A COMPILATION OF SELECTED RATIONALE AND RESEARCH IN 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

O'Dessie Oliver McNabb, B. S., M. Ed.
Denton, Texas

May, 1975

McNabb, O'Dessie Oliver, A Compilation of Selected Rationale and Research in Play Therapy. Doctor of Education (Counseling and Personnel Service), May, 1975, 404 pp., 5 tables, bibliography, 335 titles.

Literature in the area of play was surveyed, summarized, and organized. The historical approach was used for the collection of data for this study. Materials gathered were acquired through the sources provided by library services as well as current authorities in the field of play therapy. As the material was collected, the focus areas or sections began to naturally develop because of the commonality of the articles. The material found was divided into theory, approach, position, and research. The material found on theory and approach was organized into Chapter II. The material found on position and research was organized into Chapter III.

After an exhaustive search of the literature, it was found that the material was scattered throughout many volumes of journals and books. An observation of the material found showed the early writing on this subject tended to consist of "armchair philosophy," unsupported theory, and complete case study protocols. This work tended to tie into a theory which had been developed for

working with adults and served to translate adult theories to child theories. More recently, the material found has been more specific. It has dealt with specific variables affecting the play therapy process and outcome. Also, this literature reports more documentation and research methods in the area of play therapy. However, even though there is increased accountability, an overall scarcity of documented material was found. Very little research in any focus area was identified. The research which was reported tended to show inconclusive evidence and is reflective of an embryonic stage of development. It seems that instead of following the usual pattern of a scientific model (which includes movement from hypothetical to research to theory), persons in play therapy have started at the theory stage. Some research has been done in order to begin filling in the gaps. However, this research is scant, lacks sequence, and tends to provide inconclusive evidence.

Recommendations for the development of more sensitive outcome research in the field of play therapy would include defining behaviors and personality dimensionally rather than globally; defining changes in behavior rather than changes in personality; and developing measures sensitive to specific behaviors.

Recommendations for the development of sounder procedures in process research would be to develop methods of evaluation of process which combine many ways of assessing activity and interaction; to develop additional verbal interaction scales between the therapist and child which allow the therapist to immediately check out the level of experiencing of the child; to develop verbal interaction scales which allow the therapist to assess the level of experiencing of both therapist and child; and to develop methods for recording biofeedback. The entire area of physical space between the therapist and child has not yet been researched. This could be accomplished through the use of video cameras, certain kinds of marked floors, raters, and timers.

Body movements of both child and therapist offer much research possibility. Since most of the child's language is nonverbal, it is critical that persons develop ways of evaluating and identifying his body signals. Research is needed on the potential use of every toy which is included in the playroom. Research is needed on the potential potency and effect of every type limit set within the play therapy process. Research is needed on the effect of the therapist on the process. Research is needed in reference to training models for the development

of play therapy skills in professionals, paraprofessionals, and parents.

TABLE OF CONTENTS

TABLE OF CONTENTS--Continued

LIST OF TABLES

CHAPTER I

INTRODUCTION

Play therapy has grown out of attempts to provide the child an avenue for growth using his most natural language, play (5). Rousseau (14) was one of the first writers to advocate the study of children's play in order to understand and educate them. He recommended that a child's teacher become a child himself in order to better understand the child. He stressed that children are not little men and women but have a language and world all their own. Piaget (10) recognized the process of play in cognitive development and concluded that the child must begin at the concrete level of experience before he is able to develop to the abstract. Using play as a medium, the child is able to concretize his emotional experiences and then generalize them to a more abstract level.

Recognizing the unique therapeutic needs of children, professionals developed approaches which encompassed play as a learning-expressive modality (2, 5, 6, 16, 17, 22, 23, 12). It has been widely suggested that play is to the child what verbalization is to the adult--a medium for expressing feelings, exploring relationships, and

reaching fulfillment. In play therapy, children are provided an opportunity to be free, creative, and self-directing (1, 2, 3, 4, 5, 8, 13, 16, 17, 18).

Child counselors tend to agree that play therapy is an accepted mode of treatment (10). However, the current body of information about play therapy consists of scattered articles, research, and books. It is difficult for the student of play therapy to find comprehensive organized treatments of the subject. Twenty years ago, Lebo (15) reviewed the research which had been conducted in play therapy to that time. He described much of the literature as "meager, unsound, and frequently of a cheerful, persuasive nature" (15, p. 177).

Considering the scarcity of materials found in current journals and published materials it is highly probable that the condition as discussed by Lebo has not changed. In order to assess the current condition of the literature, a comprehensive overview of the literature--both position papers and research project reports--is needed.

The material in the field of play therapy is difficult for the student to apply or to draw conclusions from in that much of the material is outdated. In addition, much of the material is written in case study or philosophical form. Historically, adult models of therapy were modified for use with children (1, 2, 7, 20, 21). Much of the

writing in reference to approach is not tied concretely to theory.

Rationale and research in the area of play therapy are scattered through the literature in inconsistent form. Rarely are approach, rationale, and research included in the same writing. Material ranges from entire books by one author on the subject of child therapy (1, 2, 5, 6, 8, 23) to articles on position (3, 4, 12, 13, 14, 15, 16, 17, 18, 22) to interpretations of positions (9, 10, 11, 14, 15). In order that the existing body of information be in its most usable form, rationale and research have been summarized and organized in a systematic way in this paper.

Statement of the Problem

The problem of this study was to summarize and categorize theoretical positions and research in the area of play therapy into a comprehensive report.

Purpose of the Study

The purpose of this study was to systematically present the existing body of rationale and research about play therapy in such a way that it is usable to students, educators, therapists, and researchers.

Questions

Child counselors using play therapy and writers in the area generally attend to similar areas of focus. Important questions considered in analyzing the information and data available were

1. What are the rationales of authorities published in the area of play therapy in reference to the following area of focus?

    a. Theoretical position of the play therapist
    b. Specific approaches of the play therapist
    c. Positions of play therapy
    d. Process in play therapy
        (1) Stages in play therapy
        (2) Initial session of play therapy
        (3) Limits in play therapy
        (4) Use of media in play therapy
    e. Types of children seen in play therapy
    f. Parental involvement as influencing process and outcome in play therapy
    g. Therapist variables as influencing process and outcome in play therapy

2. What research was found to substantiate each rationale in the area of play therapy in reference to the following areas of focus?

    a. Process in play therapy

(1) Stages in play therapy

(2) Limits in play therapy

(3) Use of media in play therapy

b. Types of children seen in play therapy

c. Parental involvement as influencing process and outcome in play therapy

d. Therapist variables as influencing process and outcome in play therapy

Significance of the Study

Although play therapy is recognized as a treatment method for helping emotionally and/or socially maladjusted children (10), the various writers contributing in the area have not organized the existing body of theory and research into easily usable form. The material is scattered through the literature in books, articles, and compilations. The attempts made to tie approach to theory were published many years ago. Currently the trend seems to be to write on position or research, but little is being done in tying this position and research to theory. Consequently, the student of play therapy generally finds theory and approach written together which have no research included for testing the hypotheses, or they find technique and research written together without being tied to theory. The material is disorganized and massive. This lack of continuity and

explicitness in the field mandate that a professional beginning research spend hours of reading a massive amount of "armchair" writing in order to find the scant material which will provide beneficial background for the current needed research.

This study contains summaries of a great deal of this material which has been scattered through the literature. On any of the areas attended to, a future researcher in the field will be able to find most of the written work in the field in summary form within this paper. The material was organized in such a way that the reader will be able to immediately identify those sections which are most relevant as he establishes needed background for current and future research projects.

This work will assist Counselor Educators as they guide students toward understanding the need for empirical evidence as well as theory in building a body of relevant material in the field. Using this material as a reference, the beginning student will not have to spend hours reading journal articles which date back to 1928 in order to gain an overview of the excitement as well as the deficiencies in the field. In addition, students, therapists, and researchers will have an organized study of background literature to use as reference material.

Definitions of Terms

Play therapy is defined as theapeutic play in an equipped play therapy room with a play therapist present.

The play room is defined as a room equipped with a variety of specially selected toys and materials which the child can use as a medium of expression.

The term individual play therapy is used to describe that therapy which occurs in the play room with one child in the presence of one play therapist.

The term child therapy is used to describe all therapeutic work done with children.

Areas of focus are defined as those dimensions of the play experience which influence process and outcome. Areas of focus attended to in this study were

a. Theoretical position of the play therapist
b. Specific techniques of play therapists with varying orientations
c. Philosophical need for play therapy
d. Process
    (1) Initial session
    (2) Limits
    (3) Play media
    (4) Types of difficulties
    (5) Parent involvement
    (6) Setting
    (7) Therapist variables

e. Short-term versus long-term therapy

f. Outcome

Limitations of the Study

Materials gathered for this study were limited to those the writer was able to locate through Education Index, Education Resource Information Center (ERIC), Psychological Abstracts, bibliographies, Child Development Index, Dissertation Abstracts, journals, textbooks, and suggestions by selected authorities in the field of play therapy. Data were gathered from the libraries at North Texas State University, Texas Tech University, Texas Tech University Medical School, Southwestern Medical School, Southern Methodist University, Texas Christian University, University of Houston, and through the inter-library loan system. In addition, materials from selected authorities were used.

Basic Assumptions

It is assumed that the above named sources have provided access to a comprehensive amount of data on the subject.

Procedures for Collection of Data

The historical approach was used for the collection of data for this study. Materials gathered were acquired through the sources provided by library services as well as current authorities in the field of play therapy.

Bibliographies were collected from bibliographical sections of books about play therapy and from authorities in the field. Bibliographical entries were also obtained from Psychological Abstracts, Dissertation Abstracts, Government publications, Education Resources Search Center, Education Index, and Child Development Index. Selected authorities such as Virginia Axline, Elaine Dorfman, Lucio L'Abate, Clark Moustakas, and the Director of Research for Health, Education and Welfare, Child Development, Washington, D. C., were contacted, and replies were received from Lucio L'Abate, Clark Moustakas, and the Dallas Regional Office of Health, Education and Welfare.

All bibliographical entries were combined and a list of over 500 entries was taken to the library for further research. The articles were read, summarized, and placed on large cards. In most instances, entire articles were thermofaxed for future reference. The material was then typed and transferred to the appropriate sections which reflected their subject content. As the material was collected, the focus areas or section titles began to develop because of the commonality of the articles. In each section the material found was divided into theory, approach, position, and research. The material on theory and approach was organized into Chapter II. The material on position and research was organized into Chapter III.

CHAPTER BIBLIOGRAPHY

1. Allen, F. H., Psychotherapy with Children, New York, W. W. Norton and Company, Inc., 1942.

2. Axline, Virginia M., Play Therapy, Boston, Houghton Mifflin, 1947.

3. Conn, Jacob H., "The Child Reveals Himself Through Play," Mental Hygiene, XXII (1939), 49-69.

4. Dorfman, Elaine, "Play Therapy," in Carl R. Rogers, editor, Client-Centered Therapy, Boston, Houghton Mifflin, 1951.

5. Freud, Anna, The Ego and the Mechanism of Defense, translated by Cecil Baines, New York, International Universities Press, 1948; London, Hogarth Press, 1954.

6. _____, The Psychoanalytic Treatment of Children, translated by Nancy Proctor-Gregg, 3rd edition, London, Imago, 1946; New York, Anglo-Books, 1951.

7. Freud, Sigmund, Analysis of a Phobia in a Five Year Old Boy, Standard Edition, Vol. X, edited and translated by James Strachey, London, The Hogarth Press, Ltd., 1955.

8. Ginott, Haim G., Group Psychotherapy with Children, New York, McGraw-Hill, 1961.

9. Haworth, Mary R., editor, Child Psychotherapy, New York, Basic Books, Inc., 1964.

10. Hendricks, Shirley J., "A Descriptive Analysis of the Process of Client-Centered Play Therapy with Boys," unpublished doctoral dissertation, North Texas State University, Denton, Texas, 1971.

11. Kessler, Jane W., Psychopathology of Childhood, New Jersey, Prentice-Hall, Inc., 1966.

12. Klein, Melanie, "The Psychoanalytic Play Technique," Mental Hygiene, XXII (1939), 49-69.

13. Landreth, Garry, Louise Allen and Willard S. Jacquot, "A Team Approach to Learning Disabilities," Journal of Learning Disabilities, II (1969), 24-29.

14. Lebo, Dell, "The Development of Play As a Form of Therapy: From Rousseau to Rogers," American Journal of Psychiatry, CXII (1955), 418-422.

15. _____, "The Present Status of Research on Non-directive Play Therapy," Journal of Consulting Psychology, XVII (June, 1953), 177-183.

16. Levy, David, "Release Therapy in Young Children," Child Study, XVI (1939), 141-143.

17. _____, "Trends in Therapy: III, Release Therapy," American Journal of Orthopsychiatry, IX (1939), 713-736.

18. Levy, John, "Relationship Therapy," American Journal of Orthopsychiatry, VIII (1938), 64-69.

19. Piaget, J., Play, Dreams, and Imitation in Childhood, New York, W. W. Norton, 1951.

20. Rank, Otto, Will Therapy, New York, Alfred A. Knopf, Inc., 1936.

21. Rogers, Carl R., Counseling and Psychotherapy, Boston, Houghton Mifflin Company, 1942.

22. Solomon, J. C., "Active Play Therapy," American Journal of Orthopsychiatry, VIII (1938), 479-492.

23. Taft, Jessie, The Dynamics of Therapy in a Controlled Relationship, New York, The Macmillan Company, 1933.

CHAPTER II

RATIONALE AND APPROACH OF MAJOR THEORISTS

This chapter includes an overview of the development of child therapy. A background of theoretical and technical orientations is presented as a basis for the exploration of research presented in Chapter III. Kessler (19) divides theories of child therapy into two general categories. These, she describes, are the psychodynamic therapies which are derived from psychoanalysis and the behavior therapies which are derived from learning theory. The psychodynamic theories about child therapy will be attended to in this writing. These include the psychoanalytic, structured, relationship, and client-centered theories of psychotherapy.

Therapists working with children tended to work within the framework of a viewpoint originally defined for adult clients and to modify the approach for their work with children. To clarify for the reader, a historical basis for each of the theories of child therapy is described.

Psychoanalytic Viewpoint

The psychoanalytic method for working with children grew from the teachings and writing of Sigmund Freud. For

a thorough discussion of this theory, the reader is referred to Sigmund Freud (14), The Basic Writings of Sigmund Freud, and Hall and Lindzay (16), Theories of Personality.

Kessler has briefly summarized the basic psychoanalytic tenets as follows:

> 1. Psychic determinism is the sine qua non of all theories of personality development. Every thought, feeling, or action has a cause, and can be understood in terms of antecedent conditions.
> 2. The same principles of behavior operate, under different conditions and to a different extent, in both normal and disturbed individuals. The difference between the mentally ill and the normal is a difference in degree, not of kind.
> 3. Psychoanalysis established the tremendous power of repressed thoughts and feelings. Children have an unconscious storehouse of memories and feelings.
> 4. Anxiety and the mechanism of defense against it are a major cause of repression to unconsciousness and account for much of what seems irrational and unrealistic. This anxiety can arise from inner conflict as well as from conflict with the outside world. This concept is necessary in the understanding of neurosis.
> 5. There is abundant evidence of the importance of past events in present behavior, but psychoanalytic investigations demonstrated the long arm of unconscious memory, reaching back to the first five years of life.
> 6. Sexual feelings and conflicts in early childhood are particular sources of difficulty, whether the reasons for these are biological, environmental, or a combination of both (19, pp. 9-10).

In 1908, Sigmund Freud referred to child's play and compared it to "poetic creation." He suggested that the child at play creates a world of his own, or rearranges

the things of his world in a new way that pleases him. As Freud developed his concepts dealing with the principle of repetition, which he saw to be used as a way of mastering situations, he began to regard play as a text to be decoded. Freud stressed that the objects used in the play of children were not symbols but signifiers. They are not representational; it is only the use the child makes of them which throws light on the feeling or representation. The child had absolutely no need for a nursery full of toys; he could contrive to convey his meaning with anything at all (27). Freud further indicated that the toy a child used was his language.

To Freud, childhood memories assumed importance in that in reconstructing his childhood, the subject reorganized the past according to his desire. This is like a small child at play who reorganizes his past or present world to suit his fancy. Freud stressed that in psychoanalysis, the verbal accounts of children as well as of adults refer us not so much to realities, as to worlds of desires and dreams (27).

