and that these growth impulses are released within the therapeutic relationship established between the therapist and the child (28).

In reviewing the literature which has been published in the field of client-centered play therapy, it appears to have been first used and described by Jessie Taft as "... a therapy which is purely individual, non-moral, non-scientific, non-intellectual, which can take place only when divorced from all hint of control, unless it be the therapist's control of himself in the therapeutic situation (32, p. v)."

Taft's definition of client-centered play therapy was a breaking away from the schools of thought regarding play as therapy which were current at the time. The one common characteristic to which the client-centered approach, as represented by Taft, the analytic school as represented by A. Freud and Klein, the release therapy of Levy, and the directive play therapy of Conn and Solomon were in agreement was that the relationship established between the child and the therapist must be accepting and permissive. Even this agreement would be qualified by Freud's and Klein's definition of acceptance as involving love, transference, and dependence, and the stressing of a relationship rapport
without emotional involvement by Conn, Levy, and Solomon (7, 21, 31).

Although some form of acceptance is present in all types of play therapy, there are striking differences among the schools of thought in regard to its other characteristics. Free play, interpretation, reassurance, transference, and questioning are characteristic of child analysis as developed by Freud and Klein (13, 18). Conn, Levy, and Solomon set up situations, ask direct questions, interpret freely, outline possible courses of action, and offer reassurance as they proceed on the theory that it is the reliving of an experience which helps to overcome the conflict associated with it (7, 21). Client-centered play therapy has its orientation in the present rather than in the past as in analysis. It allows the child to find the best way to help himself in the therapeutic situation rather than directing the process toward a therapist-defined goal.

Regardless of specific theoretical background, the play activity of children is generally regarded by all schools of treatment as a non-verbal form of expression - the language of the child. It is his natural medium for communicating his own personal relationship to the world (15).

The relatively small number of experimental studies which have been published in the field of child psychotherapy point to the difficulties of designing and carrying out research in this area. Bloomberg (17, p. 425) points out that
experiments designed to help children do not always lend themselves to scientific research. The studies which are available are interesting; some are significant, verifying the generalizations that the process of play therapy can be measured objectively, and that children's expressions of feelings are changed during therapy. They leave unanswered, however, questions regarding behavioral changes following play therapy and the effectiveness of play therapy when compared to other methods of treatment.

Statement of the Problem

This study was concerned with determining the effectiveness of play therapy as measured by behavioral changes in interpersonal relationships, mature behavior patterns, and more adequate use of intellectual capacities.

Hypotheses

The following hypotheses were tested:

I. Children who have had a minimum of ten weekly individual play therapy sessions will score significantly higher in positive interpersonal relationships as measured by sociometric testing than will children who have had a minimum of ten weekly individual play sessions, and than will children who have had neither play therapy nor play sessions.

II. Children who have had a minimum of ten weekly individual play therapy sessions will score significantly higher in mature behavior patterns as measured by the Vineland Social
Maturity Scale than will children who have had a minimum of ten weekly individual play sessions, and than will children who have had neither play therapy nor play sessions.

III. Children who have had a minimum of ten weekly individual play therapy sessions will score significantly higher in more adequate use of intellectual capacities as measured by improvement in school grades than will children who have had a minimum of ten weekly individual play sessions, and than will children who have had neither play therapy nor play sessions.

IV. Children who have had a minimum of ten weekly individual play therapy sessions will score significantly lower in undesirable behavior patterns as measured by the Haggerty-Olson-Wickman Behavior Rating Schedule than will children who have had a minimum of ten weekly individual play sessions, and than will children who have had neither play therapy nor play sessions.

V. Children who have had a minimum of ten weekly individual play therapy sessions will score significantly higher in total personality adjustment as measured by the California Test of Personality than will children who have had a minimum of ten weekly individual play sessions, and than will children who have had neither play therapy nor play sessions.
Background and Significance of the Study

Erikson, developing a rationale for play, writes that

... the child's play is the infantile form of the human ability to deal with experience by creating model situations and to master reality by experiment and planning. ... The most obvious condition is that the child has the toys and the adult for himself and that sibling rivalry, parental nagging, or any kind of sudden interruption does not disturb the unfolding of his play intentions, whatever they may be. For to 'play it out' is the most natural self-healing measure childhood affords (8, pp. 557-671).

Amster, in discussing play activity as the natural medium for self-expression of the child notes that

... Play is an activity a child comprehends and in which he is comfortable, an integral part of his world, his method of communication, his medium of exchange, and his means of testing, partly incorporating and mastering external realities. Provision of play materials means the provision of a medium, a natural means of communication through which the child's problems may be expressed more readily and the treatment be more likely to succeed (2, pp. 62-68).

There is at present an increasing interest in play as therapy in the treatment of children (14). Its effectiveness, however, has been explained primarily on the basis of philosophical constructs arising from the growth-principle developed from Rogers' client-centered counseling with adults (27). Small-scale studies reported by Landisberg and Snyder (19) and by Finke (11) however, conclude that play therapy has its own characteristic pattern which distinguish it from adult forms of therapy.
There have been no reported large-scale investigations of the process of play therapy. Studies involving small samples report little long-term therapy and few follow-up studies. This has limited to a serious degree generalizations which can be drawn from the situations tested to other situations.

Moustakas (23, 24) reported two studies on the process of play therapy. In the first he hypothesized that in play therapy, a child goes through a sequence of emotional growth that corresponds to the normal emotional development of early childhood. He compared the behavior of disturbed children with that of well adjusted children and found that as therapy progressed, negative attitudes of the disturbed children became similar to those of the well adjusted; they were expressed more clearly, more directly, less frequently, and less intensely.

Other researchers (4, 29) have reported process studies which appear to verify the generalizations that (1) the process of play therapy can be measured objectively; (2) children's expressions of feelings are changed in a discernible direction during therapy; and (3) chronological age and aggressiveness affect the type of statements made by children in play therapy.

There are a number of studies reported on the outcomes of play therapy (29, 25, 5). Dorfman (9, pp. 235-277), in an
investigation of the outcomes of client-centered individual play therapy, found that reliable personality test improvements occur concomitantly with a series of therapy sessions, and that time alone does not produce reliable improvements on test scores. A serious shortcoming of the study, as pointed out by Ginott (15), is that it lacks data on behavioral changes expected after therapy such as improved interpersonal relationships, more mature behavior, and more adequate use of intellectual capacities. It cannot be assumed that test improvements reflect actual changes in personal adjustment.

Ginott (15) cites the need for research in the area of behavioral changes following play therapy, particularly in view of a large-scale investigation which reported no positive behavioral outcomes as a result of therapy. Teuber and Powers (33) studied therapy outcomes among pre-delinquents. They found no difference in later delinquency between therapy cases and control cases as measured by the number of subsequent appearances in court.

Lebo (20) and Ginott (15), in reviewing the research which has been done in the field of play therapy with children, note that such research is meager and that much of it is unsound. Lebo (17, pp. 421-422) describes much of the current research as "... emotional, cheerful, persuasive propaganda, lacking in clear hypotheses, adequate controls, and rigorous method". He notes that play therapy is left a rather
thin framework when stripped of the philosophy of the love of children and idyllic purposefulness emphasized in many of the current research articles.

In discussing the implications of play therapy for education of children in the classroom, Axline (3, p. 142) writes of her feeling that the relationship that is built up between the teacher and students is probably the most important single factor in developing sound mental health. "It is the permissiveness to be themselves, the understanding, the acceptance, the recognition of feeling, the clarification of what they think and feel that helps children retain their self-respect; and the possibilities of growth and change are forthcoming as they develop insight." Ginott (15, pp. 147-149) cites research (3, 4, 5) which indicates that the emotional relief which some children attain in play therapy allows them to express their true learning ability.

There are a number of studies (15, 20) which attest to progress and improvement in children who are involved in therapy. How much of the observed progress or improvement can be attributed to the effects of play therapy? How much of the observed progress or improvement would have occurred anyway as a natural outcome of the ongoing growth process? How much of the observed progress or improvement can be attributed to the special attention often given to children who are involved in therapy? These are the critical questions which highlight the research needs in this area and which must be answered if play therapy is to achieve scientific status.
Definition of Terms

1. Behavioral change--As used in this study, behavioral change is defined as improved interpersonal relationships, more mature behavior, more adequate use of intellectual capacities.

2. Play therapy--As used in this study, play therapy is defined as therapeutic play in a fully equipped play therapy room with a therapist present. The child is given the opportunity to use a particular time period in the way he wishes, subject to a few broad limitations. He may use the play materials which lend themselves as media for the expression of his needs or he may choose not to use them. The therapist establishes a relationship that is understanding, caring, and permissive, one in which the child is able to "play out" his feelings in a manner that is similar to the way an adult "talks out" his problems. Freed from the need for defensive action, the child is provided the opportunity to be free, creative, and self-directing.

3. Play session--As used in this study, play session is defined as a regularly scheduled play period at the Pupil Appraisal Center. Students assigned to the play sessions may read, work puzzles, color pictures, or play with simple toys in the children's waiting room at the Center. A graduate assistant or an intern will be assigned to be responsible for each of the students. Those responsible for these students
will establish a friendly supervisory relationship with them, but no efforts to initiate a therapeutic relationship of any kind will be made.

Limitations of the Study

This study was limited to children from Denton County schools who were referred to the Pupil Appraisal Center of North Texas for treatment.
CHAPTER BIBLIOGRAPHY


CHAPTER II

REVIEW OF THE LITERATURE

Description and Rationale

Carl Rogers (6, pp. vii-viii), in the introduction to Axline's *Play Therapy*, writes of his feeling that through play therapy it is possible to find the doorway to the inner world of childhood. "Here are children seen from the inside, their fears, their deep-felt needs, their bitter hatreds, their outgoing affection, their desire to be larger in spirit as well as body - here are children as they really are." Rogers believes that the play therapy relationship releases the curative forces which exist within each individual regardless of age. "Children find the strength necessary to look squarely at themselves, to accept themselves, and to work out a constructive adjustment to the difficult reality in which they live.

Axline (6, pp. 10-15) advances a tentative theory of personality structure as a rationale for play therapy as a method of helping children help themselves. The basis of her theory is that there appears to be a powerful force within the individual which strives continuously for complete self-realization. This drive toward independence, maturity, and self-direction is expedited if the individual is allowed to be himself, to accept himself, and be accepted by others,
and to be accorded the sense of dignity to which every human being is entitled.

The individual undergoes a constant reorganization and integration of his attitudes, feelings, and thoughts through psychological and environmental forces which change his perspective and focus. The resulting flexibility of personality and behavior makes possible an awareness on the part of the individual that he has a part to play in the direction of his life. When he accepts the responsibility of self-direction, he is able to plan his own course of action with authority and accuracy.

According to Axline (6, p. 13-14) the well-adjusted individual consciously and purposefully directs his behavior by evaluation, selectivity, and application toward his ultimate goal of self-realization. The maladjusted individual lacks the necessary self-confidence to develop his plan of action openly, attempts to move toward self-realization vicariously rather than openly, and does little to direct this drive in directions which would be more constructive and productive. His inner self attempts to approximate a full realization of self which is not consistent in terms of his behavior. The greater the inconsistency between behavior and the concept of self, the greater the degree of maladjustment.

For Axline (6, p. 16) play therapy is an opportunity for the child to experience growth under the most favorable conditions. The child plays out his feelings of frustration,
aggression, tension, insecurity, fear and confusion in the open where they can be faced, controlled, or abandoned. "Playing out" affords emotional relaxation, and it is at this stage that the child begins to realize that he has the power within himself to think for himself, to make his own decisions, to become psychologically more mature, to be an individual in his own right, and through these releasing experiences to realize himself as a person.

Axline (7, pp. 53-63) further defines play therapy as a relationship which enables a child to utilize the capacities within himself to develop a constructive and happier way of life. Learning is a cumulative and integrative process, affected by the individual's unique and personal perception of himself. In order for a child to learn how to function on his own, it is necessary for him to experience an increased awareness of his feelings, a sense of measuring himself against himself, a seeking for an understanding of himself that will bring inner peace, and a feeling of being at one with the world.