Freud, however, did not actually work directly with children. His main interest was in the observation of them as an aid to learning more about personality dynamics and development. In his work with the child, Little Hans (24), Freud worked with the father of the child who worked directly with the boy.

The work of von Hug-Hellmuth on infant sexuality was closely observed by Freud. In her reported work with one child, von Hug-Hellmuth (18) stressed that play was essential in child analysis when treating children seven years of age or younger. She did not develop a technique of play therapy per se, but she used play as a substitute for free association by arranging for play situations rather than depending on the emergence of spontaneous incidents. She supplemented her work by trying to see the child at home and trying to become familiar with his day-to-day life. Her work tended to be educative in nature and she practiced without taking into account repression or the Oedipal problem (18).

Anna Freud and Melanie Klein translated the analytical model as described by Sigmund Freud in different ways. They differed basically in their beliefs concerning the development of the child's ego and superego and also in their techniques of analysis (19, 25, 29). Anna Freud began her work in the study and therapy of children in Vienna in the 1920's and moved to London in 1938 to continue her practice and teaching. Her approach has developed among her followers into the "Vienna School of Child Psychoanalysis" (29). Melanie Klein began her work in Berlin and after five years, in 1926, accepted an invitation from Dr. Ernest Jones to come to London to continue her study and therapy with

children. There she developed the psychoanalytic play technique referred to as the "English School of Psychoanalysis" (29).

Anna Freud

Theory.--In reacting to the question as to the relevance of child analysis, Anna Freud stated that she sometimes felt that the method was too difficult, too costly, and sometimes even that pure analysis accomplished very little (11).

Anna Freud indicated that where children are concerned, analytic methods require special modification and adjustments and can only be undertaken subject to precautions. And further, that it is natural that in coming to fresh decisions, one should rely on past successes and failures of similar cases (11, 13). In other words, Anna Freud was stressing the fact that a therapist assesses and modifies his approach as he works with and learns from various cases in his career. In recognizing the differences between the needs of children and adults in psychotherapy, Anna Freud developed a technique which encompassed basic psychoanalytic tenets, yet had as its focus not the technique, nor the theory, but the child.

The major wish in adult analysis is that the client in the beginning ally himself with the analyst against a

part of his ineffective inner being. Since the decision for treatment rarely comes from the child and since the child is usually not the sufferer, he generally does not perceive the trouble in himself at all. Therefore, this alignment with the analyst is not easily accomplished. The adult, it is hoped, comes voluntarily to analysis with insight into the malady. Anna Freud stresses that the child comes to therapy with none of these, and these must be induced in the child by "wooing" (11, 13).

She stressed that it is crucial to make the child "analyzable" in the sense of the adult. This "wooing" involves inducing insight into the trouble; imparting confidence in the analyst; and turning the decision for the analysis from one taken by others into the child's own. She suggested that this period has nothing to do with the real analytical work. It is simply used to convert an unsuitable situation into a desirable one.

To "woo" the child (11, 13), she used all the means which were at the disposal of an adult dealing with a child. She reported that if the child showed her some rope tricks, she made better ones; if he made faces, she made funnier ones; she wrote him letters and made things for him during the earlier sessions (10). She strongly believed in the importance of the establishment of rapport and the relationship as a basis for all further work. This

preanalytic period was when she stressed the use of toys and play material. She felt that this time was essential in developing "readiness on the part of the child" (11, 12, 13). Anna Freud discussed one small child whose malady took the form of "acting out" behavior. Through the work done during the preanalytic period, the child gained insight into his "trouble" and was more analyzable as a consequence. This initial work involved the development of a strong relationship between therapist and child.

In discussing the initial fright of another child, she stressed that the therapist should use herself in providing the child with security from the very beginning. The child who is in the presence of a stranger cannot be expected to "follow an unknown path." Anna Freud suggests that the therapist should offer herself as an ally to the child and give the child the "promise of cure" in order to wrap the child in security (13).

Anna Freud took great pains to cause the child to establish a strong attachment and to bring the child into a relationship of real dependence. She felt that this was important in that her concept of analysis could only be carried out in the presence of a strong transference. A child, she stressed, requires much more attachment than does an adult. She indicated that successful upbringing always stands or falls with the pupil's attachment to the

person in charge of it. She stressed that the analyst must succeed in putting herself in the place of the child's ego ideal for the duration of the analysis. In order that this be achieved, the analyst must have a higher authority than anyone else (13).

She attempted to become a person of interest to the child. She aligned herself strongly with the child and became a strong ego ideal. Since she was not a "shadow" the child did not displace his feelings of parents and others onto the analyst, but was forced to see the analyst as the strongest person in his life. This was the basis for her feeling that the child forms no transference neurosis in that the child is never able to see the analyst other than as a person in his own right (11, 12, 13, 29). This, she felt, forced the child to display his reactions to the parents because this original relationship still existed and was not transferred to the analyst (29).

Approach.--Anna Freud took the basic techniques of adult psychoanalysis and adapted them to her work with children. She stressed the techniques of history taking, dream interpretation, free association, and drawings.

One basic technique in adult analysis is the gaining of a history of the malady through the patient's unconscious memory. With the child, memory does not reach very far back because the child is taken up by the present and

generally does not remember the reason for or beginnings of his malady. Since the child is rarely able to compare himself with others, Anna Freud suggests that the case history be taken from the parents of the child (11, 13).

Two other techniques, dream interpretation and free association, used in adult analysis were adapted by Anna Freud for use with children. Anna Freud contends that a child dreams neither more nor less than an adult. In the dreams of a child, one can find the same resistances and distortions of wish-fulfillment as in adults. As she once pointed out to a small client, "No dream can make itself out of nothing; it must have fetched every bit from somewhere" (13). Then, being fully involved with the child, she "sets off" with the child in search of the origins of the dream. She contends that the child can easily get into the interpretation in that the child stands nearer to his dreams than the adult. She stresses that even unintelligent children can be successful at dream interpretation (13).

The technique of free association was used by Anna Freud as she encouraged the child to verbalize daydreams or fantasies. When she felt that the child was having difficulty in discussing his feelings and attitudes, she encouraged him to sit quietly and "see pictures." By using this technique, the child was enabled to learn to

verbalize his innermost thoughts and using the interpretations of the analyst, discover the meaning of these thoughts (13).

In addition to using toys during the initial "wooing" period, Anna Freud saw the use of toys as being particularly valuable in working with the very young child. Through toys, the child, who is still limited in verbal skills, is able to create an environment in miniature. In this world, he is able to carry out all the actions which, in the real world, remain confined to a fantasy-existence. By using toys, the therapist has the opportunity to get to know the child's various reactions: the strength of his aggressive impulses or of his sympathies, as well as his attitude toward the various things and persons represented by the toys (13, 29).

In summary, Anna Freud modified her father's work as she developed an approach for working with children. She felt that his stressing of interpretation was not always relevent in working with children. She used dream analysis and interpretation but modified the approach so that as it became relevant to the child, the use of dream material took on a different meaning than it did when used with adults by Sigmund Freud. Her approach modified yet another technique described by her father, that of free association. Free association described by Sigmund Freud

was focused on an adult population and tended to be cognitive in nature. Anna Freud developed a modified version of the technique. In this modification, her approach tended to involve the child in a feeling level experience. She used this technique in almost a "story telling" experience with the child. Then, as she and the child worked through the "let's 'see' a picture" experience, the child was enabled to describe his "picture" as well as to understand its meaning. This allowed the child "insight" into his unconscious.

In reading the original works of Anna Freud, it seems apparent that her understanding of the world of the child was uncanny. In initial exposure to psychoanalytic theory and approaches, it is difficult to project that the mechanics of the theory could have been interpreted in such a relevant way for use with children. The writing of Anna Freud indicates that she was moving from a very humanistic orientation. She used technique as she wished, in her own way. The flexibility of her adaptation supports the writer's opinion that major contributions in the field of child therapy are made by persons with courage and insight enough to use themselves and their own intuitions in their work.

Melanie Klein

Theory.--Melanie Klein was influenced in the forming of her approach by Karl Abraham and Sigmund Freud. In her initial work with psychotic children, Klein stressed the role of the Oedipal fear which she felt the child internalized and projected onto the outside "threatening" world. She disregarded the effect of reality almost entirely and operated exclusively with the biological, innate factors. In this respect, the logic is reminiscent of Jung (22). She attributed complicated psychological conflicts to the infant and stressed that the Oedipal complex exists in the first year of life (24). This was the basis for her opinion that all children can profit from analysis.

Sigmund Freud stressed the fact that guilt is a painful affect between anxiety and aggression. It is aroused by the conscience or superego. In 1923 Freud coined the term "superego" and related it to the passing of the Oedipus complex. He suggested that before the final internalization of socially acceptable standards we should not speak of a sense of guilt or of conscience in the child for at this stage, there is only the dread of discovery (19).

Klein stressed that the development of the superego begins in the second quarter of the first year (21). This is based on her view in reference to the projection of the death instinct onto the outside world for the sake of

self-preservation. She contended that there exists in the child a full superego of the utmost harshness and cruelty before the resolution of the Oedipus complex. Klein held that there is developed in the child a very intricate psychic system elaborated soon after birth and capable of highly sophisticated fantasies (19).

Klein disagreed with Anna Freud's guidelines of adjustment and educability. She followed the ideas of Abraham and Sigmund Freud in stressing that the matter to be studied lay in the fantasy aspect of the mother-child link. She highlighted the fierceness of the destructive tension that accompanies the love drive (20, 21).

Based on this idea of ambivalence she stressed the importance of the play of opposites in the conception of the object relationship, using the expressions good/bad, give/receive, preserve/destroy. In her view, the child divides the world into "good" and "bad" objects. He attributes these to protective and aggressive roles against the danger which he places--sometimes inside himself and sometimes outside himself (27). She contended that this presence of aggressive intention in all love drives unconsciously impels the child in states of crisis to attempt to repair an "imaginary injury" he thinks he has inflicted on his mother (20).

Klein held that every infant undergoes phases of grave abnormality and that, ideally, mental health can best be safeguarded by early and universal child analysis. According to this view, the individual experience of the child is not crucial in the production of a neurosis, nor is speech essential in the treatment (22).

Approach.--The psychoanalytic play technique developed by Klein grew from her experiences beginning with her first patient, a five-year-old boy. As the child, Fritz, expressed fantasies, anxieties, and defenses through play, Klein consistently interpreted the preconscious and unconscious meaning to him.

She was guided in her work by three basic tenets of psychoanalysis: (1) free association as being the most accurate avenue to the unconscious of an individual; (2) the exploration of the unconscious as the main task of the psychoanalytic procedure; and (3) the analysis of the transference as the means of achieving this (20).

Klein assumed that to the child, play activities were like free associations of the adult. She interpreted these associations and attempted to find beneath every act, its underlying symbolic function (11). In substituting the technique of adult association for the play technique of children, Klein contends that action is more natural for the little child than speech (11). As she worked with

children, Klein stressed both the use of toys and dramatizations as avenues for discovering the fantasy world of the child.

In her beginning work with children, she first saw the child in his own home using his own nursery full of toys. However, after observing that the children were inhibited in their home setting, she felt that transference could only be established and maintained if the patient could feel that the consulting room or the playroom was something separate from his ordinary home life. Only under these conditions would he be able to overcome his resistances against experiencing and expressing thoughts, feelings, and desires which are incompatible with convention, or in contrast to much of what he had been taught (29).

After her discovery of this concept in working with Rita, a child patient, she gathered a few toys for the child and put them into a cardboard box. This box became the prototype for her later playroom closet of materials. Each child patient had a box which contained toys chosen especially for him. This box and the toys within became an individual experience for each child. It was taken from the cabinet before each session and locked up after each session. The child was aware of the uniqueness of himself in that no one else had access to his toys (self).

This box was only explored within the context of the psychoanalytic session (20). In putting at the child's disposal a host of tiny playthings, Klein felt that he could act out his feelings in the play world. She stressed that the actions which the child carried out through play were like the adult's spoken ideas. And thus, she interpreted this play just as analysts do with adult verbal offerings (20).

Educational and moral influence were not used. Instead, Klein adhered to the psychoanalytic procedure which stressed understanding the patient's mind and conveying to him what goes on in it. Klein (20) described the value of interpretation in her work with a specific child. The child picked up a few toy figures and surrounded them with bricks, and the analyst interpreted the figures to symbolize people who were in a room. This, Klein felt, presented the first contact with the child's unconscious. Klein stressed that through the interpretation, the child came to realize that the toys stood in his mind for people and therefore, the feelings he expressed toward the toys related to people.

She contended that before the interpretation the child had not been aware of this. The child thus gains insight into the fact that one part of his mind is unknown to him; in other words, the unconscious exists. It also became clearer what the analyst was doing with him. Klein

stressed that this does not mean that the child will necessarily be able to express verbally what he experienced. She contends that at any point during the interaction, the analyst should be able to read on the child's face that "telling look." This often shows clearly that the child has understood something about himself and that he feels this insight to be helpful and valuable. The child, she indicated, usually does or says something which substantiates the conclusions made by the analyst (20).

The focus of analysis, according to Klein, was centered on anxieties and on the defenses against them. She contended that by focusing attention on these anxieties which are revealed through play and by interpreting the content, she was able to diminish the anxiety within the child. In so doing, she made use of the archaic language of symbolism which she felt to be an essential part of the child's mode of expression. She stressed that the little toys and the child's use of them were representational of a variety of meanings. These symbolic meanings were bound up in the child's fantasies, wishes, and actual experiences. Klein used the meanings attached to this archaic mode of expression much like Freud did as he interpreted dreams. She considered each child's use of symbols in connection with his own particular emotions and anxieties and in relation to the whole situation which was presented in the analysis (20).

Anna Freud (13) criticized Klein's use of interpretation with children. Klein in reply to this criticism contended that even the very young child was able to intellectually understand and benefit from the interpretations (19). She stressed this was true if the interpretations were such that they related to the salient points of the material. She also suggested the analyst should use the child's expressions in interpretation. Klein held that often the capacity of the child for insight was greater than that of an adult. She attributed this to the fact that the connections between the conscious and the unconscious are closer in young children than they are in adults, and that infantile repressions are less powerful (29).

In reference to the third tenet, Klein contended, like Sigmund Freud, that the patient transfers his early experiences and his feelings and thoughts in relation, first to his parents and then to other people, onto the psychoanalyst. It is by analyzing this transference that the past as well as the unconscious part of the mind can be explored (21). Thus, Klein stressed taking the desires and anxieties in the patient-analyst relationship back to where they originated--to infancy and in relation to the first love objects. She contended that by re-experiencing early emotions and fantasies, and by understanding them in connection to his primal relationships (mother and

father), the child could revise these early relations at their root and thus effectively diminish his anxieties (20).

Structured Viewpoint

Structured play therapy is described by Hambridge as a technique used within the playroom setting in which the therapist designs a series of specific stimulus situations which the child plays out (17). This type of therapy has been referred to by David Levy (26, 25) as "release therapy"; by J. C. Solomon (33, 34, 35, 36) as "active play therapy"; and by Jacob Conn (7, 8, 9) as "the play interview." The major theorists using this particular orientation differ slightly in approach. However, they share the attitude that structured therapy offers economy of effort and close approximation to the desired result (17).

Structured play therapy developed as an "offshoot" of psychoanalytic play therapy. Like the psychoanalyst, the structured therapist assumes the major responsibility for the therapeutic experience. They assume they are more aware of the needs of the client than he is of his needs. Because of this knowledge of the child's difficulties, they justify the controlling of the direction of the therapeutic hour. During specific stages in the therapy,

they use this technique in order to provide a controlled setting which will encourage specific abreaction.

Conn (7, 8, 9) and Levy (25, 26) both suggest there is no need for the development of a strong relationship between the therapist and the child. Conn indicates there should not be "ties of gratitude" (7, 8, 9). Solomon (33, 34, 35, 36), however, stressed the development of a relationship between the therapist and the child is crucial to the total treatment. Hambridge (17) contended the play experience should not be structured until the relationship has been firmly established, and the child is completely comfortable in the therapeutic setting.

Hambridge (17), Solomon (33, 34, 35, 36), and Conn (7, 8, 9) concur that structuring the play situation is a form of activity which can serve the already established functions of play therapy. The technique should be used selectively with different patients and at different times during the treatment of one patient. Hambridge contended that "with certain patients, it should not be used at all" (17, p. 601).