Play therapy is, according to Axline (7, p. 16), "... a play experience that is therapeutic because it provides a secure relationship between the child and adult so that the child has the freedom and room to state himself in his own terms exactly as he is at that moment in his own way and in his own time."
Kawin (33, pp. 14-16) describes play therapy as diagnostic in terms of understanding the child's needs and the underlying causes of his problems and as therapeutic in terms of providing acceptable outlets for emotional release. Seeman (57, pp. 493-500), in discussing the implications of play therapy to the educational setting, states that the effectiveness of the process is dependent on the relationship between the child and the therapist. It includes the child's expression of his feelings. Basically, play therapy is a learning situation for the child; it means reorganizing old attitudes and learning new ways of feeling and behaving toward himself and others. Play is the natural mode of self-expression for children.

Play therapy, as seen by Solomon (62, pp. 296-300) is a device for modifying the behavior of the child. The child uses play as a means of communication with the outside world, and the therapist uses the relationship as a means of contact with the child's world. The play situations are living experiences for the child, and according to Solomon, the child survives his own instinctual expressions in experiences with the therapist, and thereby gains confidence in all human relationships.

The "third person" approach that play therapy provides is considered by Mann (46, p. 14) to be successful treatment. While being involved in play, the child can "view objectively
what is going on at the same time that he is actively participating in an intimate discussion of his own attitudes."

Moustakas (50, pp. 79-99) traces the emotional growth of a well-adjusted child from the level of infantile undifferentiated feelings, through an ambivalence of feelings period to differentiated and focused feelings. He contrasts this development with that of the disturbed child whose normal emotional growth pattern has been impaired at some level of development. While well-adjusted children are motivated by self-attitudes of acceptance, faith, and respect, disturbed children are motivated by feelings of anxiety and hostility. Moustakas has found that through an interpersonal relationship in play therapy, the child reflects his attitudes in his symptoms and problems. The relationship allows him to grow through the expression and exploration of the various levels of the emotional process. As attitudes are modified, the child's symptoms and problems disappear and he achieves emotional maturity. Play therapy allows the child to express both negative and positive feelings. This freedom of expression helps the child to feel adequate and able to express himself in terms of his real potential and abilities.

Arthur (1, pp. 484-498) establishes a rationale for play therapy for children by pointing out her findings that much more material must be drawn, de-symbolized, and interpreted from the activities of children than with adults because of their limited ability to verbalize conflicts.
The aim of all therapy, according to Ginott (28, p. 7), is "to effect basic changes in the intrapsychic equilibrium of each patient. . . . Therapy brings about a new balance in the structure of the personality with a strengthened ego, modified superego, and improved self-image." He finds play to be the most suitable therapeutic medium for children. "Play" in therapy means "... freedom to act and react, suppress and express, suspect and respect"; the usual recreational meaning of the term does not apply.

Hammer and Kaplan (31, p. 9) point out from a psychoanalytic orientation that the choice of play therapy or a verbal form of therapy should be determined by the particular needs of the child in question. The child who, for whatever reason, has not developed adequate speech would likely respond only through the medium of play. In addition, children who are overly inhibited in terms of feeling or motoric motility and children who are overly fantasy-ridden or withdrawn appear to be more easily helped in the play therapy setting. Here it is possible for the child to actively discharge his pent-up feelings and energies without fear of incurring the anger of an adult.

Hammer and Kaplan (31, p. 10) say it is not the playing per se that is the essence of play therapy. Play provides the therapist with a microcosm of the child's world and makes possible the therapeutic relationship between child and therapist which is so necessary for the achievement of emotional growth and maturity. Bringing feelings out into the
open is not necessarily therapeutic. It is the bringing out of feeling in the presence of someone who not only accepts the feelings, but understands them and communicates his understanding, that is therapeutic.

The Therapist in Play Therapy

The role of the therapist in client-center play therapy is a unique one. He enters the playroom, according to Axline (6, pp. 64-67), not as a supervisor, not as a teacher, not as a parent-substitute, but as a person who is totally committed to the philosophy of human relationships which "... stresses the importance of the individual as a capable, dependable human being who can be entrusted with the responsibility for himself." He is at all times actively alert and sensitive to what the child is doing and saying. He is understanding, accepting, and genuinely interested in the child. Because he respects the child, he treats him with sincerity and honesty; he is straightforward and at ease.

The age and sex of the therapist seem to be of no importance in terms of success in working with children. The important element seems to be the underlying attitude of the therapist toward the child. Only if he is honest and consistent in his complete acceptance of the child will he be able to be himself fully. Acceptance negates passing judgment. Every individual has the right to be himself and to make his own decisions.
Axline (6, pp. 68-75) further defines the therapist as an adult with whom the child can express himself in any way he chooses. Since he does not have to be concerned with pleasing the therapist, his life, openly charted, can become a happy and exciting adventure.

Solomon (62) found that it is possible to establish a meaningful relationship even with children who are completely withdrawn from reality. It is a test of the therapist's acumen to be able to use the play medium as a means of entering the child's world.

Moustakas (50, pp. 79-90) notes that the play therapy process does not occur automatically in a play situation. It becomes possible only in a therapeutic relationship where the therapist responds in constant sensitivity to the child's feelings, accepts the child's attitudes, maintains a sincere belief in the child and his abilities, and develops a deep respect for him as he is.

In analyzing therapist-child interaction in play therapy, Moustakas and Schalock (53, pp. 143-157) report that their data revealed that the therapist's primary role in therapy with well-adjusted children as well as with maladjusted children was that of "being there", interacting with the child by observing, listening, and making statements of recognition.

Hammer and Kaplan (31, pp. 28-29) suggest that researchers who have concentrated their efforts toward the development of systems and techniques of therapy are now beginning to recognize
that the personality of the therapist may be an equally, if not more, important variable in the determination of success in therapy. They see as essential to the development of an effective therapist an awareness of an openness to his own personality characteristics, the ability to communicate, sexual and emotional maturity, and the ability to relate well.

Cognitive knowledge of the therapy process is not enough for the practice of therapy with children, according to Hammer and Kaplan (31, p. 35). The personality and natural faculties of the therapist are equally, if not more, important. "Success in therapy with children depends as much, if not more, on what the therapist is than on what he does."

Good therapists have strong impact values. They have a natural capacity to instill in others a feeling of comfort and security without really trying to achieve this as a deliberate goal. The good therapist is sensed, say Hammer and Kaplan (31), as genuine with a warmth that emanates within and warms those around him. He is not a role player or technician. He feels himself to be an authentic person, and this is communicated to the child who immediately knows this is someone he can depend on for strength and support should he need it. This is a kind of security that the child in therapy has rarely experienced. Now he can take a chance, try new behaviors, experiment with new attitudes, and experience new feelings.
Ginott (28, pp. 124-134) emphasizes the impact of the therapist's personality on children in therapy. He says that children tune in on and respond to not only the fundamental attitudes of the therapist but to transitory feelings and errant thoughts which the therapist may erroneously believe are hidden. Ginott differentiates between the personality traits and training techniques of the child therapist and the therapist who works with adults. Training in adult therapy does not necessarily transfer to child therapy.

The main role of the therapist, according to Ginott, is that of creating an atmosphere in which the child is motivated to learn about his self and his world. He does this by experiencing in his own person an acceptance of the child as he really is and by communicating this acceptance to the child. If he is able to accomplish this, the child is free to explore and express fears, hatreds, guilt, joys, as well as his strivings for appreciation, independence, and status. The therapist has no reservations and sets no conditions for acceptance. He is consistently non-judgmental, able to listen with sensitivity, and maintains an unwavering regard for the child.

The Playroom and the Toys

The selection of toys for the playroom is a matter of contradiction. With few exceptions, the selection is based on intuition rather than investigation. Ginott (28), Arthur (1)
and Slavson (6) advocate a playroom with many enticing toys, while Fraiberg (26) thinks that therapy proceeds more effectively when the child is given only a few toys so that he is not absorbed in fancy materials and fascinating activities.

Ginott (29, pp. 243-246) feels that the child, through the manipulation of toys, is better able to show how he feels about himself and the significant persons and events in his life, than he is able to express in words. For this reason he feels that the selection of toys cannot be left to intuition. He formulates criteria for the selection of appropriate toys for play therapy with children under the age of ten. A treatment toy should: (a) facilitate the establishment of contact with the child, (b) evoke and encourage catharsis, (c) aid in developing insight, (d) furnish opportunities for reality-testing, (e) provide media for sublimation.

The feeling being expressed through play with toys may be clearly understood by the child, but even the expert therapist may not always share this understanding. In choosing toys which facilitate the therapeutic relationship, Ginott recommends materials whose presence reflects permissiveness. The playroom should provide some toys, tools, and activities which have been refused the child in the past. In choosing toys which encourage catharsis, he warns against assuming that children project their emotional needs on any play material and that all acting out has therapeutic value. In
planning for therapeutic catharsis, the playroom should be furnished with toys that elicit acting out related to the child's fundamental problems. Materials which evoke hyperactivity should not be included. For reality testing, a playroom should contain materials of graded difficulty so that each child is able to achieve some measure of success. Ginott believes it is also important to offer children opportunities to enjoy forbidden pleasures in acceptable substitute ways.

Lebo (37, pp. 23-24) states that the selection of toys for play therapy should be objective rather than inferential. He developed a verbal index formula from a study based on actual use of the toys, statements made while the toys were in use, and the expressive variety of the statements made. A rank order arrangement of the twenty-eight best toys, based on their obtained Verbal Index are: doll house, family, and furniture, poster paints, brushes, paper, easel, paint jars, sandbox, blackboard and colored chalk, cap guns and caps, coloring books, hand puppets, balloons, nursing bottles, films and viewers, water in basin, pop guns, bubble goo, coffee pot, cord and rope, animals, wood, balls, crayons, baby dolls, bow and arrows, clay, cars, checkers, shovel, masks, toy soldiers, and water colors.

Play therapy rooms are meant to be therapy rooms rather than merely play rooms. Play materials have value primarily as children are able to express themselves through them (59).
Mann (46, pp. 14-19), in writing about persuasive play, found the medium of "doll dramas" useful as a technique for bringing about changes in behavior. He found that the dramas enacted by the child as he played with the dolls were more realistic if the child was also provided with toy furniture which he could arrange, with appropriate sets, on a miniature stage. The themes of the dramas almost always concerned difficulties which had appeared at a specific time in the child's life situation.

Axline (6) says that while it is desirable to have a room set aside and furnished for the play therapy room, it is not absolutely necessary. She mentions effective therapy which took place in corners of schoolrooms, nurseries, and in workrooms. However, she suggests that if money and space are available, a special play therapy room with its own furnishings should be provided. The room should be soundproofed, have a sink with running water, have protected windows, and floor covering which are strong and easily cleaned. Playthings should be simple in construction and easy to handle. They should be durably constructed. All materials should be stored on shelves which are readily accessible to the children. She recommends letting the child make his own choice of materials with which to play, rather than structuring the session by making only therapist-selected toys available to him.

Toys and materials should be selected which are consistent with the specific goals of therapy according to Hammer.
and Kaplan (31, p. 13). They choose materials for diagnostic purposes, materials for building frustration tolerance, materials for children who need to be more aggressive or expressive, materials for improving the sense of adequacy and sexual identification, materials for promoting the therapeutic relationship, and materials for promoting sublimation.

The Process and Outcomes of Play Therapy

The outcomes of client-centered play therapy have been tested by Dorfman (22). She hypothesized that personality changes occur during a therapy period, do not occur in the same child during a no-therapy period, and do not occur in control cases. Roger's Test of Personality Adjustment, Machover's Human Figure Drawing, a verbal sentence completion test, and follow-up letters to the participants were used to test these hypotheses. The experimental group of twelve boys and girls, ages nine to twelve, were of average intelligence but were considered maladjusted by their teachers. The experimental group was tested at a "pre-wait" time thirteen weeks before therapy, at pre-therapy time which was immediately before therapy began, at post-therapy time, immediately after therapy, at follow-up time which ranged from a year to a year and a half after the therapy ended. Dorfman used an "own-control" method which allowed her to compare test-score changes during a no-therapy and therapy period with each child serving as his own control and a "time control" in
which a separate group of seventeen children was given pre- and end tests over a time interval which was equal to the experimental group's therapy period.

Dorfman found that reliable test improvements occur concomitantly with a series of therapy sessions (average number of sessions was seventeen). She also found that time alone does not produce reliable improvement on tests. Two subsidiary hypotheses, (therapy can be conducted in a school setting by an outsider; child therapy is possible without parent treatment) were also supported by Dorfman's findings.

Moustakas (52, pp. 225-230) reports a study which was concerned with normal children who are faced with a disturbing new family experience which they consider to be threatening. Two children experiencing anxiety over the arrival of a new baby in their families were studied. These children were given an opportunity to resolve their feelings in situational play therapy sessions. Each child gained in terms of emotional insight and feelings of security and comfort following play therapy.

Client-centered play therapy has also been found to be effective in helping children solve reading problems. In a descriptive study of the use of this medium with poor readers, Axline (5, pp. 61-69), found that play therapy was successful in building up a readiness to read and, at the same time, in bringing about a better personal adjustment in the students.
In a later study (8, pp. 156-161) she analyzed the play-responses of three children in terms of the emotional attitudes they revealed. She found the "reading problem" of each of the children to be emotional in nature and pointed to the need for the teacher or therapist to be sensitive to the revelations of the child's play. Here again, she made the point that if the therapist provides an atmosphere that is accepting, the child can and will help himself.

Bills (11) found that play therapy helped the retarded reader improve in reading ability as a result of a change in the child's concept of himself as a poor reader to that of a good reader. Following six weeks of play therapy, he noted the following outcomes: (1) significant improvement in reading ability; (2) measurable changes occurred after six individual play sessions and three group sessions; (3) improvement occurred in the group members although there did not appear to be common personality maladjustments within this particular group.

In another study, Bills (12, pp. 140-149) selected eight well-adjusted but retarded readers from a third grade class. Following individual and group play therapy experiences, he found not only significant increases in reading ability, but also that the gain in ability was directly proportional to the amount of emotional maladjustment present in the child. He found, also, that the gains a child achieves through the
play therapy experiences are well-rounded and not specific to any one subject matter field.

In a follow-up study in which Axline (7, pp. 53-63) asked child participants to describe their play therapy experiences as they remembered them, the experiences were summarized as having been emotional in nature; experiences which sharpened the children's awareness of themselves as "feeling" individuals. The children changed their self-perceptions and became "real persons in a doing world". Axline concluded that if adjustment is defined as being free to act spontaneously, to be one's self, to be a doing person, to be a real person, to be a together-person in a real world, to be a person who can "feel his feelings", then these children had achieved adjustment in self-awareness, self-acceptance, and self-actualization.

Bost and Martin (15, pp. 276-280) studied the role of play in the clarification of reality for nineteen five-year old kindergarten children. Tape recorders and a modified diary recording were used to keep a running record of the play as it progressed in the kindergarten. The following conclusions were drawn:

a. Only infrequently in their play did the children demonstrate a distinct recognition of the bounds between reality and fantasy.

b. The extensive range of facts, theories, and ideas concerned with physical reality dealt with in the course of play led to the conclusion that the children's concept of physical reality were clarified and extended through the play.
c. A great deal of the content of the play was given to playing out social roles and relationships, with a resultant clarification of social reality for the participating child.

d. There was evidence that in their play, the children explained and clarified rudimentary concepts of good and evil.

e. The children's concepts of cause and effect and their ability to reason hypothetically were clarified through the play experience.

Landisberg and Snyder (34, pp. 203-214) studied four play therapy cases of children, ages five and six, using three different therapists. An analysis was made of all therapist and client statements made during the play sessions. The major conclusions of the study were (1) the therapists were consistently non-directive in their approach; (2) three-fifths of all the responses were made by the children; (3) non-directive statements made by the therapists preceded 84.5 percent of all client responses; (4) slightly less than 10 percent of therapist statements were simple acceptance of client remarks; (5) the child released much feeling during therapy with emotional release rising from 50 per cent during the first two-fifths of therapy to 70 per cent during the last three-fifths; (6) negative feelings increased in frequency during therapy; (7) the major part of the child's feelings was directed toward others rather than toward himself or the therapist; (8) no statements were made which could be classified as insightful, leading the examiners to suggest that the
amount of insight achieved in play therapy is closely related to age and intellectual maturity.

Client-centered play therapy does not formally consider the influence of aggression or age in its method. Studies of the process of non-directive play therapy generally reveal that children undergo the same process, no matter what their age. Lebo and Lebo (37) tested this generalization by formulating certain hypotheses based on a theoretical consideration of aggression and age. The hypotheses were then tested on a group of eighty-nine children of normal intelligence selected on two bases. The first of the bases was that of age; there were twenty, twenty-two, twenty-four, and twenty-three children aged four, six, nine, and twelve years respectively. The second bases for selection was teachers' ratings of classroom behavior. According to these ratings, twenty-six children were designated as aggressive, twenty-seven as intermediate in aggression, and thirty-six as non-aggressive. These children were given three one hour individual sessions of non-directive play therapy with the same therapist in the same play room. Verbatim notes were made of their speech and other vocal responses. It was according to these categories that specific predictions were made. The outstanding findings of this study would appear to be that amount of aggression and age exert a marked influence on the amount and variety of speech produced by normal children in the non-directive play therapy situation.

It was found that the aggressive child makes more aggressive statements, threats to limits set for the play room, and
expressions of decisions. His speech contains more story units and more favorable statements about himself. He makes more attempts to establish a relationship with the therapist than non-aggressive children. Non-aggressive children have more conventional expression in their speech than aggressive children. Six year old children were found to make the majority of aggressive verbalizations, followed closely by the four year olds, who were, in turn, followed by the nine year olds. The twelve year old children made the least use of speech falling into this category.

Younger children made more attempts to relate to the therapist and made more favorable comments about themselves than did children twelve years of age. Twelve year old children employed fewer story units in their speech than did younger children. Children in the six year old age group made the most use of story units.

Professional people who work with children must often decide whether the negative attitudes of hostility, anxiety, rigidity, or regression constitute basic personality disturbances or whether they are merely variations of normal behavior. Moustakas (51, pp. 309-325) studied a group of nine well-adjusted children and a group of nine disturbed children, all four years of age and matched in other characteristics. Each group was given four play therapy interviews. A total of 241 negative attitudes were reliably selected from the first and third play interviews. Both groups expressed about the same
types of negative attitudes. The disturbed group expressed a significantly greater number of negative attitudes with considerably greater severity of accompanying feeling. The attitudes expressed were more severe negative attitudes of hostility, hostility toward home and family, cleanliness anxiety, orderliness anxiety, and regression in development. The well-adjusted children expressed more frequently, but not more intensely, the negative attitudes of hostility toward siblings. Though both factors were significant, intensity of attitudes differentiated disturbed children from well-adjusted children more clearly than frequency.

Moustakas found that as therapy progresses, the negative attitudes of the disturbed child may become similar to those of the well-adjusted child. These attitudes are expressed more clearly and directly, less frequently, and with mild or moderate intensity of feeling.

While Landisberg and Snyder (34, pp. 203-214) used adult categories of statement content to determine what really goes on in play therapy, Finke (24) analyzed children's statements made during play therapy to devise her own categories for use in the study of the process of play therapy. She emphasized expressions of feeling, as these were felt to mirror the child's changing emotional reactions resulting from play therapy. Complete protocols from six play therapists concerning six children, ages five to eleven, who had been referred for behavior problems were selected. She found
that different children undergoing therapy with different therapists showed similar trends which appeared to divide play therapy into three stages:

(1) Child is either reticent or extremely talkative. He explores the playroom. If he is to show aggression at any time during therapy, a great deal of it will be exhibited at this stage.

(2) If aggression has been shown, it is now lessened. The child tests the limitations of the playroom. Imaginative play is frequently indulged in here.

(3) Most of the child's efforts are now expanded into attempted relationships with the therapist. The child tries to draw the therapist into his games and play.

Since no trends for negative statements were found and since the verbal characteristics of adult counseling sessions did not appear, Finke concluded that non-directive play therapy has its own characteristic pattern which is repeated in case after case.

Lebo (40, pp. 330-336), using Finke's categories, undertook a study of the possible relationship between chronological age and the types of statements made by children during play therapy.

Twenty children were given three play therapy sessions by the same therapist in the same playroom. The children were reasonably equated for intelligence and social adjustment. Five age stages were represented with two boys and two girls in each stage. Children were selected who were four, six, eight, ten, and twelve years of age.
Fifteen pages of verbatim style notes were selected by a table of random numbers from the 166 pages of protocol. These fifteen pages were then categorized by three experienced play therapists. Their percentages of agreement were adequately similar to one another. All of the protocols were then analyzed by the examiner.

It was found that maturation, as represented by chronological age, did seem to account for some definite trends in the types of statements made by children in the play therapy situation.

As the children became older, they told the therapist fewer of their decisions. They spent less time on exploring the limitations. They made fewer attempts to draw the therapist into their play and they expressed more of their likes and dislikes.

Play therapy has also been used to treat children who had confirmed allergic symptoms. Miller and Baruch (48) cite a five-year old asthmatic boy who used attacks of asthma to gain contact with his mother as representative of their subjects and treatment. His asthmatic attacks cleared after five months of play therapy.

Emotional factors may be the underlying cause in some cases of children who are seen as mentally deficient. Axline (4) reports evidence which indicated marked improvement in IQ scores for some children who have completed play therapy. She explains the increase in IQ scores by saying the child was freed from emotional restriction and could thus more adequately express his true capacities.
Fleming and Snyder (25, pp. 101-116) attempted to determine if measurable changes in social and personal adjustment resulted from non-directive play therapy. Three simple personality tests were administered to forty-six children. Seven children, ages eight to eleven years, who scored poorly on the tests were selected for play therapy. After a period of twelve weeks, thirty of the original forty-six children were available for retesting. The three girls in the group showed improved adjustment indicating a greater amount of positive feeling toward themselves. The least amount of improvement for the girls was in the social area. Except for one who showed poorer adjustment, the four boys made no significant changes. The control group showed no change at all on their post-test scores. Fleming and Snyder concluded from an analysis of the data that the greatest change for the subjects was in personal feeling toward the self and in day dreaming. They offered the theory that personal changes in adjustment must precede social change.

Cowen and Cruickshank (19) and Cruickshank and Cowen (20) supplemented an early report of Axline's (6) concerning the use of play therapy with the physically handicapped child. Five physically handicapped children, each of whom had at least one emotional problem were given thirteen sessions of play therapy. The teachers and parents of the children made an essay-type report on the child's problems at the start of the program and also when it was completed. Cruickshank and
Cowen found that three of the children showed considerable observed improvement at home and at school. One child made slight reported gains, and one showed no improvement. They concluded that "the non-directive play group offers an ideal setting for the self-solution for a particular type of emotional problem, namely those stemming from the specific disability of the physically handicapped child (20, pp. 193-215)." 

Moustakas (50) found that disturbed children show the following process in play therapy:

(a) diffused negative feelings, expressed everywhere in the child's play; (b) ambivalent feelings, generally anxious or hostile; (c) direct negative feelings, expressed toward parents, siblings, and others, or in specific forms of regression; (d) ambivalent feelings, positive and negative, toward parents, siblings, and others; (e) clear, distinct, separate, usually realistic, positive and negative attitudes, with positive attitudes predominating in the child's play.

Two groups of children, nine in each group, who were living in an orphanage were studied by Cox (17). The two groups were matched on several measures of adjustment plus a sociometric rating. The experimental group was given ten weeks of play therapy while the control group received no therapy. The adjustment scores and peer-ratings of about half the children in the experimental group showed improvement immediately after therapy and at a follow-up fifteen weeks later. The control group showed no gains.
Levi (43) studied the variables affecting outcomes of play therapy. The variables were type of parents, concomitance of parent treatment, identity of therapist, age length of treatment, sex, and symptoms of the child. Of these variables, only the therapist's identity and the length of treatment were found to be related to outcome. The therapist's identity was very significantly associated with outcome while the length of treatment was significant only when the therapist was of merely ordinary competence. Levi's study concurs with Dorfman's (22) finding that child therapy is possible without parent treatment. In Levi's study, children in therapy improved about the same with or without parent treatment.

Seeman, Barry, and Ellinwood (58) report a recent study concerned with play therapy outcome. One-hundred fifty second and third grade children were given a modified version of the Tuddenham Reputation Test, and the teachers of the children completed the Radke-Yarrow Teacher Rating Scale. Both of these instruments make possible the classification of behavior into categories of high adjustment, aggression, and withdrawal. A composite adjustment rating was devised, and the sixteen children rated lowest in adjustment comprised the subjects in the study. Eight children were placed, by random selection, in the experimental group, and eight were placed, by random selection, in the control group. Both groups were equivalent in age, sex, total adjustment scores, and type of adjustment.
Each child in the experimental group came to the clinic once a week for individual play therapy. The median length of play therapy for the group was thirty-seven sessions. The rating scale and reputation tests were administered before therapy, at the end of the school year which was seven months after therapy began, and finally, one year after the second testing. The interval from first to last testing was nineteen months.