Theory of Structured Therapists

Structured therapy is an "offshoot" of the psychoanalytic school. The structured therapists adhere to the basic tenets of psychoanalytic theory in reference to the development of personality. Their difference is in

the approach used. The rationale for the approach which they use lies in their attitude that the therapist is more aware of the dynamics of the personality than is the client himself. They "play" situations so that the client will have the opportunity for catharsis and abreaction of certain feelings. They contend that in allowing for the catharsis to occur and relearning to be introduced, the client will be able to reconstruct in the areas which have hindered development.

Approach of Structural Theorists

Gove Hambridge

Hambridge, in describing his use of the structured technique, states,

> The structured play situation is used as a stimulus to facilitate the independent creative free play of the child in treatment. The patient should already be acquainted with the playroom, which should in turn be supplied with materials of proven value from a clinical point of view. The child will then have the opportunity to choose other play materials beyond those which are given him at the outset of structured play (19, p. 602).

Hambridge further suggested that since the child's selection of toys is an important and significant element in treatment, play therapy should not be conducted with limited space and materials (17).

Hambridge stressed that, through the use of the history gained from the parents and through the observations of the

child at play, he defines those situations which he feels are causing the current stress in the child. He recreates in dramatic play an event or situation like the one he has defined and allows the child to abreacate that which has been precipitating and maintaining his anxiety.

In order to insure that the child feel safe within the situation, Hambridge (17) suggests that the therapist should be cognizant of the child's integrative capacity in the face of such emotions as anxiety and tensions. Hambridge, like Levy, stresses that flooding (a massive and uncontrolled release of all kinds of uncompleted acts from the past) should be avoided and the situation should be controlled so that this flooding and the accompanying regressive and disintegrative states do not occur.

Hambridge suggested the nature of play should be carefully selected in that some play is more threatening to a child than are other forms. For example, play dealing with sibling rivalry is less threatening than play dealing with genital differences. A further task of the therapist, contends Hambridge (17), is that significant persons in the child's environment should be informed of the expected increase in aggressiveness of the child. They should be told to maintain the usual restraints. The therapist has obligation in helping the parents structure their handling of the child with this new motility of feeling.

Hambridge (17) warns that the technique incorrectly used is much like the tools of surgery in the hands of an unskilled surgeon. He indicates that the play therapist is to facilitate play. The therapist has to be skilled in knowing how much to enter into play with the child.

He also suggests that structured play should be followed by free play and that this play should show

> . . . direct manipulation of the dolls, relatively complete absorption in the play so that the child is practically oblivious to his surroundings and, playing out the primary impulses involved (17, p. 609).

When this type of play is exhibited, Hambridge indicates that abreactive value, impulse modification, and ego mastery are occurring.

David Levy

Levy based his theory of release therapy on the rationale that one never outgrows the need for the relief afforded by primary process thinking. In addition, the importance of play and imagination is greatest in childhood (19, 25, 26).

Stressing the controversial assumption that abreaction has therapeutic value, Levy stressed that after a child had experienced a traumatic event, the simple reenactment of it would allow the child to "release" the pain and tension it caused. He contended that as a child reenacts the experience his role changes from a passive to an active

one. In the original traumatic situation, the child was done to; in play, he is the doer. He can control the game in that he can start and stop it when he chooses. He can work over the experience bit by bit as he is able to assimilate it. The play experience leads to mastery of the experience, which allows the child to safely forget the situation (19, 25, 26).

Release therapy was originally designed and formulated to be used with children who had been clearly diagnosed as having had an acute traumatic experience. Levy advocated that if the appropriate reaction to a traumatic event was originally suppressed, the affect remained undischarged and did not lose its hold on the subconscious (25, 26).

Levy (25, 26) differentiated two forms of release therapy. He labeled them specific release therapy and general release therapy.

Specific release therapy is used when the symptom has not been evident for a long duration; when the child is younger than ten; and when the problems are uncomplicated by family difficulties. The child in this situation is permitted to engage in free play initially in order that he can gain familiarity with the room and the therapist. The therapist introduces the structured situation when he feels it is appropriate by asking questions and using the play materials in order to reproduce specific episodes.

General release therapy is used when it is determined that the child's difficulties are a result of excessive demands made on him at too early an age. In general release therapy, no specific experiences are reproduced and no actual names are used. It is used to modify social attitudes, to release aggression, to release infantile pleasure, and to release masculine striving in girls. Occasionally, specific and general release therapy are combined (25, 26).

Levy used the technique of release therapy as a research method and as a therapeutic procedure (25, 26). One of the interesting aspects of his writing is that he very specifically defined types of play situations. These were situations in the child's environment which the therapist perceived to be causing the child trauma. These situations were designed around certain themes, such as new baby at mother's breast (sibling rivalry play), balloon bursting (for release of aggression), peer attack, punishment or control by elders, separation, or genital differences. Each scene involved specifically selected and designed toys. For example, in the "new baby at mother's breast" scene, Levy used a mother doll, a baby doll, and a self-doll. The therapist used modeling clay to mold a mother's breast and encouraged the child to act out his feelings about the new baby being succored at this breast (25, 26).

A discussion of the techniques Levy used in research will be presented in Chapter III. In addition, descriptions of the way he applied his technique to case studies will be presented.

J. C. Solomon

Theory.--Using the Freudian concept of personality development, Solomon developed a theory which stresses the importance of the integration of the ego as primary in the development of self (36). He used the play technique as a means of direct therapy for the child and also as a diagnostic tool and as a research device (36).

He indicated that the child who comes to therapy is suffering from a confusion or conflict of motivations. These motivations are the instincts or derivatives of the instincts and the internalization of the learnings which inhibit the instincts. He differentiated the difficulty of the child from that of the adolescent and adult dilemmas by stating that the adolescent problem is generally one of confusion or conflict identities, and the adult problem is generally one of confusion of values. In the child, the therapist is mainly concerned with conflicts involving the primary motivations or instincts, either with each other or with the secondary motivations represented by the superego. He contended that the conflict embodies

an "internalization" of the problem which requires a realignment of the inner thought mechanisms in addition to the alteration of the external pressures represented by the outside world (36).

In discussing the relevance of ego development on treatment processes, Solomon stressed that if the integration of the ego has occurred prior to the onset of the symptom, i.e., if the ego has developed and crystallized before the traumatic event or the occurring of the symptomology, then the prognosis for establishing communication with the child and the prognosis for successful outcome of treatment is positive. Conversely, the child who has been traumatized very early in life often has less organization to build on. He stresses that this child comes to the treatment with perceptual rather than conceptual thinking processes and is characterized by a poorly developed ego structure. He concludes that the child with the original ego base is more amenable to therapy in that this base helps him to weather the storm of his life situations (36).

In describing the two main parts of the personality, Solomon stated,

> The ego is made up of one part considered the ego proper and another part called the superego. Both the superego and the ego can be looked upon as having inhibitory effects upon the direct expression of the

> instincts. The main ego consists of the stored memories of gratification and masteries of the individual. It operates to postpone, evaluate, and integrate the impulses in terms of reality (36, p. 593).

He relates these dimensions of personality to a therapeutic model in that he contends the ego is able to associate impulse with the knowledge that it can be gratified or dealt with in some way. The superego, incorporating pain and admonitions of parent figures, is the other area.

When actual traumatic events or a threatening atmosphere occur, stored memories of pain surface. These furnish the imageries of impending catastrophe whenever pleasurable discharge is sought (36).

Continuing, Solomon states that "it is these catastrophic outcomes which operate in the direction of the disintegration of the organism" (36, p. 594). And using this rationale as a basis for development of a theory for treatment, he further states,

> In therapy with the child, the reversibility of the secondary perceptions or fantasy world is comparatively easily accomplished. The fantasies are translated back into the actual events of the life history which had set the whole process in motion in the first place (36, p. 594).

He describes this as the first stage of integration through the use of play. He contends that the play technique is particularly useful in this endeavor in that it furnishes the medium whereby a go-between is offered

which permits pleasures (ego) to be enjoyed as well as releasing the rage which results from the frustrations of pleasure (brought about by conflict caused by super-ego). He further suggests that

> . . . through play the child is able to express his own regressive tendencies, thereby lessening the need to act out such forms of behavior in his real life situation. Instead, he is afforded the opportunity to move forward toward more realistic solutions for his problems (36, p. 394).

He contends that by allowing the child through play to convert the fantasy formation into the primary memory experience, the child is able to disengage himself, with the help of the therapist, from his "magical thinking." This concept, he stressed, is highly important since real causality must be established in contrast to supernatural causality. This is true especially if they are related to unrealistic punishments.

He concluded that the use of play with a child allows the child a means of expression, and also provides a way in which the therapist can talk with the child. He suggests that "the world of the child is extremely distant to the adult and play is useful in narrowing this gap" (38, p. 403). Solomon defined change within the therapeutic relationship as being "movement from the indefinite to the definite, from the unreal to the real, and from the magical to the reasonable (34, p. 594).

Approach.--Solomon has been identified with an active therapeutic technique in working with children. In his beginning work, he tended to use more created play situations than he did during his later years. He stated,

> I do find that my methods have changed considerably. I have not abandoned the use of the suggested or created play situations, but have become cautious of dosages. I now concentrate on the emotional responses of the child rather than on the dramatic aspects of the play constructions (35, p. 404).

Solomon based his concepts of the structured play technique and the usefulness of abreaction on his assumptions that the release of aggression or hostility with its appropriate emotion was therapeutic. He suggested that as a process of therapy, through play, the child is able to express these emotions of unbridled rage and the corresponding fear. The abreaction and ventilation of these feelings are therapeutically useful when expressed within the confines of therapy where the feared consequences do not occur.

Another goal of therapy is that of secondary integration, which Solomon further defines as "reparative mastery." He suggests this occurs as the child (who has there-to-fore been misdirecting his energy on activities which have not gotten what he needs and wants), learns to redirect his energy in a more acceptable, useful way. As an example, he describes the boy who was jealous of his

little brother. The child spent his energy in tantrums and in hurting his brother. As a part of the redirection of energy he learned that being kind to his brother caused his mother to have time for him because she was not spending so much time in keeping the two boys from fighting (35).

A further goal of therapy is for helping the child to learn to deal with time in a three-dimensional manner. Solomon contended that the early traumatized child lives his life in terms of past and future. He fears the future will hold events as bad as the past. Through therapy, the child learns that all events do not have the same outcome. The therapist can alleviate anxiety when hope is offered that certain threats may not exist in the future or that the child will be able to cope with them later on in a different way. The therapist can also help the child recognize the past for what it was--not something threatening now or later (36).

Solomon stressed the importance of the relationship and states that "the main problem of therapy is one of making the therapeutic sessions meaningful and useful to the child" (36, p. 593). He further stated in reference to the importance of the relationship,

> There is little question that this is the more important aspect of therapy. Even though immediate or manifest anxiety is more easily provoked by active than passive methods, it is readily relieved by the

> introduction of a doll representing the therapist toward which the child can abreact some of his feeling, thus relieving a burden from the superego (35, p. 405).

He suggests that this relationship cannot be structured, but it is an outgrowth of the child's tacit admissions as well as of the interest and understanding expressed by the therapist.

In his use of the structured play technique, Solomon used dolls to represent significant persons in the life of the child. In addition, he introduced a doll to represent himself. He contended there were many things in the relationship which the child would need to work out. He stressed that it would be easier for the child to work these feelings through with a doll than to have to talk with the therapist face to face. He further suggested that after the child practiced his verbalizing to the doll then he would be able to transfer this verbalization to the therapist. In this way, he would learn he could use the dolls representing members of his family and his peer group in the same way (35).

Solomon recognized different types of children who were brought to treatment. He recommended differential techniques for these different personality types. A more thorough discussion of these types of children will be presented in Chapter III.

Jacob Conn

Conn contended that his goal as a therapist was not to "make over" the child, but to restore what was there originally (9). He developed his method of "play interview" to supplement, not replace basic child guidance procedures. This technique provides a wealth of information quickly (8).

Because of the way in which the situation is structured, the child quickly learns that random play is not the focus of these sessions. He quickly learns that he has not come to play or to be entertained, but to participate as an equal who has something to contribute as well as to learn (9).

The therapist may play many different roles during the play interview. He may speak directly for one of the dolls; he may represent the "voice of experience"; or he may introduce new topics of conversation. The therapist permits free play, but the emphasis is placed upon planned life situations. He plans the next interview according to the way the dolls and toys are used by the child (7).

Case studies presented by Conn are discussed in Chapter III. This discussion includes the type of child he recommended working with as well as his techniques in each situation.

Relationship Viewpoint

Relationship therapy evolved from the philosophy of Otto Rank. It has been described for use with children by Frederick Allen (2), Jessie Taft (37), and C. E. Moustakas (28).

Rank (30) stressed the premise that every person shares the common trauma of birth, leaving him with a permanent fear of "individuation." Emphasis is on the conscious cooperation of the patient which implies a corresponding deemphasis of his unconscious and past history. Rank's view is that the source of therapy lies in the understanding and constructive use of the patient's reaction to the therapeutic situation.

The relationship therapist does not stress transference as being relevant in treatment, but instead stresses the development of the relationship as crucial. The relationship therapist places much emphasis on the use of time. He uses the limit of time both for the duration of treatment and also for the duration of that particular hour as an integral part of the relationship. Taft (37) suggests that the human problem could be phrased thusly, "If one cannot live forever, is it worthwhile to live at all?" (37, p. 13).

The existential orientation emphasizes the present while looking neither to the past (birth) nor to the

future (death). Taft, in explaining his view on the existential dilemma states,

> . . . the reaction of each individual to limited or unlimited time betrays his deepest and most fundamental life pattern, his relation to the growth process itself, to beginnings and endings, to being born and to dying (37, p. 13).

Jessie Taft

Taft based her rationale on the existential orientation and stressed the importance of the present in her approach. She defined therapy as "a process in which the individual finally learns to utilize the allotted hour from beginning to end without undue fear, resistance, resentment, or greediness (37, p. 17).

She also stressed the power of an intensive, intimate relationship as vital. She stated that it represented "a depth of union never risked since birth or weaning" (37, p. 291). She contended that there is curative power within the relationship between the therapist and the child. Also, the power of the therapy depends to a great extent on the personal development of the therapist.

Taft viewed the process of separation at the end of each hour and at the end of treatment as a major focus of the process. She further viewed them as reenactments of the original trauma, birth. She contended that if the therapeutic experience has a favorable outcome, the

patient "takes over the birth fear and transforms it into an ego achievement" (37, p. 282). Since the time limit was set on the calendar before the beginning of the therapy relationship, then the termination is viewed as an integral part of the process itself. She stressed that the termination of the relationship within this context

> . . . diminishes the fear of individuation, since to leave convincingly is to find that one can bear both pain and the fear of withdrawal . . . and to discover within the self a substitute for the lost wholeness (37, p. 291).

Frederick Allen

Although Allen, like Taft, was concerned with the problem of differentiation and individuation, he used a physiological rather than a philosophical frame of reference. For example, in discussing the trauma of birth, Taft considered it to be traumatic because of the issue of existential separation. Allen considered it to be traumatic because of the extreme physical and biological changes the newborn child experiences at the moment of birth. In referring to this experience, he stated, "Birth ushers in a new and final phase of differentiation" (2, p. 22).

Allen stressed the importance of the relationship between the therapist and the client as being the crucial factor in the successful outcome of the treatment. In discussing this importance, he suggested,

> Therapy begins when the therapist is brought into a relationship as a supporting and clarifying influence around the patient's need and desire to gain or regain a sense of his own worth (2, p. 22).

Even though he tended to emphasize the present rather than the genetic development of problems and conflicts, he did not set the limit of time as did Taft. He stressed that the child has to be able to live in a "day-to-day" experience and has to be helped to affirm his value in an active, changing world. He attempted to help the child focus his interests ahead and away from the "shackles of the outlived past" (2, p. 306).

Allen held that it was important to be involved with the child, yet he stressed that this involvement was not to be confused with being friendly. He contended that the therapist should be able to allow the child to express himself freely, yet be able to set limits when they were called for.

Allen respected the child's capacity for growth. He did not take over the child's responsibility in the growth process, and did not desire to "recreate" the child. Instead, he stressed acceptance of the child at his stage of development. He held that the therapist should concentrate on those difficulties which most concern the child (2).

Clark Moustakas

Theory.--Moustakas described therapy as being a unique growth experience which involves not only the person seeking and needing help, but also the person who accepts the responsibility for offering it. He contends that the aliveness and the integrity of the relationship between the child and the therapist provide the potency for the growth experience (28).

Mooney, in the foreword of the book, Psychotherapy with Children, The Living Relationship (28) describes this potency. He states,

> . . . by centering himself in the successive transpositions and opening himself to the case, he can experience the being of the child in psychic birth while also experiencing the being of the therapist who sustains the child during the transformation. As with other births, there will be found a counterpoint of pain and glory in the experience for both the child and the therapist, since both are undergoing birth of themselves in the same emergent flow (28, p. ii).

So, according to Moustakas and Mooney, the process of birth is a never-ending, "moment-to-moment" experience. It involves any human when he is in a relationship with another, if they allow themselves to experience the process.

The therapist is responsible for growing and experiencing as a result of the living relationship with this other individual, the child. To do this, the therapist has to be cognizant of his own strengths and limitations

in this "here and now" experience. Moustakas stresses that the relationship can be no more honest than the two members involved. In other words, the child cannot experience a meaningful process while in the presence of a dishonest relationship. The child can grow no farther than the therapist can experience (28).

Mooney further suggests that the therapist is the person in the culture who emphasizes man's need for discerning and comprehending. The therapist then provides the appropriate forms of psychic nourishment. This therapist is not seen as a code bearer for the culture, nor as a person who instills the values of society, but one who actively participates in the living process with the child. Mooney stresses that by opening self to the growth experience, the therapist finds greater vitality and richer meaning (28).

Moustakas contends that this relationship must also be one in which each participant is regarded as an individual. There are no rulers in life, only participants and companions. This relationship is not one in which one person does something to another person, but rather one in which both participants are "being." The child is a person who is regarded as having resources of his own which will contribute to the living experience. These resources will bring about his development as part of the process (28).

Moustakas discounts the concept of neurosis and illness and does not view the relationship as one which encourages dependency. He views the process of self-growth as involving an internal struggle between dependency needs and strivings for autonomy. He stresses that the individual eventually feels free to face himself if he is in a relationship where his human capacity is recognized and cherished within the context of acceptance (28). In accordance with the "here and now" philosophy, the therapist always focuses on the living present and deals with feelings rather than symptoms or causes (28).

Approach.--To Moustakas, the role of the therapist involves self-awareness and continued openness for growth. He also stresses the importance of beginning with the child where he is and conveying unqualified acceptance, respect, and faith (28).

He indicates that the many ways this respect is conveyed are all a part of the therapeutic process. One way the therapist shows this respect is by allowing the child to make his own decisions. The play time is not structured. The therapist does not choose the toys, interpret, nor guide the play. He allows the child to lead the way.

Moustakas further exhibits respect for the child by really listening to him. Listening involves more than simply being able to repeat what the child has said.

Moustakas stresses that the therapist must be able to listen for the feeling and attitudes behind the words of the child. He urges the child to explore his thoughts and feelings. He does not make any attempt to interpret these feelings nor to direct the activities of the child in an effort to allow their release. He contends that these are the feelings of the child; he has a right to cherish them and to express them in his own way (28).

Moustakas does not advocate passivity within the playroom setting. Although he does not direct activities, he is an active participant in the plans the child makes. He always allows the child to lead the way, but at times, if the child wishes he becomes actively involved in the planning, and even plays with the child (28).

In summary, the central focus is the emergence of a significant relationship in which the adult maintains a deep concern for the growth of the child. Included also is the special interest in the individuality of the child and an understanding of the capacity for self-growth within the child. There is an educated talent for sensing feelings, understanding, examining, and exploring the child's experience with the therapist. It is a mutually enlivening, living, relationship.

Client-Centered Viewpoint

In describing the development of client-centered play therapy, Elaine Dorfman states,

> . . . it is apparent that from the Freudians have been retained the concepts of meaningfulness of apparently unmotivated behavior, of permissiveness and catharsis, of repression, and of play as being the natural language of the child. From the Rankians have come the relatively ahistorical approach, the lessening of authoritative position of the therapist, the emphasis on response to expressed feelings rather than to a particular content, and the permitting of the child to use the hour as he chooses. From these concepts client-centered play therapy has gone on to develop, in terms of its own experiences (10, p. 237).

Carl Rogers developed a theory of personality which grew out of his experiences in working with individuals (16). Based on these experiences, he developed a theory of therapy and personality change. For a complete summary of this theory, the reader is referred to Hall and Lindzey, Theories of Personality, 1957, pp. 29-74. The part of his theory which fits with most relevance to the work of Axline is presented in the following summary.

1. Characteristics of the infant: An infant perceives his experience as reality and has predisposition toward activation in reality perceived. He behaves wholistically and engages in a valuing process, moving toward those things positively valued.

2. Development of the self: Part of the actualizing tendency in the child becomes differentiated and symbolized

in awareness, which is described as self-experience. This awareness becomes elaborated, through interaction with the environment into a concept of self.

3. Need for positive regard: This universal trait develops from awareness of self. It is reciprocal in that when the person satisfies another, it becomes self-satisfying. Thus the expression of positive regard by a significant other can be more compelling than the organismic valuing process.

4. Development of the need for self regard: This is a learned need developing out of self experience and the need for positive regard.

5. Development of conditions of worth: In the event that the person experiences only unconditional positive regard, no conditions of worth develop. Self regard should be unconditional--hypothetically fully functioning.

6. Development of incongruence between self and experience: Experiences are perceived selectively. Those in accord are accurately symbolized to awareness; those not in accord are denied awareness.

7. Development of discrepancies in behavior: Some behaviors maintain self concept so as to make congruence. Others are unrecognized or distorted so as to be consistent.

8. Experience of threat and the process of defense: An incongruent experience is perceived as threatening.

This leads to the development of anxiety. Rigidity, distortion, and inaccurate perception of reality result due to omission of data and intensionality.

9. Process of breakdown and disorganization: When a person has a large degree of incongruence between self and experience and the defense is unsuccessful, disorganization results.

10. Process of Reintegration: Because the person is able to experience conditions of worth in an atmosphere of unconditional acceptance an increase in unconditional self-regard occurs (31, pp. 184-256).

Virginia Axline

Theory.--Virginia Axline and Elaine Dorfman have both made contributions in the adaptation of the client-centered approach to child therapy. Dorfman, in her writing, elaborated on the work of Axline (10).

In translating the personality theory as described by Carl Rogers (18, 31, 32), Axline suggested that as the child begins to differentiate himself from his environment, he almost immediately begins a reciprocal relationship with that environment. He forms his sense of self because of the way in which he perceives the perceptions of significant others. Axline described this ever-changing development in the following way:

> . . . the dynamics of life are such that every experience and attitude and thought of every individual is constantly changing in relation to the interplay of psychological and environmental forces upon each and every individual, so that what happened yesterday does not have the same meaning for the individual today as it had when it happened because of the impact of the forces of life and the interaction of individuals; likewise, the experience will be integrated differently tomorrow (6, p. 11).

Two basic premises held by Axline are (1) the child loves growing and strives for it constantly and (2) there are certain basic needs within each individual, which the organism is constantly striving to satisfy. Axline further adds that "the behavior of the individual at all times seems to be caused by one drive, the drive of complete realization" (6, p. 12).

Axline (6) suggests that when a child is able to direct his behavior by evaluation, selectivity, and application to achieve his ultimate goal in life (complete self-realization) then he seems to be well adjusted. In the maladjusted child, one observes a child who has not had success in his efforts to gain the necessary requirements for the satisfaction of his needs. He has learned devious methods for obtaining what he wants. The inner struggle for growth in the child continues, yet he is constantly blocked in his efforts by his environment. This causes incongruence within the self and the child

eventually departs from realism both in his perceptions and in his experiencing (5).

The emotionally disturbed child is one who is in a state of incongruence between self and experience. He has developed a defensiveness toward his environment which results in rigidity and distortion. At the extreme of this continuum, the child is at a stage of complete disorganization.

Axline contends that if this child is allowed to experience conditions of worth in an atmosphere of unconditional acceptance an increase in unconditional self-regard will occur. This allows the child to move from disorganization to reorganization. Using this philosophy of personality reorganization, she continued that the child has within him all the necessary components for growing and becoming. Stressing this as critical, Axline developed the nondirective approach. The client will move where he needs to when he is ready if the conditions are right. The major focus of the therapist then becomes making sure that the conditions are there.

Approach.--In describing her view of therapy, Axline states,

> Nondirective therapy is based on the assumption that the individual has within himself, not only the ability to solve his own problems satisfactorily, but also this

> growth impulse that makes mature behavior more satisfying than immature behavior (4, p. 34).

The basic premise of the nondirective therapist is that the therapeutic experience should be different than any other experience the child has had (5). The playroom, the relationship, the total experiencing of self within this new context allows the process of reintegration to occur (6). When the conditions are different than those which contributed to the disorganization, the child is able to make a new synthesis and continue his forward movement in a well-adjusted way (3).

Critical to the understanding of the concepts of client-centered therapy is the awareness that this is not a technique, but it is a philosophy or set of attitudes in reference to the significance and worth of each individual. The process occurs because the therapist has incorporated a certain set of values into his personality. In discussing this concept, Rogers states,

> . . . the counselor who is effective in client-centered therapy holds a coherent and developing set of attitudes deeply imbedded in his personal organization, a system of attitudes which is implemented by techniques and methods consistent with it (32, p. 19).

The therapist described by Rogers holds a basic belief that the individual has the capacity for growth, decision making, and motivation for forward movement. He has as his basic goal the provision of a relationship

with the child that will enable him to use the capacities that are within him toward constructive living.

An opportunity for experiencing growth under the most favorable conditions is offered to the child through the play therapy experience. It is generally agreed that play is to the child what verbalization is to the adult (3, 4, 5, 6, 28, 15, 23).

Play is the most natural language of the child. When the child is allowed to express himself naturally, the feelings surface. The child, within the acceptance and permissiveness of the playroom is provided the safety of a nonconditional relationship. He is able to realize the power within himself to be an individual in his own right, to think for himself, to make his own decisions, and to become psychologically more mature. This allows him to realize selfhood (4). The child does not have to practice devious methods in order to fill his needs. This allows his real self to unfold and have full expression. Gradually, within this setting and relationship of unconditional acceptance, the child is able to give up his compensatory behaviors. As the child is freed of the anxiety and tension which have been produced and maintained by the incongruence and disorganization within his sense of self, he has more energy for forward moving growth. Again, the environment and the sense of self of the child act in a reciprocal

manner. As the child becomes more congruent and realistic in his orientation to his environment, the significant others in his environment respond differently. The circular destructive process is reversed and the circular positive process occurs (4, 5, 6).

The eight basic principles, as stated by Axline, which should guide a therapist in nondirective play therapy contacts are the following:

> 1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
> 2. The therapist accepts the child exactly as he is.
> 3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
> 4. The therapist is alert to recognize the feelings the child is expressing and reflects those back to him in such a manner that he gains insight into his behavior.
> 5. The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.
> 6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.
> 7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
> 8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship (6, pp. 75-76).

Axline suggests that the relationship is structured within the framework established by these eight basic principles.

> The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible (6, p. 77).

In discussing the establishment of this rapport, Axline (6) stresses that the therapist from the beginning, strives to establish this relationship, but in a different way than the child is used to. The therapist does not follow the traditional ways of dealing with a child--bribery, compliments, shame, and various other dehumanizing methods. Instead, she recognizes the child's human feelings and reflects those feelings to the child. She attempts from the first to establish with the child the attitude that she recognizes his individuality and personhood. She does this by simply acknowledging to the child that his feelings are understood and accepted.

> The therapist accepts the child exactly as he is (6, p. 87).

Axline (6) stresses that complete acceptance of the child seems to be of primary importance to the success of the therapy. As the child begins to differentiate himself from his environment he becomes aware of the significant persons in his environment. He begins to see his worth reflected back by these persons. This

reflection plays a significant part in the way he comes to see himself.

In order for the therapist to establish a relationship which is entirely different than the ones which have contributed to the disorganization within the child, it is basic that she accept the child where he is. She accepts his feelings expressed; his right to be where he is in his development; and his right to move at his own rate. Acceptance does not imply approval of what the child is doing, but rather, acceptance recognizes the child's right to himself. The therapist respects the child, allows him to make choices, is nonsuggestive and nondirective.

> The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely (6, p. 93).

The therapist does not have a preconceived plan as to the nature of the session, nor of the feelings and activities of the child. "The therapy hour is the child's hour to be used as he wants to" (6, p. 93). The therapist can structure this attitude by her verbalizations such as, "You may play with these toys in any way you like" (6, p. 93). She further structures the attitude by her nonverbal attendance to the child as he "uses the toys in any way he likes." Permissiveness does not imply that the child is free from limits, but it does imply that he is permitted to express himself in his own way. He is free

to stumble, grope, remain silent, or search for himself in any way he needs to without the interference of a directive, authoritarian adult. The therapist focuses her attention on the center of the child, on his needs. She follows.

> The therapist is alert to recognize the feelings the child is expressing and reflects back those feelings in such a manner that the child gains insight into his behavior (6, p. 99).

Axline (6), in stressing the need for the therapist to recognize the child's feelings and reflect them back to him, made a distinction between reflection and interpretation. Interpretation, according to Axline, implies explaining to the child the symbolism he expresses in his play. Reflection has to do with verbalizing what the child is feeling so that he will know that he is being understood. Interpretation has to do with explaining the meaning of the child's play to him, while reflection has to do with sharing with the child the attitude, "I hear your feelings." As a child learns that he is understood, he is likely to gain insight from the interaction with the therapist. The therapist reflects the child's feelings with clarity. This enables the child to "see" his feelings out in the open, and to learn to deal with them while in the safety of the relationship. Not only has the child felt safe enough to express his feelings,

but they have been accepted by a significant other. They have been clarified so that the child can realistically see and understand them for himself. When they are placed in the proper context, they are no longer diffuse. He can handle them because he knows what they are. He recognizes the feelings of anger, love, hate, jealously and connects them with the experience. He has learned.

> The therapist maintains a deep respect for the child's ability to solve his own problems if given the opportunity. The responsibility to make choices and to institute change is the child's (6, p. 108).

The nondirective, nonthreatening, accepting atmosphere of the playroom experience allows the child to experience emotional peace. When this freedom comes to him with the accompanying sense of loss of anxiety, the child is free to grow. If the therapist makes the conditions right, the inner power of the child will begin to grow. He will solve his own problems, make choices, choose alternatives, and change. This can only happen when the therapist puts himself aside and focuses on the child.

> The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way. The therapist follows . . .
>
> The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist (6, pp. 121, 127).

The power for change and growth is within the child. The child will only grow when the conditions are such that

his emotional energies are not being used in anxiety and fear. Until the therapist sets the conditions of empathy, warmth, and permissive understanding in the playroom, the child will continue his maladjusted defenses. He will continue to use his same devious methods for gaining his wishes because the playroom will be no different from the outside world. When he recognizes that the playroom is a different place offering a different relationship, he will be free from anxiety. He will be free to venture out, face himself realistically, and begin to perceive accurately that which was distorted in the beginnings of his development.

In summary, the humanistic philosophy is apparent in the writing and the speaking of both Carl Rogers and Virginia Axline, two of the noted authors in the area of client-centered therapy. Roger's philosophy has grown out of his work with people in therapeutic and teaching relationships. His philosophy has been a living one, growing and changing as a result of his life experiences and of the integration of these experiences as they have affected his perceptions, attitudes, values, and finally his sense of self. The theory he describes in reference to the development of personality, and the power of self in each individual to grow and become, is evidenced in his work and writing. His is not a stagnant philosophy, but a living one.

Statements which Rogers and Axline have included in their writings in reference to clients indicate their

consideration of the client in the development of their theories.

Carl Rogers states,

> This book is about the suffering and the hope, the anxiety and the satisfaction, with which each therapist's counseling room is filled. It is about the uniqueness of the relationship each therapist forms with each client, and equally about the common elements which we discover in all these relationships. This book is about the highly personal experiences of each one of us.
>
> It is about a client in my office who sits there by the corner of the desk, struggling to be himself, yet deathly afraid of being himself--striving to see his experience as it is, wanting to be that experience, and yet deeply fearful of the prospect (32, p. 63).