Statistical treatment of the data indicated clearly that children who were involved in a play therapy experience were perceived by others as significantly less maladjusted after therapy. Comparable shifts in interpersonal judgments did not occur in the control group. The findings in this study indicate that a striking reduction in aggressiveness may result from the permissive therapeutic climate in play therapy and that children as young as seven or eight may change in the absence of systematic environmental alteration.

Summary

Ginott (28), Levitt (45), Lebo (38), and Dorfman (23) have presented summaries of research in play therapy. Only a few studies have been published since these summaries were reported. As these writers point out, the problems encountered in conducting research in play therapy are formidable and apparent. The basic research issues of comparability of groups and adequacy of the criterion measures, while being attacked, are not yet solved. Most researchers would agree
that the problem of adequate controls is the greatest stumbling block they face in attempting to set up experimental procedures in any kind of therapy research. Self-initiated requests for therapy, personality organization, and motivation for change are variables which often obscure the effect of the therapeutic process itself.

A fairly common basic description of play therapy has emerged from the literature devoted to this subject by researchers and writers of the client-centered school. It is the relationship between the therapist and the child which is the key to the success or lack of success which results from the therapy. This relationship involves acceptance of self and others by child and therapist. Acceptance of self and others becomes possible when the individual is allowed to be himself freely with no pressure to explain, defend, deny, or change. When this kind of relationship is established, the curative forces which exist within each individual, regardless of age, are released, and the individual begins to accept the responsibility for his own direction (6).

Play therapy is a learning situation. By providing outlets for emotional release which are accepted by the therapist, the child reorganizes his old attitudes and learns new ways of feeling and behaving (33). These new feelings and behaviors are tried out in the safety of the therapy relationship and gradually replace the old feelings and behaviors in the child's relationships with others.
The client-centered therapist sees the child as a person who is capable of assuming the responsibility for himself. Actively sensitive to what is being done and said, the therapist is always "there", communicating his understanding and acceptance. The therapist "is"; he is neither a role-player nor a technician (6, 53, 28, 31).

With few exceptions, the selection of toys for the play therapy room is based on intuition rather than investigation. The child is better able to show how he feels about himself and others through the manipulation of toys than through the use of words; thus an intuitive choice of toys is not reliable. Toys should be chosen that facilitate contact with the child, evoke and encourage catharsis, aid in developing insight, furnish opportunities for reality-testing, and provide media for sublimation (29). Most therapists are in agreement with Ginott's stated criteria above. There is less agreement on deciding the number of toys to be made available to the child at a given time and whether the child is free to make his own choice of play material.

There is little research evidence on which to base the premise that play therapy is effective in bringing about changes in behavior. (The few results which have been reported need further study and testing.) Controlled studies have shown that test scores improve following play therapy, that play therapy can be conducted in a school setting by an outsider, and that child therapy is possible without parent
treatment (22). There is some evidence that emotional insight and feelings of security and comfort follow play therapy (50), and several studies indicate that it is an effective means of improving reading ability regardless of the cause of the disability (5, 8, 11, 12). Self perceptions may be sharpened as a result of play therapy leading to increased self-awareness, self-acceptance, and self-actualization (7). There is some indication that clarification of reality may occur as a result of play therapy particularly as it applies to social role, concept of good and evil, as well as cause and effect (15). A recent research study found a striking reduction in amounts of aggressiveness in children following play therapy and that such changes can occur without a concomitant change in the children's environment. It was also reported that these children were perceived by others as significantly less maladjusted following play therapy (59).

Both Ginott (28) and Lebo (38) point to the fact that most of the literature devoted to play therapy leads one to erroneously assume that the principles and methods of client-centered play therapy are firmly established. They strike out against the substitution of enthusiasm, belief, and statements such as, "It works, if you only try it" for controlled objective study.
CHAPTER BIBLIOGRAPHY


47. Meister, David, "Adjustment of Children as Reflected in Play Performance", *Pedagogical Seminary and Journal of Genetic Psychology*, LXXXIII, (September, 1948),


CHAPTER III

METHODS AND PROCEDURES

This study was conducted to investigate changes in behavior which occur as a result of play therapy and to determine that such changes do not occur in the absence of play therapy. It was a direct outgrowth of an ongoing program developed at the Pupil Appraisal Center of North Texas.

The Pupil Appraisal Center of North Texas began active operation on July 1, 1967. It had as its objectives

(1) upgrading the quality of education in the Denton County Area by helping children free themselves of emotional, behavioral, reading, speech and/or hearing problems;

(2) supplementing services already offered to school children in the area by providing guidance and remedial therapy;

(3) helping teachers in the schools to recognize the different types of problems children may have, and to understand that children may, through proper remedial work, be able to solve many of these problems (11, p. 7).

The Pupil Appraisal Center of North Texas was an outgrowth of the North Texas Metropolitan Center for Educational Services. Researchers from this parent organization estimated that approximately ten per cent of the student population of Denton County needed special attention that appeared to be beyond the scope of the available school services. For Denton County, this estimate would be approximately 1,240 school
children. Schools served by the Pupil Appraisal Center are the public schools in Denton, Sanger, Krum, Ponder, Lewisville, Northwest, Argyle, Little Elm, Lake Dallas, Pilot Point, Aubrey, and a private school, Selwyn (11).

The Pupil Appraisal Center of North Texas was developed jointly by the Denton Independent School District, Chester O. Strickland, Superintendent, and North Texas State University, Dwane Kingery, Dean, School of Education. The primary responsibility for the development, implementation, and evaluation of the Center has been with members of the faculties of the School of Education and the Speech and Hearing Clinic, North Texas State University.

The staff of the Pupil Appraisal Center is headed by W. A. Miller, Jr., Director, Louise Allen, Supervising Specialist in Reading, Garry Landreth, Supervising Specialist in Counseling, W. S. Jacquot, Supervising Specialist in Speech/Hearing, and Ruth Zepeda, Specialist in Speech/Hearing. The remainder of the staff is made up of doctoral students who assist in each of the three areas and interns who are involved in doctoral program practicums (11).

The Pupil Appraisal Center has a fully equipped play therapy room containing toys and materials suggested by Axline (1) and Ginott (7). It has a one-way glass mirror which is used for supervisory observation. The three doctoral level graduate assistants who were assigned to work with the students in this study are employed at the Center as counselors and play
therapists. All three had completed course work in play therapy. Two had completed practicums in play therapy under the supervision of Garry Landreth, Supervising Specialist in Counseling, and the other had experience in a weekly televised educational play-learn program with small children. Two of the graduate assistants had public school counseling backgrounds; the other had clinical experience in a hospital.

Landreth, Allen, and Jacquot (9) describe play therapy at the Pupil Appraisal Center as a process, which, when completed, enables the child participant to become more responsible for directing his own behavior not only in the play therapy room but also in his school classroom, his home, and his everyday life.

In the safety of the play therapy room, the child can express his confusion, insecurity, hostility, or aggression without feeling guilty about having done so. Positive feelings and attitudes are also gradually expressed. Through the expression of the positive and negative aspects of himself, the child comes to view himself as neither completely good nor completely bad. He learns that it is permissible to possess negative feelings and more significantly he learns acceptable, less self-defeating ways of expressing this negative part of himself. He discovers that he no longer needs to defend those negative aspects of himself and can, therefore, devote more of his energy toward positive psychological growth and maturity (9, p. 87).

The play therapy situation at the Pupil Appraisal Center is one of acceptance of the child with an absence of hurry. There are no pressures, no attempts to change the
child's behavior, no criticisms, few limits. The atmosphere remains consistent. The child is helped to be himself by the therapist who is sensitive to the needs and feelings which he expresses verbally or through his play. This empathic, understanding, caring adult helps the child explore with greater openness the feelings he has about himself, other children, and adults.

Subjects

The schools served by the Pupil Appraisal Center constitute both rural and urban populations with the rural population predominating. The per cent of total county school population enrolled in the individual schools varies from .76 to 51.38 (11, p. 76). It is probable that, due to this widely divergent size in the school populations and the fact that students come from both rural and urban areas, the educational backgrounds of the students referred to the Pupil Appraisal Center are different.

There are certain behavioral and performance characteristics present in the students who are likely to be referred to the Pupil Appraisal Center. These are

1. Low reading ability—at least one year below grade level (grades 1-4), at least two years below (grades 5-12).
2. Very poor scholastic performance in all areas.
3. Underachieving.
4. Chronic disturbance of other persons' achievement.
5. Withdrawn.
7. Past history of poor school adjustment.
8. General lack of interest in school work.
9. Poor attendance at school.
10. Poor communication due to speech impairment.
11. Poor communication due to hearing impairment.
14. Poor motor coordination.
15. Impulsivity.
16. Short attention span.
17. Follows no logical pattern in behavior.
18. Poor "stick-to-it-iveness".
19. Wanders aimlessly about room apparently concerned with everyone's business.
20. Seldom considers consequences of behavior.
21. Rapid changes in mood and temperament.
22. Performs inconsistently and with marked variability in the various school subjects.
23. Excessive daydreaming.
24. Excessive bullying, fighting, and similar aggressive behavior.
25. Recurring instances of theft.
26. Cries easily and often.
27. Malingering.
28. Prolonged sadness.

One or many of these characteristics may be exhibited by the students who are referred (11, pp. 13-14).

During the late spring and summer of 1968, eighty-two referrals were made to the Pupil Appraisal Center. These referrals included sixty-nine boys and thirteen girls. From the total referrals, twenty boys and seven girls, six to eleven years of age, of at least average intelligence, who were referred by their schools for help with behavior problems, were chosen for this study. The twenty-seven students chosen comprised the total number of referrals made which met the requirements of age, intelligence, and specified need for
play therapy as determined by six hours of diagnosis and evaluation at the Pupil Appraisal Center.

Description of the Instruments

In summarizing the present status of research in play therapy, Ginott (7) pointed to the need for data on behavioral changes expected to occur as a result of therapy. He mentioned specifically that reliable information is needed on changes such as more mature behavior, better interpersonal relations, and more adequate use of intellectual capacities. He noted further that in order to assume that test score improvements reflect actual changes in life adjustment, it would be necessary to gather data concerning behavior outside of therapy from parents, teachers, classmates, and other interested persons.

Sociometric rating (see Appendix) is designed to measure the interpersonal preferences among members of a group. Sociometric measurement gets at feelings or judgments that individuals hold toward each other rather than toward themselves. It has been found useful in obtaining quantitative data on attraction-repulsion patterns in interpersonal relationships (2, pp. 258-275).

Cox (5) found sociometric status to be a relatively sensitive index to individual adjustment before and after play therapy. He used the TAT, an adjustment questionnaire,
and an interview along with a sociometric measure to determine behavior before play therapy and changes in behavior following play therapy. He found results from the sociometric measure to be as valid as those from the other measures in revealing behavior changes following play therapy.

The most widely used general criteria for sociometric testing are based on choice of seating companion, work companion, and play companion. Gronlund (8) states that these three choice situations are general enough to be used at any grade level and that they encompass most activities included in the school day.

In most classroom situations, it is expected that the choices made by pupils will be used to rearrange the class groups. This practice is highly desirable, but there are times when it is necessary, for diagnostic and research purposes, to use hypothetical criteria. In this case, it is important that the criteria at least reflect choice situations that are highly probable.

The California Test of Personality provides sixteen scores (self-reliance, sense of personal worth, sense of personal freedom, feeling of belonging, withdrawing tendencies, nervous symptoms, total personal worth, social standards, social skills, anti-social tendencies, family relations, school relations, occupational relations, community relations, total social adjustment, total personality adjustment). The
test has been found useful in research and is considered to be among the better personality inventories available. Tables of internal consistency indicate a fair degree of reliability for the total and the two main components - social and personal adjustment. Reliability of the total scores range from .918 to .933 based on the split-half method. Reliability of the principal component of self-adjustment range from .888 to .904 and of Social Adjustment from .867 to .908. No data are given on validity other than an appeal to the face validity of the items. Percentile norms are said to be based on over one thousand cases for the primary and elementary forms of the test. These samples form a broad geographical representation (4).

The Vineland Social Maturity Scale is used with mothers to assess quantitatively their children's behavior before and after therapy. This scale is based on the method of report rather than observation or examination. Scores derived from the 117 items are converted into a social age and then into a social quotient. The scale was developed to test social maturity from birth to twenty-five years of age. Standardization data were obtained from a total of 620 subjects. Cruickshank and Teagarden (3) report research done with the scale which attests to its value and usefulness as an index for the measurement of growth and change.

School grades assess more or less adequate use of intellectual capacity according to the teacher's criteria. For this study, school grades were converted to grade points as follows: A-4, B-3, C-2, D-1, F-0.*

*Appendix
The Haggerty-Olson-Wickman Behavior Rating Schedule A presents a list of fifteen problems to be checked in one of four columns according to frequency of occurrence in an individual. In summating for a total score, weights are assigned in terms of the frequency of seriousness of a given problem. These are standardized weightings (4).

Bonney (2) describes both forms of the Scale, "Schedule A: Behavior Problems Record" and "Schedule B: Behavior Rating Scale" and states that it is well adapted for use in elementary school. "Schedule A" consists of a list of fifteen behavior problems such as cheating, marked overactivity, bullying, and imaginative lying. The teacher checks each child on each of those kinds of problems on a scale of frequency ranging from "never occurred" to "frequent occurrence". "Schedule B" consists of a list of thirty-five questions about the intellectual and personal-social behavior of the pupils.

Cronbach (6) describes the Haggerty-Olson-Wickman Behavior Rating Schedule as a scale used for recording opinions about the behavior and adjustment of children. It is unlike purely descriptive scales in that it is scored to yield a measure of behavior difficulties. Weights were determined by identifying the frequency of each rating in groups of children known to have behavior problems. The scale requires
rating at one of five positions providing a quantitative means of recording and summarizing observations of behavior. Higher scores on this scale indicate a greater degree of maladjustment.

Procedures for Collecting Data

In April, 1968, a preliminary planning session was held at the Pupil Appraisal Center to outline general procedures for conducting the research as a part of the regular program of therapy being offered. Approval to do so was requested by the Director and granted by the Coordinating Committee, a group representing the various schools served by the Pupil Appraisal Center.

During the last two weeks of September and the first two weeks of October, 1968, the measuring instruments were administered along with the Wechsler Intelligence Scale for Children which is given to all students referred to the Center.

All subjects in the study were administered Form AA of the California Test of Personality at the Pupil Appraisal Center. The Primary Form was used with students in the first through third grades; the Elementary Form was used with the remainder of the students. The standardized conditions for testing, as outlined in the manual of instructions were followed by the graduate assistants who are responsible for testing at the Center.
Mothers of the subjects were administered the *Vineland Social Maturity Scale* as a part of the parent interview conducted at the Pupil Appraisal Center. Graduate assistants were instructed to follow the standardized conditions for administering the Scale as outlined in the manual of instruction.

The sociometric measure was administered in the school classrooms of the subjects. The teachers in these classrooms were asked to follow identical instructions in the administration of this measure.

The teachers of the subjects were also asked to follow identical instructions in checking behavior patterns on both schedules of the *Haggerty-Olson-Wickman Behavior Rating Schedule*.

School grades made by the students during the six week period immediately prior to the beginning of the experimental period were requested from their schools.

The twenty-seven referrals who were selected for the study were grouped randomly into three groups. Eleven subjects were assigned to the group which was enrolled for individual weekly play therapy sessions at the Pupil Appraisal Center; this group was referred to as Experimental Group I. Six students were assigned to the group which came to the Pupil Appraisal Center for individual weekly play sessions and was designated Experimental Group II. Ten subjects were assigned to the control group which was designated Group III.
The three groups appeared to be equated in terms of age, sex, intelligence, and adjustment after the random grouping, but it was decided to determine statistically whether significant differences existed in the mean scores, derived from at least three measures, of the three groups before the therapy period began.

The variables selected to determine whether the three groups were balanced were total intelligence quotient score as determined by the Wechsler Intelligence Scale for Children, total adjustment score on the California Test of Personality, and the composite score of Schedules A and B on the Haggerty-Olson-Wickman Behavior Rating Schedule. Pre-test scores on these three measures for all three groups were treated statistically (using the Fisher \( t \) technique) by the Data Processing Center, North Texas State University, (Table I). Fisher \( t \) ratios were determined for Group I and Group II, Group I and Group III, and Group II and Group III.

In Table I, Group I is Experimental Group I, Group II is Experimental Group II, and Group III is the Control Group. Variable 1 is the mean IQ score, Variable 2 is the mean personality adjustment score from the personality measure, and Variable 3 is the mean composite score from Schedules A and B of the behavior rating schedule.
TABLE I

COMPARISON OF MEAN SCORES ON THREE VARIABLES

<table>
<thead>
<tr>
<th>Variable Number *</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Fisher t</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group III</td>
<td></td>
<td>Group I</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>97.80</td>
<td>10.46</td>
<td>99.09</td>
<td>16.52</td>
<td>2.014</td>
</tr>
<tr>
<td>2</td>
<td>83.50</td>
<td>13.65</td>
<td>76.18</td>
<td>13.56</td>
<td>0.8631</td>
</tr>
<tr>
<td>3</td>
<td>79.10</td>
<td>12.83</td>
<td>87.00</td>
<td>14.21</td>
<td>1.3397</td>
</tr>
<tr>
<td></td>
<td>Group III</td>
<td></td>
<td>Group II</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>97.80</td>
<td>10.46</td>
<td>98.83</td>
<td>13.33</td>
<td>1.364</td>
</tr>
<tr>
<td>2</td>
<td>83.50</td>
<td>13.65</td>
<td>61.00</td>
<td>29.30</td>
<td>2.2454**</td>
</tr>
<tr>
<td>3</td>
<td>79.10</td>
<td>12.83</td>
<td>86.00</td>
<td>9.15</td>
<td>0.9901</td>
</tr>
<tr>
<td></td>
<td>Group I</td>
<td></td>
<td>Group II</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>99.09</td>
<td>16.52</td>
<td>98.83</td>
<td>13.33</td>
<td>1.364</td>
</tr>
<tr>
<td>2</td>
<td>76.18</td>
<td>13.56</td>
<td>61.00</td>
<td>29.30</td>
<td>1.5416</td>
</tr>
<tr>
<td>3</td>
<td>87.00</td>
<td>14.21</td>
<td>86.00</td>
<td>9.15</td>
<td>1.460</td>
</tr>
</tbody>
</table>

* Variable No. 1 -- Total IQ score.
Variable No. 2 -- Total adjustment score.
Variable No. 3 -- Total behavior rating score.
** Significant at .05 level.

The value of $t$ required for significance at the .05 level varies depending upon the size of the sample. Using nineteen degrees of freedom, the $t$ value required to show significant differences in the mean scores for Group III and Group I is 2.093 (10). Since the $t$ values derived for the three variables does not equal or exceed 2.093, it may be assumed that no
significant differences exist between the mean scores on the three variables for the Control Group and Experimental Group I.

In the comparison of Control Group III and Experimental Group II using fourteen degrees of freedom, the $t$ value required to show significant differences at the .05 level between mean scores on the three variables is 2.145. No significant differences appear in variables one and three, but the $t$ value of 2.2454 indicates significant difference between these two groups on total personality adjustment as tested by the California Test of Personality. Although this significant difference occurred, there was no significant difference between either one of the two groups and the play therapy group.

For Group I and Group II fifteen degrees of freedom were used to find the value of $t$ required for significance of difference between mean scores at the .05 level. A $t$ value of 2.131 is required, and the $t$ values derived for Groups I and II indicate no significant difference between the two groups on the three variables tested.

At this point, one subject was moved from Experimental Group II, on request of the parents, to the Control Group, and one subject was moved from the Control Group to Experimental Group II to fill his place. The data were rerun (Table II) to determine whether moving the two students resulted in significant differences in the mean scores of the three groups on the three variables.
### TABLE II

COMPARISON OF MEAN SCORES ON THREE VARIABLES

<table>
<thead>
<tr>
<th>Variable Number *</th>
<th>Mean Group III</th>
<th>Standard Deviation Group III</th>
<th>Mean Group I</th>
<th>Standard Deviation Group I</th>
<th>Fisher t</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>100.40</td>
<td>12.05</td>
<td>99.09</td>
<td>16.52</td>
<td>.2068</td>
</tr>
<tr>
<td>2</td>
<td>83.50</td>
<td>13.65</td>
<td>76.18</td>
<td>13.56</td>
<td>.8631</td>
</tr>
<tr>
<td>3</td>
<td>79.70</td>
<td>13.50</td>
<td>87.00</td>
<td>14.21</td>
<td>1.2277</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Variable Number *</th>
<th>Mean Group III</th>
<th>Standard Deviation Group III</th>
<th>Mean Group II</th>
<th>Standard Deviation Group II</th>
<th>Fisher t</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>100.40</td>
<td>12.05</td>
<td>94.50</td>
<td>9.84</td>
<td>.7888</td>
</tr>
<tr>
<td>2</td>
<td>83.50</td>
<td>13.65</td>
<td>61.00</td>
<td>29.30</td>
<td>2.2454**</td>
</tr>
<tr>
<td>3</td>
<td>79.70</td>
<td>13.50</td>
<td>85.00</td>
<td>8.16</td>
<td>.7542</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Variable Number *</th>
<th>Mean Group III</th>
<th>Standard Deviation Group III</th>
<th>Mean Group I</th>
<th>Standard Deviation Group I</th>
<th>Fisher t</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>99.09</td>
<td>16.52</td>
<td>94.50</td>
<td>9.84</td>
<td>.6245</td>
</tr>
<tr>
<td>2</td>
<td>76.18</td>
<td>13.56</td>
<td>61.00</td>
<td>29.30</td>
<td>1.5416</td>
</tr>
<tr>
<td>3</td>
<td>87.00</td>
<td>14.21</td>
<td>85.00</td>
<td>8.16</td>
<td>.2895</td>
</tr>
</tbody>
</table>

* Variable No. 1 -- Total IQ score.
Variable No. 2 -- Total adjustment score.
Variable No. 3 -- Total behavior rating score.

** Significant at .05 level.

No changes were made in the total number of subjects in the three groups, and the same three variables were used for comparison after the regrouping. No significant differences were found among any of the three groups on any of the variables tested with one exception. A t value of 2.131 is needed to indicate a significant difference between mean scores using fifteen degrees of freedom and the .05 level of significance.
The $t$ value of 2.2454 on the second variable in the comparison of Group III and Group II again indicated a significant difference in total personality adjustment on the California Test of Personality for these two groups.

Subjects assigned to the play therapy group began their regularly scheduled fifty minute weekly individual therapy sessions at the Pupil Appraisal Center on November 4, 1968. These students were not identified as members of an experimental group to the play therapist involved.

Three doctoral level graduate assistants in counseling and play therapy worked with the students under the supervision of Garry Landreth. The students were involved in play therapy only; help with reading and/or speech-hearing was delayed until the study was completed. It was decided that all students in the study would continue or begin play therapy immediately after the experimental period of the study was completed. Counselors in the various schools were asked not to initiate special helping activities with any of the children in the study, unless specifically requested to do so by one of the students.

Subjects assigned to the play sessions began their regularly scheduled fifty minute weekly individual play sessions at the Center on November 4, 1968.

Subjects in the Control Group were placed on the waiting list for therapy at the Center. They received no further attention until after the ten sessions of therapy ended.
For most of the students, the experimental period ended on February 2, 1969. A few students who had been ill during the period finished their sessions a little later than the others. Post-tests were administered during the period of February 4-16, 1969.

All subjects in the three groups were given Form BB of the California Test of Personality at the Pupil Appraisal Center. One subject had been dropped from the play therapy group at his parents' request and was not given the post-tests. Mothers of the subjects were given the Vineland Social Maturity Scale at the Center. Teachers of the subjects were asked to check the Haggerty-Olson-Wickman Behavior Rating Schedule. The sociometric measure was again administered in the school classrooms by the subjects' teachers. School grades made by the subjects during the third six week's grading period were requested. All post-tests were administered under the same conditions set for the pre-tests.

Treatment of Data

The research hypotheses were converted to the null hypotheses for statistical treatment.