And Virginia Axline wrote,

> And when a child is sad and depressed, his figure droops, his movements are slow and heavy, his eyes mirror the unhappiness that is in his being. He is unhappy from the top of his head to the bottom of his feet (6, p. 63).

And so, the client-centered philosophy which was first described by Rogers and interpreted for work with children by Virginia Axline had as its focus, the client. The feeling for the individual seeking a warm empathic relationship is encompassed in the work by these authors.

Summary

In this chapter, the writer has presented a summary of the writings of the early theorists in the field of

play therapy. Only the theory and approach of each theorist was attended to. The variables in reference to the process and outcome of play therapy will be discussed in Chapter III.

The work of the psychoanalytical child therapists was presented through a summary of the writing of Anna Freud and the writing of Melanie Klein. The similarities and differences in their theoretical and technical base was explored. The structured theory and techniques of Gove Hambridge, J. C. Solomon, Jacob Conn, and David Levy were presented. In addition, the work of the relationship theorists, Frederick Allen, Jessie Taft, and Clark E. Moustakas, was summarized. Finally, the client-centered philosophy was explained. The adaptation of this theory to work with children was explored through a discussion of the writing of Virginia Axline and Elaine Dorfman. In each instance, the writer provided a historical frame of reference before relating the historical theory to its adaptation in the area of child therapy.

There are strong similarities among the psychodynamic theories. This relationship being that they function on the assumption that what has been done to the child can be undone. In addition, the psychodynamic theories stress that the relationship between the therapist and the child

is crucial. They all provide opportunity for abreaction and re-education.

It was also found that certain theoretical and approach commonalities tend to exist among all the psychodynamic theories presented. These commonalities tend to be more common than the differences. More commonality is evidenced in theory than in technique. There is a strong theoretical relationship between the psychoanalytic orientation and the structured orientation. And, there is a strong relationship between the orientation of the relationship theorists and that of the nondirective therapist.

The psychoanalytic and structured theories assume that the therapist is cognizant enough of the needs and dynamics of the personality of the client that he can define the deficiencies as well as the supplements. They assume that the plan for the therapy lies within the therapist and not the client. In this situation, the client is the recipient while the therapist does "something" which causes cure.

The client-centered and relationship theories stress that the power for growth and development is within the client. The client has the potential for growth and development. The therapist or counselor provides an atmosphere (client-centered) or a relationship (relationship) which allows the client to feel safe so that the

unfolding process can occur. Unlike the psychoanalytic, structured theories, the client-centered, relationship group does not see the therapist as teacher. They feel that the answer lies in the client rather than in the therapist.

All theorists discussed work with the child in a setting which allows the use of media. The therapists make different use of the play media. The psychoanalytical approach of Anna Freud only involves media as it allows the therapist and the child to establish a strong rapport. Melanie Klein uses media so that she will be able to clearly interpret the unconscious processes of the child. The structured therapists stress that each article of play material will be valuable if the therapist structures the scene for specific abreactive effects. The relationship and nondirective therapists use media so that the child will have a comfortable, natural means of expression.

Different uses are made of the counselor-client relationship among the theorists described within the psychodynamic therapies. Anna Freud stresses the need for strong ties to be developed between the therapist and the child. She would see these as going from the child to the therapist and not being reciprocated by the therapist. She describes these ties more in terms of respect and "ideal" rather than transference. Melanie Klein felt that

in order for therapy to occur, the transference neurosis had to develop. These ties she saw as making the child very dependent on the therapist during the course of treatment.

Conn and Levy both suggested that there is no need for the development of a strong relationship between the therapist and the child. Conn indicates that there should not be "ties of gratitude" (7, 8, 9). Solomon (33, 34, 35, 36), however, stressed the development of a relationship between the therapist and the child as being crucial to the total treatment. Hambridge (19) contended that the play experience should not be structured until the relationship has been firmly established and the child is completely comfortable in the therapeutic setting.

Moustakas (28) stressed that the relationship was crucial to the progress of the child and the progress during each hour. He saw this relationship as being one in which both the child and the therapist were involved in a mutually growing developing experience. Axline (3, 4, 5, 6) indicated that the relationship was used to provide a setting of safety. She did not indicate the mutual growth of the relationship as did Moustakas, but indicated that by the responses and attitude of the therapist, the child would become aware of acceptance and so begin to accept himself. In the context of this

"different" relationship, the child would be able to re-establish congruence which had been lost as a result of the experiencing of other types of relationships with significant others.

CHAPTER BIBLIOGRAPHY

1. Abraham, Karl, "The Psycho-Sexual Differences Between Dementai Praecox," in Selected Papers on Psycho-analysis, translated by Douglas Bryan and Alix Strachey, London, Hogarth Press, 1950; New York, Basic Books, 1953.

2. Allen, F. H., Psychotherapy with Children, New York, W. W. Norton and Company, Inc., 1942.

3. Axline, Virginia, Dibs: In Search of Self, Boston, Houghton Mifflin Co., 1964.

4. _____, "Nondirective Play Therapy," in Mary R. Haworth, editor, Child Psychotherapy: Practice and Theory, New York, Basic Books, 1964.

5. _____, "Play Therapy Procedures and Results," American Journal of Orthopsychiatry, XXV (1955), 618-626.

6. _____, Play Therapy: The Inner Dynamics of Childhood, Houghton Mifflin Co., Boston, 1947.

7. Conn, Jacob H., "Play Interview Therapy of Castration Fear," American Journal of Orthopsychiatry, XXV (1955), 747-754.

8. _____, "The Child Reveals Himself Through Play," Mental Hygiene, XXIII (1939), 49-69.

9. _____, "The Timid, Dependent Child," Journal of Pediatrics, XIX (1941), 91-102.

10. Dorfman, Elaine, "Play Therapy," in Carl R. Rogers, editor, Client-Centered Therapy, Boston, Houghton Mifflin Company, 1965.

11. Freud, Anna, Introduction to the Technique of Child Analysis, translated by L. Pierce Clark, M. D., New York and Washington, Nervous and Mental Disease Publishing Company, 1928.

12. _____, The Ego and the Mechanism of Defense, translated by Cecil Baines, New York, International Universities Press, 1948; London, Hogarth Press, 1954.

13. _____, The Psychoanalytic Treatment of Children, translated by Nancy Proctor-Gregg, 3rd edition, London, Imago, 1946; New York, Anglo-Books, 1951.

14. Freud, Sigmund, The Basic Writings of Sigmund Freud, translated and edited by A. A. Brill, New York, The Modern Library, 1938.

15. Ginott, H. G., Group Psychotherapy with Children, New York, McGraw-Hill Book Co., 1961.

16. Hall, Calvin S. and Gardner Lindzey, Theories of Personality, New York, John Wiley and Sons, Inc., 1957.

17. Hambridge, Gove, "Structured Play Therapy," American Journal of Orthopsychiatry, XXV (1955), 601-617.

18. Hug-Hellmuth, H. Von, "On the Techniques of Child-Analysis," International Journal of Psychoanalysis, X (1929), 287-305.

19. Kessler, Jane, Psychopathology of Childhood, Englewood Cliffs, New Jersey, Prentice-Hall, 1966.

20. Klein, Melanie, The Psychoanalysis of Children, New York, W. W. Norton; London, Hogarth Press, 1932.

21. _____, "The Psychoanalytic Play Technique," American Journal of Orthopsychiatry, XXV (1955), 223-237.

22. _____, "The Psychological Principles of Infant Analysis," International Journal of Psychoanalysis, VIII (1927), 25-37.

23. Landreth, Garry, Louise Allen and Willard S. Jacquot, "A Team Approach to Learning Disabilities," Journal of Learning Disabilities, II (1969), 24-29.

24. Lebo, Dell, "The Development of Play As a Form of Therapy: From Rousseau to Rogers," American Journal of Psychiatry, CXII (1958), 418-422.

25. Levy, David, "Release Therapy in Young Children," Psychiatry, I (1938), 387-389.

26. _____, "Trends in Therapy: III, Release Therapy," American Journal of Orthopsychiatry, IX (1939), 713-736.

27. Mannoni, Maud, The Child, His Illness, and the Others, New York, Pantheon Books, 1970.

28. Moustakas, Clark E., Psychotherapy with Children, The Living Relationship, New York, Harper Brothers, 1959.

29. Murphy, Albert T. and Fitz Simons, Stuttering and Personality Dynamics: Play Therapy, Projective Therapy and Counseling, New York, Ronald Press, 1960.

30. Rank, Otto, Will Therapy, New York, Alfred A. Knopf, Inc., 1936.

31. Rogers, Carl R., "A Theory of Therapy, Personality and Interpersonal Relationships, As Developed in the Client-Centered Framework," in S. Koch, editor, Psychology: A Study of Science. Study I Conceptual and Systematic. Vol. 3. Formulations of the Person and the Social Context, New York, McGraw-Hill, 1959.

32. _____, Client-Centered Therapy, Boston, Houghton Mifflin, 1965.

33. Solomon, J. C., "Active Play Therapy," American Journal of Orthopsychiatry, VIII (1938), 479-497.

34. _____, "Active Play Therapy: Further Experiences," American Journal of Orthopsychiatry, X (1940), 763-781.

35. _____, "Play Technique," American Journal of Orthopsychiatry, XVIII (1948), 402-413.

36. _____, "Play Technique and the Integrative Process," American Journal of Orthopsychiatry, XXV (1955), 591-600.

37. Taft, Jessie, The Dynamics of Therapy in a Controlled Relationship, New York, The Macmillan Company, 1933.

CHAPTER III

RATIONALE AND RESEARCH RELEVANT TO AREAS OF FOCUS EFFECTING PROCESS AND OUTCOME

The purpose of this chapter is to organize the material found in the large body of literature dealing with play therapy. In order to form a framework of theory and technique, the work of the major theorists has already been discussed in Chapter II. The literature summarized in Chapter III is of three kinds: theoretical, pragmatic, and research. For the purposes of discussion, the material was grouped into various subject or focus areas. If, as often happened, the article covered more than one area, reference was made to that particular work in each of the relevant focus areas. In each focus area, the articles which are theoretical in nature are presented first. If there are articles describing research on that particular subject, this discussion is included after the theory section.

The major areas of focus are as follows:

I. Literature dealing with process in play therapy
   A. Stages of process: position, research

B. Initial session in play therapy: position

C. Limits in play therapy: position, research

D. Material in play therapy

1. Selection of material and facilities for play therapy: position

a. Material used with handicapped children

b. Material used with blind children

c. Material used with older children

d. Material used in a school setting

e. Material used in a hospital setting

f. Material used in structured therapy

g. Puppets used as play materials

h. Other materials

2. Selection of material: research

a. Research on materials: sex differences

b. Research on materials: age differences

E. Case studies in the play therapy process

2. Literature dealing with types of children seen in play therapy

A. Children seen by major theorists

B. Play therapy in the treatment of speech difficulties

C. Play therapy in the treatment of learning disabilities

D. Play therapy in the treatment of blind children

E. Play therapy in the treatment of psychotic disturbances

F. Play therapy in the treatment of psychosomatic disturbances

G. Play therapy in the treatment of reading difficulties

H. Play therapy in the treatment of retarded children

I. Play therapy in the treatment of older children

3. Literature dealing with parental involvement as influencing process and outcome in play therapy

A. Position

B. Research

4. Literature dealing with setting as influencing process and outcome

A. School setting

B. Hospital setting

5. Literature dealing with therapist variables as influencing process and outcome

6. Literature dealing with outcome research in play therapy

A. Outcome research

B. Duration as it affects outcome

C. Follow-up research studies

7. Literature dealing with "armchair" philosophy

8. Literature dealing with material and information related to play therapy

A. Methods used for evaluating process and outcome in play therapy

1. Testing procedures

2. Other research contributions

3. Documentation of play therapy process

4. The use of playroom laboratories

B. Diagnostic procedures using play material

1. Doll play technique

2. Play interview technique

3. Other diagnostic procedures using play material

Literature on Process in Play Therapy

Process as described in this section will refer to the interactions which occur during the course of the total play therapy experience. Process is the focus on the movement within the relationship as a result of the interaction between therapist and child. In addition, it describes this movement. For instance, the movement within the interaction could be a movement from nonrelationship to relationship, from nonrapport to rapport, or from a superficial relationship to a risk-taking relationship. Movement within the child is also a part of the process. The child either grows as a result of the therapeutic hour, or else he does not. This growth or lack of growth is a part of the process.

Strategic variables which are considered to affect this process or movement include parental involvement or lack of it, the use of limits or the type of setting, and the media used.

Some writers have indicated that they see the therapeutic process as moving through certain predictable stages

of development. During the first part of the section on process, these stages of development are explored and some research dealing with these stages of development is presented.

Stages of Process: Position

Moustakas (212), in an article dealing with emotional adjustment and the play therapy process, stresses that there is a parallel between normal emotional development in the early years of life in a family relationship and the emotional growth seen in a play therapy relationship. He reports that an analysis of the case studies of disturbed children in play therapy showed the following levels of the therapeutic process:

> (1) diffuse, negative feelings, expressed everywhere in the child's play.
> (2) ambivalent feelings, generally anxious or hostile.
> (3) direct, negative feelings expressed towards parents, siblings, and others.
> (4) ambivalent feelings, positive and negative, toward parents, siblings, and others.
> (5) clear, distinct, separate, and usually realistic positive and negative attitudes with positive attitudes predominating in the children's play (212, p. 84).

Moustakas found that the attitudes of well-adjusted children and those of disturbed children differ only in frequency and intensity, not in type. He contends that, since the growth process is impaired at some level of

development and the degree of the disturbance is a reflection of the intensity of anxiety and hostility attitudes in the family, this process must be reversed. The unique interpersonal relationship provided in the play therapy process affords the disturbed child an opportunity to achieve emotional maturity and to grow through the expression and exploration of the various levels of the emotional process. The child's problems and symptoms are reflections of his attitudes. As these attitudes are modified, his problems and symptoms disappear. In play therapy, this exploration and growth move from pervasive, generalized and negative attitudes that immobilize the disturbed child to clear attitudes, both positive and negative, which enable the child to feel adequate and to express himself in terms of his real potential and abilities.

Moustakas (212) suggests that, in the play therapy process, the movement from stage to stage does not occur automatically in a play situation. The levels overlap at many points, as do the attitudes of the child. The process does not go in a step-by-step fashion but moves in individually varying sequences. The process allows this movement to occur, because the relationship is the opposite of the one which caused the disturbance. The therapist responds with constant sensitivity to the child's feelings, accepts the child's attitudes, and maintains a sincere belief in the child.

Axline (18) also says that children undergo a process in the first sessions of play therapy which falls generally into four categories.

> (1) feelings for which the child does not assume responsibility; but rather has a doll or another toy to express his feelings;
> (2) feelings directed against a toy or an unseen recipient placed in the play-room by the child's imagination;
> (3) feelings directed at a person who is part of the child's real world; and
> (4) feelings for which the child assumes responsibility (18, pp. 72-73).

Some of the patterns of play cited are toy to toy, toy to invisible person, child to imaginary person, child about a real person, and child to the object of his feeling. Axline believes further that when successful therapy is concluded the child is assuming responsibility for his own feelings and expressing himself honestly and openly.

Cashdon (50) divides the process of play therapy into five stages, identifying these stages through drawings which the child makes.

(1) Problem statement: Cashdon suggests that the child will reveal the problem he is experiencing in the initial stage during his drawing.

(2) Relationship defining: The child will define the terms of the relationship through the drawings he produces. He will suggest power struggles, passive aggression, and other difficulties through his drawing.

(3) Emotional learning: It is also possible for the therapist to see the beginning of trust in the child and the beginnings of emotional learning. Through drawings, the child will bare his "hurt spots."

(4) Separation: The therapist will be able to see the beginning of the separation process in the relationship.

(5) Finally, the child will reveal his adaptation and adjustment through his drawing.

Writing by Miyamoto (207) suggests that just as the process of nondirective play therapy goes through stages, so can the qualitative stages of silence be explained in this way. In the beginning stages of therapy for the child, he may use silence as an indication of wanting to be left alone, or of regression to simpler, less demanding levels of development. Silence in this situation is seen as psychological blocking. It plays the role of a barrier for the next action. Miyamoto suggests, then, that silence plays a negative role in the first stage of play therapy. During the second stage of therapy, when the child is attempting to move closer to the therapist to clarify and strengthen the relationship, a positive silence is evidenced. The last stage involves the child's expressing ambivalent feelings. These positive and negative feelings are toward parents, siblings, and others. During this stage, the child gains insight in silence.