Data obtained from pre-tests and post-tests on all measures were treated statistically at the Data Processing Center, North Texas State University, for significance of difference between means of small samples using Fisher's t. Fisher's t was determined for all measures between the play therapy group and the play sessions group, between the play therapy
group and the control group, and between the play sessions group and the control group. A significance level of .05 was required for rejection of the null hypotheses for all computations.
CHAPTER BIBLIOGRAPHY


4. ———, The Third Mental Measurement Yearbook, New Jersey, Gryphon Press, 1940.


CHAPTER IV

STATISTICAL ANALYSIS OF RESULTS

The purpose of this chapter is to present and describe the statistical results obtained from this study. Data analyzed were pre-test and post-test difference scores on the criterion measures using the Fisher $t$ technique. The research hypotheses were converted to the null hypotheses for statistical treatment. A significance level of .05 was required for rejection of the null hypothesis for all computations.

Null Hypothesis I

There will be no significant difference in degree of change in interpersonal relationships as measured by sociometric testing in children who have had a minimum of ten weekly individual play therapy sessions, in children who have had a minimum of ten individual weekly play sessions, and in children who have had neither play therapy nor play sessions.

The results of the statistical treatment computed to test this hypothesis are shown in Table III.
### TABLE III

**t VALUES DERIVED ON PRE- AND POST-TEST MEAN DIFFERENCE SCORES BETWEEN GROUPS ON THE SOCIOMETRIC MEASURE**

<table>
<thead>
<tr>
<th>Variable Number</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Fisher t</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group III</td>
<td></td>
<td>Group I</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1.90</td>
<td>2.88</td>
<td>2.80</td>
<td>4.09</td>
<td>.5350</td>
</tr>
<tr>
<td></td>
<td>Group III</td>
<td></td>
<td>Group II</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1.90</td>
<td>2.88</td>
<td>.83</td>
<td>3.53</td>
<td>.5492</td>
</tr>
<tr>
<td></td>
<td>Group I</td>
<td></td>
<td>Group II</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2.80</td>
<td>4.09</td>
<td>.83</td>
<td>3.53</td>
<td>1.0126</td>
</tr>
</tbody>
</table>

In the comparison of pre- to post-test difference means for Control Group III and Experimental Group I, a *t* value of 2.101 is required for significance using eighteen degrees of freedom. The *t* value obtained, .5350, fell below the level of significance.

For Control Group III and Experimental Group II, using fourteen degrees of freedom, a *t* value of 2.145 is required for significance. The *t* value of .5492 was not significant.

For Experimental Group I and Experimental Group II, the *t* value required for significance, using fourteen degrees of freedom, is 2.145. The *t* value found, 1.0126, fell below the level required for significance. Since none of the derived *t* values were significant, null hypothesis I was accepted.
While no significant change was measured between the groups by the sociometric instrument, mean scores on the pre- and post-tests on this measure gave additional information as shown in Table IV.

TABLE IV
MEANS AND STANDARD DEVIATIONS OF SOCIOMETRIC SCORES

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean Pre-test</th>
<th>Post-test</th>
<th>S.D. Pre-test</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental I</td>
<td>3.5</td>
<td>5.3</td>
<td>2.50</td>
<td>4.01</td>
</tr>
<tr>
<td>Experimental II</td>
<td>4.7</td>
<td>5.5</td>
<td>4.18</td>
<td>2.74</td>
</tr>
<tr>
<td>Control III</td>
<td>4.0</td>
<td>5.9</td>
<td>5.79</td>
<td>8.03</td>
</tr>
</tbody>
</table>

While all three groups showed improvement in mean scores on the pre- and post-tests, there was little difference in mean gains between the groups.

Null Hypothesis II

There will be no significant difference in degree of change in mature behavior patterns as measured by the Vineland Social Maturity Scale in children who have had a minimum of ten weekly individual play therapy sessions, in children who have had a minimum of ten individual weekly play sessions, and in children who have had neither play therapy nor play sessions.
The results of the statistical treatment computed to test this hypothesis are shown in Table V.

**TABLE V**

<table>
<thead>
<tr>
<th>Variable Number</th>
<th>Mean</th>
<th>S.D.</th>
<th>Mean</th>
<th>S.D.</th>
<th>Fisher t</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group III</td>
<td>Group I</td>
<td>Group III</td>
<td>Group I</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>1.15</td>
<td>4.57</td>
<td>3.90</td>
<td>2.30</td>
<td>1.4376</td>
</tr>
<tr>
<td></td>
<td>Group I</td>
<td>Group II</td>
<td>Group I</td>
<td>Group II</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>1.15</td>
<td>4.57</td>
<td>.83</td>
<td>5.15</td>
<td>.1433</td>
</tr>
<tr>
<td></td>
<td>Group I</td>
<td>Group II</td>
<td>Group I</td>
<td>Group II</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>3.90</td>
<td>2.30</td>
<td>.83</td>
<td>5.15</td>
<td>1.3884</td>
</tr>
</tbody>
</table>

A \( t \) value of 2.101, using eighteen degrees of freedom, is required for significance in the comparison of Control Group III and Experimental Group I pre- and post-test difference means. The \( t \) value obtained, 1.4376, does not indicate significant change between the groups.

Using fourteen degrees of freedom, the \( t \) value required for significance of difference is 2.145 in the comparison of Control Group III and Experimental Group II. The \( t \) value of .1433 for these two groups could not be considered significant. Using the same \( t \) value of 2.145 for Experimental Group I and
Experimental Group II, the $t$ value found, 1.3884, fell below the level required for significance. No significant difference was found between the three groups on this measure; thus, null hypothesis II was accepted.

Mean scores between pre- and post-tests on the social maturity measure are given in Table VI.

TABLE VI

MEANS AND STANDARD DEVIATIONS OF SOCIAL MATURITY SCORES

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
<th>S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-test</td>
<td>Post-test</td>
</tr>
<tr>
<td>Experimental I</td>
<td>75.5</td>
<td>79.4</td>
</tr>
<tr>
<td>Experimental II</td>
<td>71.3</td>
<td>72.2</td>
</tr>
<tr>
<td>Control III</td>
<td>79.65</td>
<td>81.0</td>
</tr>
</tbody>
</table>

All three groups showed mean score improvement between pre- and post-tests on the Vineland Social Maturity Scale. On this measure, the group which had experienced play therapy showed the greatest mean gain, 3.9, as compared to 0.9 for Experimental Group II and 1.35 for Control Group III, indicating change in the hypothesized direction.

Null Hypothesis III

There will be no significant difference in degree of change in more adequate use of intellectual capacities as measured by
improvement in school grades in children who have had a minimum of ten weekly individual play therapy sessions, in children who have had a minimum of ten individual weekly play sessions, and in children who have had neither play therapy nor play sessions.

The results of the statistical treatment computed to test this hypothesis are shown in Table VII.

**TABLE VII**

**t VALUES DERIVED ON PRE- AND POST-TEST MEAN DIFFERENCE SCORES BETWEEN GROUPS ON SCHOOL GRADES**

<table>
<thead>
<tr>
<th>Variable Number</th>
<th>Mean</th>
<th>S.D.</th>
<th>Mean</th>
<th>S.D.</th>
<th>Fisher t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group III</td>
<td></td>
<td></td>
<td>Group I</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>-.15</td>
<td>.54</td>
<td>.54</td>
<td>.63</td>
<td>2.6895*</td>
</tr>
<tr>
<td>Group III</td>
<td></td>
<td></td>
<td>Group II</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>-.15</td>
<td>.54</td>
<td>.20</td>
<td>.32</td>
<td>1.1814</td>
</tr>
<tr>
<td>Group I</td>
<td></td>
<td></td>
<td>Group II</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>.54</td>
<td>.63</td>
<td>.20</td>
<td>.32</td>
<td>1.1477</td>
</tr>
</tbody>
</table>

*Significant at the .02 level.

Using eighteen degrees of freedom, the $t$ value required for significance in the comparison of mean difference gains in pre- and post-school grade points for Control Group III and
Experimental Group I is 2.101. The t value obtained was 2.6895. This value is significant at the .02 level indicating that the play therapy group made significant gains in more adequate use of intellectual abilities as measured by school grades when compared with Control Group III.

The t value required for significance in the comparison of mean difference scores for Group III and Group II is 2.145, using fourteen degrees of freedom. The t value derived, 1.1814, does not indicate a significant difference between these two groups on this measure.

Using fourteen degrees of freedom, the t value required to indicate significant difference between pre- and post-school grade points for Experimental Group I and Experimental Group II is 2.145. The t value derived was 1.1477. This value does not indicate significant difference in the mean difference scores on the measure of school grade points between these two groups. Experimental Group I, which received play therapy, showed a significant mean difference gain when compared with Control Group III, which received no treatment. However, there was no difference that could be considered significant between the two experimental groups on this measure. Null hypothesis III was rejected in part.

Table VIII presents changes in mean scores and standard deviations in pre- and post-school grade points.
TABLE VIII
MEANS AND STANDARD DEVIATIONS ON SCHOOL GRADE POINTS

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean Pre-test</th>
<th>Mean Post-test</th>
<th>S.D. Pre-test</th>
<th>S.D. Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental I</td>
<td>1.2</td>
<td>1.7</td>
<td>.86</td>
<td>.92</td>
</tr>
<tr>
<td>Experimental II</td>
<td>1.8</td>
<td>2.1</td>
<td>1.03</td>
<td>1.13</td>
</tr>
<tr>
<td>Control III</td>
<td>1.9</td>
<td>-1.8</td>
<td>1.10</td>
<td>.96</td>
</tr>
</tbody>
</table>

The difference in means of pre- and post-school grade points indicated a gain of .5 for Experimental Group I, a gain of .3 for Experimental Group II, and a loss of .1 for Control Group III.

Null Hypothesis IV

There will be no significant difference in degree of change in undesirable behavior patterns as measured by the Haggerty-Olson-Wickman Behavior Rating Schedule in children who have had a minimum of ten weekly individual play therapy sessions, in children who have had a minimum of ten weekly individual play sessions, and in children who have had neither play therapy nor play sessions.

The results of the statistical treatment computed to test this hypothesis are shown in Table IX. Lower scores on this measure indicate loss in undesirable behavior patterns.
TABLE IX

**t VALUES DERIVED ON PRE- AND POST-TEST MEAN DIFFERENCE SCORES BETWEEN GROUPS ON THE HAGGERTY-OLSON WICKMAN BEHAVIOR RATING SCHEDULE**

<table>
<thead>
<tr>
<th>Variable Number</th>
<th>Mean</th>
<th>S.D.</th>
<th>Mean</th>
<th>S.D.</th>
<th>Fisher t</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group III</td>
<td>Group I</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>-7.20</td>
<td>12.56</td>
<td>-6.20</td>
<td>13.20</td>
<td>.1690</td>
</tr>
<tr>
<td></td>
<td>Group III</td>
<td>Group II</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>-7.20</td>
<td>12.56</td>
<td>-6.50</td>
<td>10.81</td>
<td>.1024</td>
</tr>
<tr>
<td></td>
<td>Group I</td>
<td>Group II</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>-6.20</td>
<td>13.20</td>
<td>-6.50</td>
<td>10.81</td>
<td>.0439</td>
</tr>
</tbody>
</table>

Using eighteen degrees of freedom, the t value required for significance of difference between mean difference scores on pre- and post-tests for Control Group III and Experimental Group I on the behavior rating schedule is 2.101. The obtained t value of .1690 for these two groups did not indicate significant difference between them.

Using fourteen degrees of freedom, the t value required for significance of difference between Control Group I and Experimental Group II and between Experimental Group I and Experimental Group II is 2.145. The t values of .1024 and .0439 indicate no significant difference between these groups on this measure. The t values derived on this measure showed
no significant difference between any of the three groups, and null hypothesis IV was accepted.

That all three groups showed improvement in behavior rating scores is indicated by the lower mean scores on the post-test in Table X.

TABLE X

MEANS AND STANDARD DEVIATIONS OF BEHAVIOR RATING SCORES

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean Pre-test</th>
<th>Mean Post-test</th>
<th>S.D. Pre-test</th>
<th>S.D. Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental I</td>
<td>99.0</td>
<td>93.0</td>
<td>23.85</td>
<td>19.19</td>
</tr>
<tr>
<td>Experimental II</td>
<td>95.0</td>
<td>88.0</td>
<td>11.61</td>
<td>17.54</td>
</tr>
<tr>
<td>Control III</td>
<td>86.8</td>
<td>78.6</td>
<td>14.54</td>
<td>14.08</td>
</tr>
</tbody>
</table>

A comparison of the mean scores between pre- and post-tests for the three groups indicates that Control Group I showed the greatest loss in undesirable behavior patterns, 8.2, when compared to the mean loss of 6.0 for Experimental Group I and 7.0 for Experimental Group II.