A paper emphasizing the stages of process experienced by the counselor was written by Myrick (221). He presents nondirective theory and a case study which lasted over a seven-week period. Myrick suggests that he has isolated three stages in the process of play therapy. (1) The first stage involves establishing a relationship. This relationship is different from any the child has ever experienced in that it is characterized by unconditional acceptance and is client-centered. (2) The second stage involves more assertion on the part of the therapist. (3) The third stage involves a directive therapist as he helps the child make changes in his environment and his functioning in it.

Stages of Process: Research

Moustakas (216) studied the frequency and intensity of expression of negative attitudes of nine well-adjusted and nine disturbed four-year-old children. They were matched on intelligence and sociometric background. Each child had four play therapy sessions with the same therapist. Verbatim recordings of the children's statements were kept on each child. From the protocols of the first and third sessions, a total of 241 negative attitudes were selected and rated in terms of intensity of feelings expressed. Both groups of children expressed about the same types of

negative attitudes. The disturbed group expressed a significantly greater number of negative attitudes in a more diffuse, persuasive manner. Moustakas concluded that intensity of attitudes differentiated disturbed children from well-adjusted children more clearly than did frequency of such responses. This study suggests that as therapy progresses, the negative attitudes of the disturbed child become similar to those of well-adjusted children. In addition, the negative attitudes are expressed more clearly and less frequently. This is also true with mild or moderate intensity of feeling.

Because it was not feasible to force children's statements into adult categories, Finke (86) developed new categories based on an analysis of children's statements made during nondirective play therapy (see Appendix A). She used complete protocols from six therapists who worked with six children ranging in age from five to eleven years. The number of contacts varied from eight to fourteen. Expressions of feelings were emphasized. Finke felt these would mirror the child's changing emotional reactions resulting from play therapy. She found that the protocols revealed similar trends for the different children which seemed to divide the process of play therapy into three stages.

1. The child is either reticent or verbose. If he is to show aggression during therapy, much of it will be evoked in this initial stage.

2. If aggression has occurred, it will not decrease. The child tests the limits of the play therapy situation. During this stage, the child frequently indulges in imaginative play.

3. The child makes great efforts to establish a relationship with the therapist and attempts to draw him into his play and games.

Lebo (162) presents a revision of Finke's categories, referred to here as the Helen Borke (from Finke's married name) categories for quantifying play therapy process. In his paper, Lebo uses Borke's scales "A" through "U" and adds to these scales "V" and "W." He suggests that these two additional scales are needed to differentiate types of verbalizations in older and younger children. These are sound effects (such as sirens, guns, explosions) commonly used by younger children and mumbling or talking to self commonly seen in older children (see Appendix A).

In one of the more comprehensive process studies of play therapy, Hendricks (129) reports a descriptive analysis of the process of play therapy. She analyzed and described the patterns of play activities, nonverbal expressions, and verbal comments made during the process of play therapy.

In addition, she sought to determine whether phases of emotional and/or social development do exist during the process of client-centered play therapy and to describe these phases.

Ten boys, aged eight to ten, who were of average intelligence and diagnosed as having emotional and/or social maladjustment problems were used in Hendricks' study. Five of the boys were assigned to begin play therapy. The other five boys were randomly selected from those boys who had a minimum of twelve sessions prior to this study. Descriptive records were made of play activities and nonverbals. Different play activities were timed using a stop watch.

On the basis of the data gathered, Hendricks was able to report some distinctive patterns of play activities in the process of client-centered play therapy. In addition, she was able to determine distinct phases of emotional and/or social development. She found that initially, the children engaged in exploratory, noncommital, and creative play, expressed curiosity, and made simple descriptive and informative comments. Behaviors such as curiosity about the playroom and its contents, as illustrated by exploratory play, were expressed during the beginning sessions. As the process continued, Hendricks found that curiosity decreased. The first sessions were characterized

by noncommittal play which gradually changed to more definite activities as the child became more familiar with the setting. Another characteristic which tended to separate the stages of process was the testing of limits. Hendricks found that limits were not tested so much during the exploratory stage as they were during later stages.

The second stage observed by Hendricks was characterized by more creative play and more aggression. The children tested more limits. The aggression tended to move from generalized aggression in the beginning sessions to being directed to specific people or situations to final disappearance from the play activities. During the third stage, it was found that creative play yielded to dramatic and role play. In the beginning sessions, the children tended to role play impersonal matters. Gradually, they began to verbalize specific fears, anxieties, or hostilities.

During the middle sessions, the children increased in the amount of time they spent in checking the counselor's reactions, seeking approval, confirmation, and suggestions. There was a noticeable increase in the child's overtures to establish a relationship with the counselor as the play therapy progressed.

Hendricks' study tended to be in agreement with Moustakas's (216) conclusion that the levels of the emotional process and the changes in the "feeling tones" are

not always identifiable as a child goes through the play therapy experience. Changes occur, according to Moustakas, in the child's play and in his emotional behavior in the play therapy session in no specific sequential order but in individually varying sequences. He concluded that the levels of the play therapy process overlap at many points as do the child's feelings and attitudes.

In conclusion, Hendricks suggests the following:

1. Initially, the children engaged in exploratory, noncommittal, and creative play, expressed curiosity, and made simple descriptive and informative comments.

2. Second, the children began to play more creatively. Aggressive play increased. Verbal comments about family, self, and their play increased.

3. Finally, anger, frustration, and anxiety were expressed. Creative play yielded to dramatic and role play. During the final sessions, the relationship with the therapist became important.

For complete detail of this excellent work the reader is referred to the original source.

Landisberg and Snyder (156) examined the protocols of four children, aged five to six, who were seen by three nondirective therapists. Three of the cases were considered to be successful and one was incomplete. Every speech and action was categorized using Snyder's categories which

were derived from adult statements. They found that (1) three-fifths of all responses were made by the children; (2) nondirective statements made by the counselor preceded 84.5 per cent of all client responses; (3) slightly less than 10 per cent of counselor statements were simple acceptance of client remarks; (4) children increasingly released feelings 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; (5) negative feelings increased in frequency as therapy progressed; whereas, positive feeling responses remained at the same level throughout the sessions; (6) the major part of the child's feelings were directed toward others rather than toward the counselor or toward himself; and (7) no statements were found which could be classified as insight.

The investigators proposed that the amount of insight achieved in play therapy is closely related to age and intellectual maturity. Also, for younger children, the value of nondirective play therapy may be cathartic rather than insightful or educative.

Daly and Carr (67) explored the development of trust in the therapeutic experience in play therapy as evidenced by the changes in tactile contacts by the child. They suggest that one characteristic of the disturbed child

is that he withdraws from human contact, exhibiting this withdrawal by limited and inadequate physical contact. One example of this is the way the child touches. Daly and Carr suggest that in the disturbed child there is more gross body contact and less meaningful hand touching contact. The purpose of this study was to explore the role of tactile contact in relation to the development of "trust" of the disturbed child toward the therapist. The researchers contend that as trust develops, the relationship is stronger, and therefore, movement occurs in the process.

An observer recorded every movement as well as all verbalizations and tactile contacts. The number of contacts as well as the type of contact were recorded. The progress recorded by the observer was compared with the progress assessed by the therapist after each session.

The researchers found that significant differences in the nature and frequency of the tactile contacts were observed during the course of the therapy. In addition, the child changed his method of contact from gross body contacts to hand contacts.

As a result of working with children in a monitored palyroom as discussed by L'Abate (154) and Golden (107), Rogers (249) was able to identify three stages in the process of play therapy: (1) exploratory, (2) aggressive, and (3) constructive. Rogers contends that on the basis

of these stages, it is possible to chart the process of play therapy from session to session. In a further study not yet published, Rogers (250) has investigated the effects of the therapist's verbalization on process.

Initial Session in Play Therapy: Position

In this section, discussions are presented by Axline (19), Ginott (98, 101), and Moustakas (214) explaining their approach to the success of the first session in the play therapy process. They generally refer to the process which occurs during this initial session as structuring the relationship. However, it is not structuring in the strictest sense of the word in that these therapists are all nondirective in approach. Their use of the term "structuring" means providing a framework.

Axline (19), Ginott (98, 101), and Moustakas (214) all write in reference to the structuring of the relationship which begins during the initial session. Ginnott (115, 116) deals specifically with some of the technical problems which are likely to arise and possible solutions for them. For example, he suggests that the decision to receive or reject therapy should not be left up to the child. In the event that the child comes to the clinic and refuses to come to the playroom, the therapist takes a firm hand. He does not plead with the child, but he extends his hand to the child. The therapist may either

take the child himself or allow the mother to take the child into the playroom. Mothers should be given all the information possible about the playroom so that they can help the child through the initial session. Ginott stresses that the mother should be prepared by the therapist in advance to deal with fear, crying, and clinging of the child should it occur. He further suggests that the parents should be aware that the playroom is not a place where the child is coming to "have fun." It is a place where the child learns to make decisions, to gain independence, and to express his thoughts and feelings in a constructive way.

The therapist should be prepared for the tricks the child is likely to try, such as the bathroom need, temper tantrums, coughing, and other escape mechanisms. Once the child is in the playroom, the therapist can reflect the child's feelings and empathize with the child.

Ginott (98, 101) stresses that children will try behaviors which are akin to their previous relationship patterns. He suggests that this relationship should offer from the beginning the fact that it will be different from any other relationship the child is engaged in. He cites in particular the withdrawn child who is likely to present special problems. The therapist has to be careful not to be "rapport-chasing." The child should initiate

therapeutic movement. The therapist can empathize with the child's feelings of being fearful and accept the child. He should exhibit a faith in the child's capacity to move forward under his own steam.

The therapist structures the relationship by his initial responses. He essentially conveys to the child his respect and acceptance. The therapist conveys this by a simple statement, such as "You can play with these toys any way you want to."

Not only does the therapist interview the child during the first session, but the child is also interviewing the therapist. The child is finding out about limits, attitudes, and how he will be treated by the therapist. It is important to be able to look beyond the verbalized words to the feeling that the child is stating.

Moustakas (214) suggests that during the initial session the child is introduced to the playroom and the permissive nature of the situation is conveyed to him. Through the statements of the therapist, the child gains an understanding of the therapeutic relationship and the nature of the freedom and responsibility of the setting. Structuring statements, such as "This is your time and place," are suggested by Moustakas (214) as being helpful in aiding the child to become aware of himself, to face inner conflicts, and to work through painful, negative

self-attitudes. These statements give recognition to the child's self and help him to come to terms with himself. They also allow him to express his own feelings, thoughts, choices, and wishes.

Axline (19) defines structuring to mean the building up of the relationship according to the eight principles of therapy she suggests. The structure is not verbally explained, but it occurs because of the successful establishment of the relationship.

Limits in Play Therapy: Position

Most child therapists seem to agree that reasonable and consistent limits are necessary in play therapy with disturbed children. However, there are differences in opinion about the specific limits required in therapy. Therapists such as Bixler (36) and Ginott (98, 103, 104, 105) stress that limits are an integral part of the process. Axline (19, 12) and Moustakas (214) insist that the setting of limits allows the process to occur and adds unique dimensions to the play therapy relationship. Others such as Dorfman (77) and Schiffer (263), who actually did activity therapy rather than play therapy, set very few limits in their work with children.

In reference to the setting of limits within the play therapy process, Klein states,

> It is an essential part of the interpretative work that it should keep in step with fluctuations between love and hatred; between happiness and satisfaction on the one hand and persecutory anxiety and depression on the other. This implies that the psychoanalyst should not show disapproval of the child's having broken a toy; he should not, however, encourage the child to express his aggressiveness, nor suggest to him that the toy should be mended. In other words, he should enable the child to experience his emotions and fantasies as they come up. It was not part of my technique to use moral influence (172, pp. 228-229).

Klein (150) stresses that she would not tolerate attacks on herself by the child because such attacks are likely to arouse guilt within the child. In addition, such measures protect the analyst. Klein contended that since she is careful not to inhibit the child's aggressive "fantasies," he does not need to act out in an aggressive manner.

Solomon (280) suggests that the therapist set some carefully defined limits. If the child destroys property or attacks the person of the therapist, the therapist must make every effort to curtail such activity, but without anger or vindictiveness. Solomon suggests telling the child that he "can do anything he wants to the rubber doll representing me (therapist) but that he must not attack me actually" (280, p. 408). In working with an anxiety-phobic case, care should be taken not to further repress the child by repressive limits. In other words, Solomon

is suggesting that limits should be set for each child according to his unique needs.

Maisner (194) describes appropriate limits for the retarded child in a training school setting. She stresses that the child "cleans up his mess at the end of the hour, and the child is not allowed to hurt another child, nor to destroy irreplaceable property" (194, p. 242).

Taft (291) stresses the limit of time in therapy. Following the work of Rank, she suggests that if the child can learn to live within the framework of one minute, and one therapeutic session, he has within his grasp the ability to live all minutes to the fullest. In addition, with the separation of the therapist at the end of each hour, the child has the opportunity to re-experience the separation from the womb at birth. He learns that he can survive further future separations.

Moustakas (214) contends that one of the most important aspects of relationship is the setting of limits. He stresses that without limits "there would be no therapy." The limits for a child define his boundaries within the relationship and tie the relationship to reality. They remind a child of his responsibility to himself, to the therapist, and to the playroom. This offers the child security and at the same time permits him to move freely and safely within the playroom (214).

Limits are important to the child in that they furnish the child with a feeling of reality and allow him to function freely without taking chances on the stimulation of anxiety and guilt. Moustakas stresses the following limits as necessary: (1) The time limit is stated at the beginning of each session. In addition, he tells the child when only a few minutes are left. (2) Moustakas suggests that the child cannot take toys home. (3) The child is not allowed to destroy expensive or irreplaceable items. (4) The child is not allowed to physically abuse the therapist nor to damage his clothing. (5) The child is not allowed to re-enter the playroom if he once leaves it. (6) Health and safety limits are set as the need arises.

Dorfman (77) is quite conservative in the setting of limits. She emphasizes that the therapist should set no limits on the child's verbal expression of feelings and suggests further that the setting of limits involves directing the child's physical expression of feelings into acceptable channels. For example, a child is not allowed to express anger by breaking windows, but he is allowed to pound on the floor, shout, or throw unbreakable toys.

Dorfman differentiates between playroom limits and those outside the playroom in suggesting that the playroom limits are fewer, and there is an acceptance of the child's

need to break the limits. She concurs with Axline and Ginott in stressing that the child is not allowed to attack the therapist. This, she suggests, would do the child harm and would interfere with the relationship between the child and the therapist.

According to Dorfman, limits are beneficial to the therapeutic process in that they lend structure to the situation and reduce its anxiety-inducing potentiality. They further help to increase the predictability of the situation and thus add to the security of the client and therapist.

In describing her views on limits, Axline states,

> The therapist establishes only those limitations that are necessary to anchor therapy to the world of reality and to make the child aware of his responsibility in the relationship (19, p. 130).

Axline suggests that the limits within a nondirective relationship should be few. They should be confined to material things such as limiting the willful destruction of the play materials, damaging the room, and attacking the therapist. Other limits which are necessary for the protection of the child should be included. The limit of time is placed on the child by describing the length of the session in advance and giving the time warning before the session is near the end (12).

Axline (19) prohibits any attack on the therapist. She contends that this will damage the potentiality of the

relationship and cause the child emotional harm. The child needs control, and this control is conducive to good mental health. The use of limits anchors the play therapy experience to the world of reality. The consistency of the therapist gives the child security and allows him to feel accepted. Again, Axline stresses that limits are placed on time and activities. She does not limit the right of the child to feel any way he wants. She acknowledges the child's right to feel as she offers him alternate ways of expressing these feelings. She does not allow the child to hit the therapist, but suggests that he can hit "Bobo" or the floor. In this way, she acknowledges his feeling of anger and his right to that feeling.

Ginott (98, 102) suggests the following limits which he feels are conducive to therapy: (1) He stresses the use of a time limit. The normal time as suggested by Ginott for a play therapy session is fifty minutes. The child is told five minutes before the session is over that he has five more minutes to play. The child is not allowed to break the limit of time, nor is he allowed to dawdle. The child is not allowed to terminate a session before the hour is over. (2) Ginott advises that toys in the playroom cannot be taken home. The relationship between the therapist and the child is based on "emotional rather than material sharing." (3) Limits are set in order to prevent the child

from doing damage to expensive or irreplaceable toys or to the playroom itself. (4) The child is not allowed to physically attack the therapist. To allow this to occur would harm the child emotionally and interfere with the therapist's ability to relate to the child.