Null Hypothesis V

There will be no significant difference in degree of change in total personality adjustment as measured by the California Test of Personality in children who have had a minimum of ten
weekly individual play therapy sessions, in children who have had a minimum of ten individual weekly play sessions, and in children who have had neither play therapy nor play sessions.

The results of the statistical treatment computed to test this hypothesis are shown in Table XI.

**TABLE XI**

* t VALUES DERIVED ON PRE- AND POST-TEST MEAN DIFFERENCE SCORES BETWEEN GROUPS ON THE CALIFORNIA TEST OF PERSONALITY

<table>
<thead>
<tr>
<th>Variable Number</th>
<th>Mean</th>
<th>S.D.</th>
<th>Mean</th>
<th>S.D.</th>
<th>Fisher t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group III</td>
<td>2.00</td>
<td>16.69</td>
<td>9.50</td>
<td>13.97</td>
<td>1.1469</td>
</tr>
<tr>
<td>Group I</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group III</td>
<td>2.00</td>
<td>16.69</td>
<td>-2.17</td>
<td>5.52</td>
<td>.5518</td>
</tr>
<tr>
<td>Group II</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group I</td>
<td>9.50</td>
<td>13.97</td>
<td>-2.17</td>
<td>5.52</td>
<td>1.5451</td>
</tr>
<tr>
<td>Group II</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A t value of 2.101 is required for significance of difference on mean difference scores between Group I and Group III using eighteen degrees of freedom. The t value of 1.1469 cannot be considered significant.

Using fourteen degrees of freedom, the t value required for significance of difference between Control Group I and
Experimental Group II, and between Experimental Group I and Experimental Group II is 2.145. The $t$ value of .5518 for Groups III and II, and 1.5451 for Groups I and II indicated no significant difference between these groups on this measure.

Null hypothesis V was accepted since the $t$ values derived on this measure between the groups did not indicate significant difference.

A further analysis of the mean scores between the pre- and post-tests is presented in Table XII.

**TABLE XII**

**MEANS AND STANDARD DEVIATIONS OF TOTAL PERSONALITY ADJUSTMENT SCORES**

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean Pre-test</th>
<th>Mean Post-test</th>
<th>S.D. Pre-test</th>
<th>S.D. Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental I</td>
<td>74.2</td>
<td>84.0</td>
<td>13.28</td>
<td>21.95</td>
</tr>
<tr>
<td>Experimental II</td>
<td>67.7</td>
<td>65.5</td>
<td>21.92</td>
<td>19.33</td>
</tr>
<tr>
<td>Control III</td>
<td>84.1</td>
<td>86.1</td>
<td>14.35</td>
<td>21.68</td>
</tr>
</tbody>
</table>

Both Control Group III and Experimental Group I showed improvement in total personality adjustment as indicated by the mean gains on the post-test of this measure. Control Group III showed a gain of 2.0, while Experimental Group I indicated a gain of 9.8. Experimental Group II showed a mean loss in total personality adjustment scores of 2.2. The larger gain made by
Experimental Group I indicated that the change in personality adjustment on this measure was in the hypothesized direction.

Summary

The purpose of this chapter was to present and describe the data obtained in the course of this study. The null hypotheses were stated, and the .05 level of significance was required for rejection.

No significant differences were found between the three groups in improved interpersonal relationships on the measure used, and null hypothesis I was accepted.

Although all three groups showed some gains in social maturity mean scores, the gain made by the group which had experienced play therapy was considerably greater. However, the t values between the groups were not significant, and null hypothesis II was accepted.

The t value between the play therapy group and the control group on more adequate use of intellectual capacities as measured by improvement in school grades was statistically significant. There was no significant difference between the two experimental groups on this measure. Null hypothesis III was rejected in part.

No significant differences were found between the three groups on change in undesirable behavior patterns on the behavior rating schedule. Null hypothesis IV was accepted.

No significant differences were found between the three groups in total personality adjustment, although the mean gain
from pre- to post-test scores on the personality measure was considerably higher for the play therapy group. Null hypothesis $V$ was accepted.
CHAPTER V

NON-STATISTICAL INFORMATION

It is often difficult to describe behavior with checklists and other kinds of printed measurements. There are nuances of behavior which do not lend themselves to marks or numerical weights, but which oftentimes provide insightful information when added to that gained from printed behavior measures.

After marking a printed measurement of behavior, the teachers, parents, and the students who were involved in this study, more often than not, responded with a "Yes, but . . . .", revealing discomfort at the thought of limiting the complexities of behavior to a single mark or response.

In talking with parents and teachers of the children in this study, and in reading their more informally written descriptions of the children's behavior (included as a part of the original referral), many clues to understanding were gained which added to the total behavior picture of the children involved as well as to the problem of controlling the study of human behavior.

There were many observed behavior patterns which were common to all of the children included in this study. Almost all of them were described as lacking interest in school. Their lack of interest might be manifested in different ways,
but a generalized feeling of disinterest predominated in the observations of the children's behavior. Although this one observation was mentioned more often than any other one pattern, there appeared to be little, if any, understanding of its cause on the part of the parents and teachers.

"Gives up easily on assignments", "Doesn't apply himself to school tasks", "Refuses to take part in school activities", "Cheats", "Won't listen to instructions", "Sees no need to do homework", "Fools around", "Says he can't do the work right anyway", "Doesn't like to read", "Has to be pushed", "Would rather stay at home", "Failing", "Just can't keep his mind on what he's supposed to be doing" are descriptive phrases which were heard over and over from the teachers and parents as they talked about the youngsters' feelings about school.

The majority of the children were described as having poor self-concepts. According to the teachers and most of the mothers, the children did not see themselves as being as capable as others, as being likable, as having worthwhile contributions to make to the school or home situation. Most of the children appeared to be reluctant to extend themselves in either individual or group activities. They seemed unable to see themselves as capable of coping with additional risks. Many of the children appeared to simply withdraw from whatever was going on around them, while others "acted out" against both the activity and the other children involved in it.
The poor self-concept, whether manifested in withdrawing or acting-out behavior, appeared to be a self-defeating behavior for the children. Most of them were seen as being unpopular with the other children in their classrooms. They seemed more often to be daydreaming according to their teachers, and spent more time inside watching television than playing outside with other children according to their mothers. Several of the children were described as being more comfortable with younger children in play situations.

The children's behavior was most often described as being either hyperactive or apathetic. Few observations fell in between. The apathetic children were seen as withdrawn, sullen, uninterested, and uninvolved. The overactive children jumped impulsively from one behavior to another, were unable to stay with tasks until they were completed, bothered their classmates, evidenced poor coordination more often than not, were quick to anger, and cried easily and often.

Most of the children were seen as having unusual difficulty in expressing themselves. Few could be drawn into class discussions, some were able to participate in small group discussions, a few had a friend with whom each could talk, and some of the children were described as rarely talking much at all.

Assessing post-therapy behavior change is both rewarding and frustrating. Rewarding because of the many positive changes which are observed and reported verbally, the
assessment is, at the same time, frustrating because the changes are not always noticeable on printed measures of behavior.

All children involved in this study were seen as having made some degree of improvement in their behavior at school during the experimental time period. However, teachers reported far more positive changes in behavior for the experimental play therapy group than appeared significant in the statistical computations. For example, the following excerpt from a letter written by a teacher and received by the Pupil Appraisal Center, Denton, Texas, on March 18, 1969, is typical of many reports which were made about changes in behavior in the children in the play therapy group.

I've seen such a wonderful change in since September. He is not nearly so hostile (noticeable especially on the playground) as he had been. Tempers have calmed; he is more friendly with me and with the other children in his class. He is well-liked by the other children and seems to be very aware of this and pleased.

I am very pleased with your work with and greatly appreciate everything you have accomplished with him.

Thank you again for meeting his needs. By the way, his oral reading and speaking tones have improved also.

While the whole tone of this letter could only be described as enthusiastic, the youngster involved was still rated high in terms of undesirable behavior patterns, a discrepancy in description which was apparent for many of the children in
the play therapy group. This does not necessarily discredit the teachers' observations of their behavior. "He has so far to go." "His behavior was so bad to start with . . . ." were typical of the reactions to this kind of discrepancy.

Another question was raised as a result of the discrepancy between the observed and reported changes in the behavior of the play therapy group at the Center and the information derived from the statistical treatment of the measuring data. This was the question of whether the measuring instruments were sensitive to the kinds of changes in behavior which were reported and observed.

Aside from the obvious difficulty encountered in measuring behavior changes with printed measuring instruments, the question of whether simply referring children for special help caused their parents and teachers to become more interested in helping them work through their problems was raised.

Most of the teachers of the students in this study appeared to become more involved with the children, regardless of the group the children were in. Teachers of the control group students mentioned several times that they were using the time the students were spending on the waiting list for play therapy for a good purpose. "I'm really trying to help him myself." "Maybe he won't even need special help by that time." "You know, he's not such a bad child. You just have to get to know him." The point of concern here, is whether these children would have received the kind of help which many did receive in their own schools, had they not been referred in the first place? If,
in fact, referral for special help increases the likelihood that a child will develop a more positive and profitable relationship with his parents and teachers, then this is also a factor which is involved in the results of controlled studies of behavior.
CHAPTER VI

SUMMARY, RESULTS, INTERPRETATION AND RECOMMENDATIONS

This study was conducted to investigate changes in behavior which occur as a result of play therapy and to determine that such changes do not occur in the absence of play therapy. The study was designed to test behavioral changes in children who had experienced play therapy as compared with children who had experienced play sessions and with children who had experienced neither play therapy nor play sessions.

The Problem

The problem was the relationship of play therapy to behavioral changes in the areas of interpersonal relationships, mature and desirable behavior patterns, more adequate use of intellectual capacities, and improved personality adjustment.

The Hypotheses

The following hypotheses were tested:

I. Children who have had a minimum of ten weekly individual play therapy sessions will score significantly higher in positive interpersonal relationships as measured by sociometric testing than will children who have had a minimum of ten weekly individual play sessions, and than will children who have had neither play therapy nor play sessions.
II. Children who have had a minimum of ten weekly individual play therapy sessions will score significantly higher in mature behavior patterns as measured by the Vine-land Social Maturity Scale than will children who have had a minimum of ten weekly individual play sessions, and than will children who have had neither play therapy nor play sessions.

III. Children who have had a minimum of ten weekly individual play therapy sessions will score significantly higher in more adequate use of intellectual capacities as measured by improvement in school grades than will children who have had a minimum of ten weekly individual play sessions, and than will children who have had neither play therapy nor play sessions.

IV. Children who have had a minimum of ten weekly individual play therapy sessions will score significantly lower in undesirable behavior patterns as measured by the Hag-gerty-Olson-Wickman Behavior Rating Schedule than will children who have had a minimum of ten weekly individual play sessions, and than will children who have had neither play therapy nor play sessions.

V. Children who have had a minimum of ten weekly individual play therapy sessions will score significantly higher in total personality adjustment as measured by the California Test of Personality than will children who have had a minimum of ten weekly individual play sessions, and than will children who have had neither play therapy nor play sessions.
The Method

The subjects were twenty-seven students, six to eleven years of age, of at least average intelligence, who were enrolled in Denton County public schools, and who had been referred to the Pupil Appraisal Center of North Texas for help with behavior problems. All twenty-seven students were specified as needing play therapy on the basis of their referral plus six hours of diagnosis and evaluation at the Pupil Appraisal Center.

All twenty-seven subjects were administered the California Test of Personality at the Center. Their mothers were given the Vineland Social Maturity Scale at the Center. The sociometric measure was administered in the school classrooms of the students, and their teachers were asked to check the Haggerty-Olson-Wickman Behavior Rating Schedule. School grades for the previous grading period were requested from the schools.

The twenty-seven referrals were grouped randomly into three groups. Eleven subjects were assigned to the group which received play therapy, six subjects were assigned to the group which came to the Center for play sessions, and ten subjects were assigned to the control group.