In discussing his approach to the setting of limits, Ginott (98, 102) suggests that they should be set in a friendly manner. They should be total rather than conditional and should leave no ambiguity in the relationship. They should not be presented in such a way as to arouse anger and should not be punitive. Ginott suggests a four-step sequence in setting the limits.

> (1) The therapist recognizes the child's feelings or wishes and helps him to verbalize them as they are. (2) He states clearly the limit on a specific act. (3) He points out other channels through which the feeling or wishes can be expressed (he provides alternatives). (4) He helps the child to bring out the feelings of resentment that are bound to arise when restrictions are invoked (102, p. 107).

He further adds that there are times when a limit can be set nonverbally by simply offering the child another toy.

According to Ginott (98, 102), the reasons for using limits in play therapy are as follows:

1. Limits direct catharsis into symbolic channels. The child is able to release his feelings symbolically where he is not able to release to the real object. The

child can enact incestuous and destructive urges. He can express anger, hatred, and love. The child is able to discover that his inner impulses can be discharged without hurting anyone and without dooming himself.

2. Limits enable the therapist to maintain attitudes of acceptance, empathy, and regard for the child throughout the therapy contacts. It is humanly impossible for a therapist to remain accepting of a child who is allowed to destroy the clothing of the therapist, put paint on him, and otherwise attack him. In order to maintain feelings of acceptance and warmth toward the child, the therapist should limit all acts of aggression toward himself. The therapist should set limits according to his own tolerance level. If the therapist is uncomfortable with the child, it makes it difficult for the therapeutic relationship to develop.

3. Limits assure the physical safety of the children and the therapist in the playroom. The therapist should set limits which will provide for the safety of both the child and the therapist. Some of these would include not allowing the child to drink dirty water, hang out of the window, throw sand, pull hair, or punch with scissors.

4. Limits strengthen ego controls. The therapist hopes to become the external authority figure valued in the child's life to the point where the child will absorb

and introject the values of the therapist. The child should not be made to feel falsely impotent but should begin to distinguish between wishes and deeds. He learns that he may feel any way he likes but is limited in his actions. In the event that a child is allowed to act according to his wishes, he experiences guilt. In a therapy situation with limits, he learns to accept and control impulses without excessive guilt.

5. Some limits are set for reasons of law, ethics, and social acceptability. These limits would include not allowing the child to engage in sexual play in the playroom; urinating and defecating in the playroom; or in yelling obscenities into the hall from the playroom.

6. Some limits are set for budgetary considerations. These include not allowing the child to destroy expensive toys (98, pp. 103-106).

In his article, "Limits Are Therapy," Bixler (36) suggests that the most effective rules to use in the establishment of limits are those which feel comfortable to the individual therapist. He indicates that most therapists use limits and that these limits are essential. A few therapists limit some verbal behavior in children, but almost all limit the range of nonverbal activity. Limits should protect the rights, property, and physical well-being of others. They allow the therapist to maintain his

accepting attitude toward the child. Provision of limits also helps to differentiate this relationship from others the child has known and so allows the relationship to develop on a level of integrity.

Bixler explains that the general rule is to set a minimum number of limits. This is easier to do if the therapist plans a playroom specifically for the use of play therapy and if all superfluous materials are excluded. Bixler sets the following limits as basic:

1. The child should not be allowed to destroy any property or facilities in the room other than play equipment.
2. The child should not be allowed to attack the therapist in the physical sense.
3. The child should not be allowed to stay beyond the time limit of the interview.
4. The child should not be allowed to remove toys from the playroom.
5. The child should not be allowed to throw toys or other material out of the window (36, p. 2).

Bixler (36) continues that the use of well defined limits allow the therapist and the child to be more comfortable in the relationship. In the event that there is an unclear line of demarcation, the poorly adjusted child will find it and capitalize on it. The intangible limit also further causes insecurity in the child. The best time for limit setting is at the time of the act. The child learns what he is permitted to do as he explores the setting and the relationship. Bixler suggests that

the following steps may be used successfully in the setting of limits:

> (1) reflect the desire or attitude of the child
> (2) verbally express the limit
> (3) provide an acceptable alternative, and finally
> (4) control by physical means if necessary (36, p. 4).

Bixler states that as a last resort the child may be taken from the playroom in order to enforce the limit of aggression toward the therapist. He indicates that children often leave the office with a sense of relief because their aggressiveness was controlled. Bixler's conclusion is that properly set limits can provide the crux of therapy and will be accompanied by positive changes at home.

Schiffer (263) discusses two types of permissiveness--that which is structured on a foundation of insight to the needs of children and that which has deteriorated into approval of disorganized, asocial behavior. He suggests that the correct application of permissiveness is a primary requisite in play group therapy, and that without it, there is no therapy.

Schiffer defines permissiveness as the acceptance of all behavior as it appears in the group--aggressive, hostile, sadistic, or masochistic--without reproof, censure, or restriction on the part of the therapist. He contends that the child should be free to "build or destroy; to

mold with clay, or to throw it; to hammer or saw on a table (or the table itself); to paint a picture; or the walls; to withdraw into isolation, or to play, run, and shriek; to provoke or to be provoked" (263, p. 258).

Schiffer argues that the onset of total permissiveness allows the child to experience the therapist in a way he has never experienced an adult heretofore and that gradually, controls within the child and the group will develop. These controls are based on reality as it is seen in society.

In his article referring to activity therapy, Schiffer distinguishes between permissiveness and sanction. He stresses that the therapist should never "sanction" asocial behavior. Aggressive, destructive actions are "permitted, not approved" (263, p. 260). He concludes,

> Permissiveness is a therapeutic tool with which the therapist manifests unconditioned love for the child. It sets the stage for the dynamic processes that take place in activity group therapy. By virtue of the permissiveness, the child is enabled to develop the transference necessary for treatment.
>
> Sanction, the approval of negative behavior, is a denial of values and a threat to the already weakened structure of personality. Activity group therapy must fail when the therapist fails to distinguish between permissiveness and sanction (263, p. 261).

Many of the writers who have included sections on the use and value of limits in regard to the play therapy process have also discussed counselor action in the event

that the child refuses to accept the limit. Axline (19) stresses the need to remain accepting of the child even when the limit is broken. The therapist should "stay right there with her reflection of feelings" (19, pp. 132-133). The therapist should try to prevent the breaking of a limit with the child "if she can do so without engaging in a physical battle" (19, p. 133).

According to Bixler (36), in the event that a child breaks a limit and the therapist is unable to enforce it without a physical battle, the therapist should terminate the session. He contends that an initial warning should be given before the termination and removal from the playroom.

Ginott (98, 102) contends that to put a child out of the playroom in order to enforce a limit allows the child an avenue for manipulation and a way of defeating the adult. The child may need to be told, "I am bigger and stronger than you." Ginott suggests that it is sometimes helpful to transfer a child who will not adhere to limits to a group setting, possibly with older, stronger children. He further suggests that when a child breaks a limit, the therapist must maintain a calm "authority and must not become argumentative or verbose." There should be no opportunity for argument nor manipulation to occur. When a child breaks a limit, he feels anxious and the therapist must

behave in a consistent manner to allow the child to feel secure in the ability of the therapist. The therapist should in no way damage the child's self-respect and should be careful not to allow a battle of wills to begin.

Moustakas (214) states that when limits are broken, the therapist must enforce them. He may place a toy or an area of the room out of bounds, or stand by the child and repeat the limit. Throughout the process of enforcing the limit, he must continue to help the child to feel accepted.

Moustakas views limits as a set of new experiences which occur during the play therapy process which need to be dealt with. Every limit, he contends, depends on the child and the situation. Moustakas further suggests that when a limit is broken, or rejected, it furnishes the therapeutic relationship with new material. It introduces a dimension which the therapist is not aware of. Like Ginott (98, 102), Moustakas emphasizes that the therapist should not terminate the session when a limit is broken. To terminate negates any possibility of incorporating this new dimension of the relationship into the experience. The therapist should perceive the situation, the issue, or the conflict as an opportunity to face the child "freshly" and to participate in a "new dimension of experience." He contends that the nonacceptance of the limit offers

an avenue for a new growth in the relationship if the non-acceptance is dealt with (214).

Limits in Play Therapy: Research

Two articles were found which have to do with research on setting limits in the process of play therapy. Both of these articles, however, are efforts to identify types of limits set. No research was found on the effect of limit setting.

Ginott and Lebo (104) investigated the most used play therapy limits by sending a questionnaire on limits to 227 play therapists (100 psychoanalytic, forty-one nondirective, and eighty-six adherents of other schools). They asked which of the following limits they regularly used with children who were aged three to ten years old (see Appendix B).

Ginott and Lebo conclude from the data obtained by the questionnaires that the most used limits included protecting the playroom property, protecting the child's safety, and protecting the person of the therapist. Over 90 per cent of the therapists set limits on other destructive acts such as breaking windows, putting paint on the therapist, and drinking dirty water. Children were limited in disturbing persons in the hall and from being destructive to the playroom. In addition, a large number prohibited the child from urinating and defecating in the playroom.

The least used of the limits listed on the questionnaires were the following: the use of racial slurs, speaking profanities in the playroom, writing four-letter words, drawing obscene objects, and taking home paintings from the playroom. Few therapists set limits on the child's bringing food in or taking home clay objects.

The authors concluded that the following two patterns emerged from their study:

> 1. Child therapists show great permissiveness in some areas that are prohibited in society at large. They allow children to verbalize profanities, to write four-letter words on the blackboard, to draw, paint, and make obscene objects, and to use racial slurs. Aware of society's attitude, therapists do not allow children to yell profanities at passers-by.
> 2. Blatant physical aggression is not tolerated in the playroom. Children are not allowed to destroy costly furnishings and ruin equipment or physically to attack the therapist (104, p. 159).

In summary, therapists writing on the subject of limits tend to agree that limits affect process. It was also found that all therapists reporting the use of limits shared some general concepts on the nature of these limits. These generally have to do with limiting aggression toward the therapist and limiting the destruction of expensive or irreplaceable objects in the playroom. Most therapists did not allow the child to abuse the rights of others, violate social mores, or harm himself.

Ginott and Lebo (105) describe the results of a questionnaire which they sent to play therapists. The results are based on summarizing information obtained from 227 respondents (psychologists, social workers, and psychiatrists). The questionnaire, which was designed to find the correlation between the use of limits and the theoretical orientation of the professionals assessed, contained fifty-four discrete limits. Respondents included 100 who considered themselves to be psychoanalytic, forty-one nondirective, and eighty-six from other schools.

On the basis of the results obtained, Ginott and Lebo concluded that the therapists of the three approaches employ a similar number of limits in their work with children. There is some difference in the kinds of limits imposed, but a considerable body of prohibitions are employed by all. The results reported by Lebo and Ginott are as follows:

> Physical aggression against the therapist
> Practitioners of all schools concur to the same degree in prohibiting a child from squirting water on the therapist, painting his clothing, throwing sand, or forcefully attacking him. They differ, however, in that the nondirectivists were significantly more permissive in allowing a child to shoot darts at or to hit the therapist and significantly less permissive in allowing a child other such privileges.
>
> Physical aggression against equipment
> All practitioners concur to the same degree in prohibiting a child from spilling sand, painting walls and furniture, starting fires, breaking windows and inexpensive toys, and

> throwing objects around the room. They differed in that nondirectivists were significantly more permissive in allowing a child to pour much water into the sandbox, paint and break expensive toys. "Other therapists" were the least permissive.
>
> Socially unacceptable behavior
> Practitioners of all schools similarly prohibited a child from smoking, using racial slurs, speaking or writing profanities in the playroom, making obscene objects, painting his face or clothing, undressing, and masturbating. They differed, however, in that the "other" therapists were significantly less permissive in allowing a child to urinate or defecate on the floor.
>
> Safety and health
> Practitioners of all schools similarly prohibited a child exploding a whole roll of caps, climbing on high window sills, drinking dirty water, or eating mud, chalk, or fingerpaints. They differed, however, in that the nondirectivists were significantly more permissive in allowing a child to decide whether or not to enter the playroom, to read books, and to do his schoolwork there. The psychoanalytic therapists were significantly more permissive than members of the two other approaches in allowing a child to bring drinks and food into the playroom.
>
> Physical affection
> Practitioners of all schools similarly prohibited a child from sitting in their laps, hugging, and kissing them. They differed, however, in that nondirectivists were significantly less permissive in allowing a child to fondle them (105, p. 34).

The research done in the area of limits as described by Ginott and Lebo (104, 105) were surveys. These investigators identified types of limits used. No research was found which explored the effect of the limit on process, per se. However, Hendricks (129) did find that children

tested limits more after the relationship had developed than they did in its initial stages.

Selection of Material and Facilities for Play Therapy: Position

There is a considerable amount of literature dealing with the selection and use of media in the playroom. It was found that persons using play therapy approaches make different assumptions about what media to use and they make different interpretations of the way the child uses the media.

Some of the written material focused on a specific child population for the inclusion of certain media. For example, considerations in the selection of media to be used with the retarded child, the blind child, and the older child were described. Other sets of material focused on the selection of media to be used for specific technique orientations. For example, consideration in the selection of media for use in structured therapy, puppet play, art therapy, and role playing were identified. The value of certain media such as masks, clay, darts, and drawing materials were also dealt with.

Anna Freud stressed the use of toys especially during the introductory phase of treatment. This treatment period was described as the preanalytic period and the major goal of Anna Freud at this time was to "woo" the child in any way possible. She considered play technique useful

for diagnostic observation and also used drawing in the analytical phase. However, she does not mention having elaborate paraphernalia in her office (220).

In describing Melanie Klein's use of toys, Anna Freud (90) suggests that the play technique as described by Klein is valuable for observing the child because this allows the child to establish a domestic environment in the analyst's room and allows him to move about under the eye of the analyst. Anna Freud contends that this will allow the analyst to get to know the child in his various reactions. The toy offers an advantage over the observation of real conditions because it is manageable and amenable to the will of the child so that "it carries with it all the actions which are in the real world, but will remain confined to fantasy-existence." Anna Freud further suggests that these techniques are indispensable for familiarization with small children who are not yet able to express themselves verbally (90).

Melanie Klein kept a box of miniature toys for each child in a separate drawer. The individual drawer came to signify the "private intimate relation between analyst and patient, characteristic of the psychoanalytic transference situation" (150, p. 227). This box, which was used throughout the child's analysis, was added to or deleted from, depending on the needs of the child in his

analysis (150). Klein suggested the use of the following miniature toys as suitable for the psychoanalytic technique of play therapy: "little wooden men and women (usually in two sizes), cars, wheelbarrows, swings, trains, airplanes, animals, trees, bricks, houses, fences, paper, scissors, a not-too sharp knife, pencils, chalks or paints, glue, balls and marbles, plasticine and string" (150, p. 226). The toys should be "nonmechanical." The simplicity of the toys enables the child to use them in a large variety of situations and to express many different attitudes (150).

Klein suggests that the equipment of the playroom should be very simple and should consist of only what is needed for the analysis. The playroom should have a washable floor, running water, a table, a few chairs, a little sofa, some cushions and a chest of drawers. Each child's playthings are kept locked in one particular drawer, and he is the only one who plays with them. The toys become equivalent to the adult associations, and the child only shares them with the therapist (150, 148).

Bender and Woltman (30) stress that the same toy selected by two children may have two different meanings. Bender and Woltman also believe that play with toys offers an opportunity for the child to create and to play out all kinds of human relationships on a realistic level. This

realism is a make-believe situation which reduces feelings of anxiety, fear, apprehension, and guilt, which would be present in a real life situation.

Despert (72) suggests that the use of equipment by the child is highly individualized. Some children will use the same toy over and over, using the same theme or varying the theme. Other children will go from toy to toy. In another article (73), Despert stressed that, although no play equipment is actually necessary in working with children, if the material is carefully selected, it tends to increase rapport. She suggests that a great variety of toys be used but notes that children spontaneously use the equipment provided in a highly individualized manner even if the cases are similar from a psychopathological point of view.

The choice and use of toys by the child stamps the child as significantly as his mood of behavior. Despert suggests further that one child may be bound to one theme and one toy and use it over and over in a repetitive manner. Another child may refrain from using the toys because of the feeling that, by using a toy, he may reveal too much. All available toys may be used for little purposeful activity by another child because he fears his own aggressiveness. Despert contends that it is futile to press the child in a direction different from the

one he spontaneously chooses since he will select the medium best suited to himself.