The three groups were checked for balance on total IQ scores, total personality adjustment scores, and total behavior rating scores, and no significant differences were found between the play therapy group and either of the other two groups.
Subjects assigned to the play therapy group were given ten fifty-minute weekly individual play therapy sessions. Subjects assigned to the play sessions group came to the Center individually each week for fifty minutes of supervised play. The subjects assigned to the control group received no further treatment following the initial testing and evaluation until after the experimental period ended.

Following the experimental period, twenty-six of the students, their mothers, and teachers were administered the post-test forms of the measuring instruments. One student had dropped from the play therapy group during the experimental period. The pre-test data for this student was taken out of the research material.

The research hypotheses were converted to the null hypotheses for statistical treatment. Data obtained from pre- and post-tests on all measures were treated statistically at the Data Processing Center, North Texas State University, for significance of difference between means of small samples, using Fisher's \( t \). Fisher's \( t \) values were determined for all measures between the play therapy group and the control group, between the play therapy group and the play sessions group, and between the control group and the play sessions group. A significance level of \( .05 \) was required for rejection of the null hypotheses for all computations.
Results, Interpretation, and Conclusions

The hypothesis that children who had experienced play therapy would score significantly higher in positive interpersonal relationships was rejected. All three groups showed some gains on this measure but the difference between the gains made by the groups was not statistically significant.

Twelve of the children in this study were in either the first or second grades and required a great deal of help from their teachers in filling out the sociometric forms. Most of these children were unable to write the names of their classmates, and the fact that they had to say the names of their choices to their teachers may have affected the reliability of this measure.

The hypothesis that children who had experienced play therapy would score significantly higher in mature behavior patterns was rejected. While all three groups showed some gains, the considerably greater gain made by the play therapy group indicated that the change was in the direction which had been hypothesized.

There was a noticeable discrepancy between the mothers' written descriptions of their children's social maturity on the original referrals to the Center and their verbal descriptions given when they were administered the social maturity scale by the graduate assistants at the Center, although only a short period of time elapsed between the two assessments. The scores on this scale indicated a much higher degree of social maturity for the children than would be assumed from
the referrals. Whether the mothers found it easier to be objective in writing about their children than in talking about them in the person-to-person evaluation required by the scale is a factor that may account for the discrepancy, or the construction of the scale itself may have accounted for it.

The hypothesis that children who had experienced play therapy would score significantly higher in more adequate use of intellectual capacities as measured by improvement in school grades was partially sustained. The gain in higher school grades made by the play therapy group when compared with the control group was significant. While the play therapy group achieved a higher mean gain in improved school grades than the play sessions group, the difference between the gains made by these two groups was not statistically significant.

The hypothesis that children who had experienced play therapy would score significantly lower in undesirable behavior patterns was rejected. The data from this measure are puzzling. School grades and the behavior rating schedule were the two measures requested from the children's teachers. It was expected that there would be a relationship between the two, but the results are in direct opposition to each other. While the play therapy group made a significant gain in improved school grades when compared with the control group, the control group showed a greater loss of undesirable behavior patterns. It had not been expected that most teachers would make such a sharp distinction between grades and behavior.
The majority of the teachers expressed negative feelings about the behavior rating schedule. They indicated that most of their responses would have been more appropriate had they been able to mark them between two adjoining behavior descriptions on the scale rather than on one or the other.

A few of the teachers indicated concern about how the post-test rating on this measure would compare with the pre-test rating. They were unable to recall how they had marked the pre-test, and although they were asked to be concerned only about the behavior of the child at the time of post-testing, their reluctance to do so was obvious.

Another factor which may have affected the results of this measure was discovered during the study. Early in the experimental period, two children in the control group were placed on mild sedatives on the recommendation of neurologists. Their teachers reported the two children's behavior as greatly improved as a result of the medication.

The hypothesis that children who had experienced play therapy would score significantly higher in total personality adjustment was rejected. This measure was administered to the children, and the considerably greater gain made by the play therapy group indicated that the children in this group viewed themselves in a much more positive way than they had prior to their play therapy experience. It may be that the more positive feelings about themselves were more apparent to them in the Center environment than in their school and home situations at the time of the post-testing.
With the exception of the behavior rating schedule and the sociometric measure, data collected and analyzed for this study suggest that positive behavioral changes did occur in the children who had experienced play therapy. However, these changes, with one exception, were trends only, suggested by mean score gains from pre- to post-tests on the statistical computations. The non-statistical data indicated that many positive behavioral changes had occurred in this group.

Conclusions

This study was undertaken in an effort to obtain needed information about what happens to the behavior of children who are involved in play therapy. An unstated but underlying purpose was to determine whether the results of the study might have implications for teachers, counselors, and parents of children who are referred for special help with problems as well as those children who are not.

As stated earlier in this report, learning experiences which are designed to help children do not always lend themselves to scientific research. With one exception, (improvement in school grades), the statistical significance of the play therapy treatment was negligible. However, observations reported by parents, teachers, and counselors involved in the therapy indicated that positive changes did occur in the play therapy group which did not occur in the other two groups of children who participated in this study.
It appeared to the majority of the parents and teachers of the children actively involved in play therapy that these children saw themselves in a more positive way than they had prior to the play therapy experience. This change in self-acceptance was manifested in more positive attitudes toward school and home responsibilities, tentative but noticeable feelings of worth and self-confidence, a more open relationship with others, a more obvious and positive response to praise, and an improving ability to communicate with others.

The majority of the children who were participating in play therapy may have been involved, for the first time, in a positive relationship with a non-judgmental adult. They had either withdrawn from or were acting out against both school and home environments, and although the parents and teachers appeared concerned about both kinds of behavior, there seemed to be little real understanding of the causes back of the behavior. There was evidence of some genuine efforts to help the children with their problems, but often-times these appeared to teachers as being too difficult to cope with in a classroom with other children.

In the play therapy room, the children were allowed to be themselves with few limits or controls. Many of the children tested these limits, often in highly aggressive ways, but this behavior was of short duration. The children responded to the therapists who understood and communicated understanding, who made no attempt to change them, who accepted them exactly
as they were, with behavior that was more purposeful, self-directing, and less aggressive.

Many teachers and parents appear to be skeptical of this approach to changing behavior and with some initial justification. They fear chaos and confusion. Granted, limits must be set in school classrooms and at home that do not have to be set in the play therapy room, but acceptance of the child as a worthwhile human being, understanding of his behavior as caused, and communication of both acceptance and understanding are concepts which do not require limits.

With few exceptions, the parents and teachers of the children in the play therapy group responded to the positive changes in the children with warmth and increased interest in their welfare. The children, in turn, responded to this support which supplemented that of the therapist in the play therapy room. Thus, the process which began in the play therapy relationship appeared to set off an ever-widening cycle of positive feelings which strengthened the children's attempts to be more self-directing and purposeful in their behavior.

The children involved in this study, with two exceptions, were making little progress in meeting the academic requirements of their teachers. The fact that the children who were participating in play therapy showed the greatest gains in improving school grades lent emphasis to the need to help the children free themselves of the emotional problems which appeared to usurp all of their energies.
That the children in the play therapy group saw themselves in a more positive light was reflected not only in their parents' and teachers' observations but in their own assessment of their behavior. These children made greater gains in terms of better adjustment on the personality measure than did the children in either of the other two groups.

The positive changes in behavior which were made by the children in play therapy did not appear to be as significant in the statistical treatment used in this study as they did to the children, parents, teachers, and counselors who were involved. The small number of subjects, the widely divergent scores on finding measuring instruments which were sensitive to the kinds of behavior measured, and the length of the therapy period are all factors which must be considered in drawing conclusions about the results of the statistical treatment. However, in the eyes of the trained observers (counselors, teachers) as well as the parents and the children themselves, there was no doubt that the children responded with positive behavioral changes to the play therapy experience.

Recommendations

On the basis of the findings of this study, it is recommended

1. Since all three groups of the children involved in this study are beginning or continuing play therapy at the Center,
that all three groups be retested on the same measures at the end of the semester to determine whether significant behavioral changes had occurred as a result of a wait-therapy-test period, a play sessions-therapy-test period, and a continuing therapy-test period.

2. That further research in this area, independent of this study, extend the length of the experimental period to determine whether extended therapy would result in stronger gains in the behavior areas measured.

3. That further research in this area be made using different measures of behavioral change than those used in this study to determine, if possible, whether some instruments are better than others for this purpose, or whether it is even possible to determine the outcomes of play therapy with pen and paper tests.

4. That further research in this area enlarge the size of the sample, where possible.

5. That further research be conducted on the process of play therapy so that more information on how changes in behavior are brought about would be available.

6. That information regarding the positive outcomes of accepting and understanding relationships be made available to parents and teachers.

7. That play therapy be utilized by elementary school counselors in their work with children in the elementary school.
BIBLIOGRAPHY

Books


Articles


Reports


Unpublished Material


Dear

We are attempting to get additional information about the behavior of in your school. Will you please help us by checking both Schedule A and B of the enclosed Behavior Rating Schedule?

Please disregard the score columns and directions for scoring. We are interested only in your rating the behavior of this pupil as requested in the directions for using the Rating Schedule.

We would appreciate so much your help in this matter. When you have completed this form, please return it to us in the enclosed addressed and stamped envelope.

We hope, as a result of this study to be able to provide an improved program for children enrolled in the Pupil Appraisal Center.

Thank you.

W. A. Miller, Jr.

WAM:mlr

Enclosures
Dear

Could you give us some additional help in evaluating the results of our work here at the Pupil Appraisal Center with . We are interested in learning about relationship with the other children in the classroom.

Would you ask each of the children in this class to write down their choices of classmates for the three areas of school activities shown on the enclosed sample? No directions other than those on the form are necessary, but we realize that with the younger children, it may be necessary to give additional help in understanding the directions and in spelling names. We would appreciate your asking the children not to discuss their choices with each other.

As soon as the choices are completed, will you please return them to us in the enclosed stamped and addressed envelope.

Sincerely yours,

W. A. Miller, Jr.
Director
Pupil Appraisal Center

WAM:mlr

Enclosures
APPENDIX C

THREE CHOICES

If we were to change the seating arrangement for our room, whom would you choose to sit near you?

A. __________________
B. __________________
C. __________________

If we were to divide our class into small groups to work on class projects, whom would you choose to work with you?

A. __________________
B. __________________
C. __________________

If we were to divide our class into small play groups, whom would you choose to play with you?

A. __________________
B. __________________
C. __________________
APPENDIX D

PRE

To the teacher:

Dear ____________________:

If you were assigning letter grades (A, B, C, D, F) to ______________________ on the work he has done since school started, what grades would he receive in the following areas:

Reading ________________
Arithmetic ________________
Spelling ________________
Language ________________
Social Studies __________

These grades are to be interpreted as follows:
A - excellent; B - good; C - fair; D - poor; F - failing.

Please return this form to the Pupil Appraisal Center in the enclosed stamped envelope.

Sincerely,

W. A. Miller, Jr.
APPENDIX E

POST

To the teacher:

Dear _____________:

If you were assigning letter grades (A, B, C, D, F) to _________________ on the work he has done during the past ten weeks, what grades would he receive in the following areas?

Reading _____________
Arithmetic _____________
Spelling _____________
Language _____________
Social Studies _____________

These grades are to be interpreted as follows:
A - excellent; B - good; C - fair; D - poor; F - failing.

Please return this form to the Pupil Appraisal Center in the enclosed stamped envelope.

Sincerely,

W. A. Miller, Jr.
APPENDIX F

Comments Made by Parents and Teachers about the Children who were in Play Therapy

1. Parent: "We can hardly believe the change in He's a different child. We all get along at home so much better now."

2. Teacher: "I don't know what you did to He's changing so much. For the first time since I've had him in my room, he seems interested in what's going on."

3. Teacher: "He hasn't had a temper tantrum in a long time."

4. Parent: "________ and his brother are actually getting to be friends. You'd have to know how they were before, or you can't appreciate what that means."

5. Teacher: "She has a long way to go, but I can begin to see some improvement."

6. Teacher: "He needs so much help! I hope he can stay in your program."

7. Teacher: "________ seems to have quit brooding about his father's death. I think you've helped him."

8. Teacher: "________ gets along better with the other children in the class."

9. Parent: "________ has settled down a lot. He was about to drive me crazy."

10. Parent: "________ is doing better in reading."

11. Teacher: "________ is much more mature. She doesn't hang on to me all the time now."