Roheim (252) discusses the cases of Indian children seen in play setting on Normanby Island. This tribe has a society much like the Massim of British New Guinea. Roheim stressed that the toys used were relevant to the society of the child and to the child's cultural orientation. He used a male doll, a female doll, Indian dolls, a dog, a rabbit, snakes, red and yellow birds, and a mirror. He used an elephant to represent himself and was careful to include the totem of the child he was working with.

Bender and Woltman (31, 306) stress the use of plastic materials--material which can be molded and modeled and shaped--as a valuable medium for self-expression in the child. They contend that this material lends itself to the repetitive-aggressive-destructive cycle in behavior seen in the playroom. It is easy for the child to handle and is three-dimensional. This offers opportunities for expression which paint and flat material would not. The patterns developed can be correlated with cognitive development in a child, and these patterns can be an expression of the child's motility pattern. Through the use of this material, the child is able to create his world. It is a suitable outlet for aggressiveness, counter-aggressiveness,

destruction and construction. It allows the child a medium to use for solving problems such as body composition, body posture, and body curiosity. It can be used for expressing problems in reference to his body, his family, and to society.

The method suggested by these authors consists of giving five to eight children clay and telling them to create freely and to make anything they wish. The examiner sits with the child. This is important because the process offers as much information into the way the child works, feels, and thinks as does the finished product. The examiner watches the way the child works as well as what he produces.

Lowenfeld (188) classified materials to be used in a child study situation into three groups. They are materials for the expression of fantasy, construction materials, and house or miniature adult material. For a complete discussion of these materials, see Appendix C.

Moustakas (211, 214) recommends that the use of unstructured materials such as sand, water, paints, and clay allow for the release of vented-up feelings. He agrees with Buhler (213) that it is possible for unstructured material to be "deformed, amassed, spilled, spread, molded, combined, torn apart, brought into shape, or destroyed." The child may also organize the materials in such a way

that significant interpersonal situations are recreated. Moustakas suggests that these materials are particularly valuable in the early stages of therapy in that they allow the child to express his feelings in an indirect way. In addition, he felt that the use of such items as guns, darts, and knives allows the child to express feelings of aggression in socially acceptable ways. Dolls and puppets allow the child to work out problems involving family crisis and sibling rivalry.

Moustakas further states that children should be given time and a place to which they can go with play materials. They should be allowed to smear and mess, to draw and paint, and to create and destroy. They should be allowed to recreate themselves, their families, and other individuals. Whether the child chooses to use the provided materials or not is his decision. Interpretations of the child's play should not be given. He feels that the child's own judgment and expressed feelings provide the best clues to the meaning of the child's play and these should be accepted exactly as they are.

Axline (19) suggests that there should be a room set aside for and furnished specifically for a playroom. Although effective therapy has taken place in the corner of a regular classroom, in unused nurseries, and in workrooms, if money and space are available, a special playroom with

its own equipment should be provided. Axline suggests that the room be soundproof, have a sink with running water, have protected windows, and walls and floors that can be easily cleaned. Materials should be kept on shelves which are easily accessible to the children. She believes in letting the child choose his own medium for expression rather than making only therapist-selected toys available to the child. Toys she suggests as offering opportunity for this expression are

> . . . nursing bottles; a doll family; a doll house with furniture; toy soldiers and army equipment; toy animals; playhouse materials, including table, chairs, cot, doll bed, stove, tin dishes, pans, spoons, doll clothes, clothesline, clothespins, and clothes basket; a didee doll; a large rag doll; puppets; a puppet screen; crayons; clay, finger paints; sand; water; toy guns; pegpounding sets; wooden mallet; paper dolls; little cars; airplanes; a table; an easel; an enamel-top table for finger painting and clay work; toy telephone; shelves; basin; small broom; mop; rags; drawing paper; finger-painting paper; old newspapers; inexpensive cutting paper; pictures of people, houses, animals, and other objects; and empty berry baskets to smash. Checker games have been used with some success, but are not the best type of material for expressive play. Likewise, mechanical toys are not suggested because the mechanics often get in the way of creative play (19, p. 57).

She further recommends the inclusion of doll families to represent mother, father, brother, sister, baby, and grandparents. In addition, hand puppets should include all the possible family members.

Axline suggests that a large sand box be placed on the floor with a seat built part way around it. In one end of the room, she suggests that a "raised" stage be built. The child can use it for psychodrama and as a playhouse. She adds that the materials should be simple and durable and should be in view of the child so that he can choose his own medium for expression. It is important that the room be kept in order. The child should not have to play where another child has left the remains of his session. In the event that the therapist can afford one, Axline (12) suggests that she should hire a maid to clean the room after each session. This keeps the therapist from displaying negativism over the messiness of a particular child. Each session for a child should be a new beginning. Therefore, all toys should be repaired after each session or replaced. Drawings and molded articles should be removed. Paints and materials should be ready for the child when he returns to the playroom experience again (12).

Ginott (96, 98) suggests that the value of any toy, object, or activity in child therapy depends on the contribution it makes to the objective of effecting basic personality changes. He suggests that there are five major criteria for selecting and rejecting materials for child therapy:

1. Facilitate the establishment of contact with the child.
2. Evoke and encourage catharsis.
3. Aid in developing insight.
4. Furnish opportunities for reality testing.
5. Provide media for sublimation (98, p. 56).

Ginott stresses that appropriate tools make it easier for a therapist to understand the language of the child and to understand what the child is trying to say. Proper materials give the therapist less room for misinterpretation. He uses the example of a child's banging two blocks together. The child may or may not be banging two "parents" together, but if the child is banging two dolls together, then the therapist will have little doubt as to the characters in the play. He suggests that every child should have in the playroom something to which he is denied access at home, such as a toy typewriter or play drums.

In providing toys for catharsis, the therapist should be cognizant of the fact that some toys elicit the expression of children's needs and problems and others limit them. The therapist must be aware of the situation which certain materials might provoke and be prepared to deal with that situation. In planning for therapeutic catharsis, the therapist should use materials that "elicit the child's acting out related to his fundamental problems, and he should avoid those materials which simply evoke hyperactivity." Ginott suggests that with over-active children,

materials such as fingerpaints will simply cause them to be more active. Materials such as pegboards, nails, and wood for construction will give form and direction to the disorganized urges of these children. Fearful fragile children should find in the playroom materials they can work with without fear of failure such as clay, dolls, chalk, and crayons. They can "state feelings one moment and erase them the next." There should be toys in the playroom which aid in reality testing. Children should not be supplied with materials which are too difficult for them to operate. There should be a graduated array of difficulty in the toys presented so that the child can have the opportunity to experience mastery in the playroom.

Ginott adds that "sand, water, paint, and clay" provide opportunity for sublimating urethral and anal drives. "Enuretic children should be given paint and running water, encopretic children should be given mud and brown clay. Children who play with fire should have cap guns, sparklers, and flashlights. All children should have miniature utensils for cooking and serving meals to sublimate oral needs; dolls that can be dressed and undressed to sublimate sexual needs; and punching bags, targets, and guns to sublimate aggressive needs" (98, p. 62).

Ginott (96, 98) feels that the physical setting for the play therapy is utmost in importance. The playroom should be "neither too small nor too large." He suggests

a room between 150 and 200 square feet. The room should provide optimum safety, be well lighted, and be child proof in that it should be easily repainted and have water-proofed floors. The furniture should be functional and strong. The playroom should contain at least two tables, a long rectangular one and a round one. In addition, it should have a blackboard with a large-size chalk. A sink with running water is helpful, and a fireman's gym or a three-way ladder or a sturdy cabinet provide children with opportunity for climbing.

The playroom should contain a large dollhouse furnished with dolls--mother, father, children, and babies--and scale-sized furniture. In the event that amputee dolls are used, they must be easily repaired because the destruction of such dolls might cause undue guilt in the child. Ginott includes animal toys and suggests that often a child is unable to project feelings onto an animal. Transportation toys, such as cars, trucks, and airplanes, are included.

Ginott suggests making provision for water play with such materials as water, bubbles, sponges, and dip and pour toys. He also suggests the inclusion of easel, paints, and water-colors. This media is particularly useful for the constricted child. In addition, finger painting should be provided for some children. Clay can provide the child many opportunities for expression because

it can be manipulated, punched and pounded. Blocks provide opportunities for creation as well as destruction. Ginott suggests the inclusion of puppets--both people and animals. In addition, he would include aggressive toys, though these must be chosen with care. Such toys as air guns, cap guns, rubber knives, punching bags, and pounding boards give the child the opportunity for expressing aggression and hostility. Ginott further suggests housekeeping equipment, such as tea dishes, pots and pans, stove, refrigerator, and toaster. He stresses the inclusion of a sand box with a shovel, a pail, a sieve, and a funnel.

Durfee (81), in an article on the use of ordinary office equipment in play therapy, suggests that he used to good advantage the typewriter, telephone, and dictaphone in a play setting. He observed that such play is more applicable to children near or over ten years, particularly boys, than is play with more childish toys. The dictaphone, in particular, furnishes a medium for revealing fantasy thinking. It takes conveniently available records of the child's exact expressions, offers an objectification of the child to himself, and provides a repetition effect having obvious values. Durfee suggests that such mechanical devices are more appropriate to the

play of children accustomed to a machine culture than our sentimental memories might lead us to believe.

Guerney (113) describes the media to be used by parents in filial therapy. He suggests a standardized group of toys which includes clay, tinkertoys, crayons and paper, a hand-puppet family, rubber knife, toy pistol, a baby bottle, a family of small plastic dolls, and a dollhouse made from a cardboard carton with plastic tape designating the rooms. He suggests that the sessions be held in a room where the family won't be worried about breakage, such as the basement or family room.

Tallman and Goldensohn (292) suggest that the facilities for play therapy should include a room which has terazza floors, washable walls, a lavatory with a sink and toilet, and a sand box which has one side for sand and one side for water. They recommend that materials such as plasticine clay, paints, crayons, dishes with spouts, bingo bed (pegs with a mallet), cars, trucks, soldiers, airplanes, guns, ships, and a collection of dolls should be provided in the playroom.

Playroom materials and equipment should be chosen for their usefulness in reaching the goals set up for therapy, according to Hammer and Kaplan (117). They indicate that materials can be used for many purposes. These include diagnosis (which is predominately unstructured media),

building tolerance (such as puzzles and model airplane and car construction), improving a sense of adequacy and sexual identification (such as tool sets and competitive games for boys and arts and crafts for girls), providing expressive and aggressive outlets (such as balloons, Bobo, toy soldiers and army equipment, transportation toys, tools for sawing and hammering, and noisemakers), promoting the therapeutic relationship (checkers and cards), and promoting sublimation (such as cooking utensils, books, toy musical instruments, dolls, and tape recorders).

Arthur (11) suggests that play equipment should include a dollhouse, dolls, guns, snakes, horses, and plenty of creative materials. The playroom should provide enough space so that the child will be able to play in a creative manner without being restricted from normal movements.

Material used with handicapped children.--In describing the re-educative process of play therapy in a school for retarded children, Maisner (194) suggests that the room should be large enough for hyperactive children to have ample room for movement. The room used in this particular setting contained a lavatory, a drinking fountain, and a closet. Other equipment included open shelves, a sand box, and a six-foot tall dollhouse. Media included amputee dolls, a long low table, a set of marionettes, fingerpainting material, hostile weapons such as "a pop-gun, water pistol,

rubber daggers, toy money, billy club, handcuffs and boxing gloves" (194, p. 241). Maisner also included dolls, a cradle, nursing bottles, a picket fence, a dollhouse, and a toy telephone.

Cruickshank and Cowen (63, 64) report that in providing facilities for small group therapy for physically handicapped students, they used a vacant kindergarten classroom not set up particularly for play therapy groups. It was forty feet by twenty feet in size and contained a piano, desk, and small chairs and tables. The media available included games, puzzles, paste, crayons, blocks, and boxes and boards for building, blankets, balls, doll carriages, cabinets, beads, and a large three-dimensional dollhouse. Finger paints were also provided. Consideration in providing materials for the physically handicapped child should be his physical limitation and his safety.

Leland and Smith (169, 170) discuss the use of unstructured material in play therapy for emotionally disturbed, brain damaged, and mentally retarded children. They suggest that proper selection of materials should be based not only on the rationale of the therapy which is being conducted, but also on the specific needs of the child in therapy.

Leland and Smith suggest that the special needs of the retarded child seem to center around three primary

areas: the need to establish a level of self, the need to establish impulse control, and the need to establish social interaction. The authors feel that these needs are best served in a situation where both the materials of play and the procedures of the therapist are fairly loosely structured. This gives the child as much opportunity to express himself as possible. The materials recommended for use in this unstructured setting include sand, water, wooden blocks, beads, pipe cleaners, snow, scraps of wood, and twigs. A minimum of tools and equipment are required. These include a sink, a sand box, a cabinet, a table, a few containers, sponges, scissors, and a broom.

Materials used with blind children.--In an article describing his work in play therapy with blind children, Jones (142) discusses the material which is beneficial in the playroom. Certain considerations should be taken into account when working with the blind child. Jones suggests that toys should be of the same size as those to which the child has become accustomed elsewhere. Any toys which are to be used together, such as dolls and dollhouses, should be in proper scale. He suggests that the number of toys and the complexity and variety of toys should be limited with the blind child.

So that the blind child will know what toys are in the playroom, Jones suggests an orientation in which the

child is taken around the room. The toys are described to the child and their various uses are discussed. This allows the child to familiarize himself with the materials and allows the therapist to have a more accurate understanding as to why or why not certain toys are used by the child.

Rothschild (257) suggests that practical media should be used and further developed for use by the blind child in play therapy. He suggests that suitable recordings and reading of stories can serve as valuable aids in helping the child to express himself. Materials need to be developed with which the blind child can identify and which he can use for self-expression. Puppet activity in which the child can offer suggestions as to what happens next would be helpful.

Raskin (242) suggests that toys which can be used in working with blind children include sand, water, blocks, clay, dolls, puppets, figures of people and animals, toy autos, and planes. There are limitations as to the use of the toys and materials in that the blind child tends to make simpler uses of the toys than do sighted children.

Materials used with older children.--Stephenson suggests ways of working with older children in play therapy situations. He says that mutual participation enables the worker to be a model and a catalyst for the

child. He suggests that drawings, paintings, and other art work can be used to illustrate and work out feeling. In addition, the overly tidy child can use this as a means for loosening up. He discusses the squiggle game in which both the therapist and child participate. One draws a squiggle; then the other makes it into a recognizable drawing. He further suggests the use of a playhouse, dolls, and puppets with latency-age children. The therapist can ask the child to pretend that he is "younger." He describes use of costume play as first discussed by Marcus (196), the mutual storytelling technique, and games such as checkers as described by Loomis (184).

Loomis (184) suggests that through the use of checkers, the analyst is able to gain insights into the dynamics of the personality of the child. These are the underlying aggressive needs and competitive drives which ordinarily might be difficult for the child to disclose. This media will give a child an opportunity to see his resistances and character defenses and, when he chooses, to retreat into play with the checker game. This media can be used therapeutically as well as diagnostically. Loomis described the use of checkers through five different case studies. Included among the presented difficulties was one child who had tics and another child who had asthma. Loomis stressed that the value of checker games lies in disclosing

the presence of resistances, aiding in analyzing them, and in helping to discover their inner meaning. So the game becomes much more than a game when used by a skilled therapist.

Meeks (198) suggests that for the child in the latency period of psychosexual development, games which are competitive and have definite rules are in order. Checkers, chess, and card games are excellent because they are realistic.

Materials for a school setting.--Basing his philosophy on that of Ginott, Nelson (222) stresses that the elementary counselor must utilize play media. Play in a child should be treated as if it is verbalized behavior. Nelson recommended unstructured material because it can be used in a variety of ways. He listed clay, paints, crayons, pipe cleaner, building materials, puppets, telephones, typewriter, finger paints, scissors, paper, soft hand puppets, and dolls. The use of unstructured materials is desirable because they invite a wide range of response and expressiveness utilized by the child.

In an article describing a desirable physical facility for elementary school counseling, Nelson (223) suggests that it should provide durability. He described a floor covering of vinyl tile or other tough material, a sand box,

a walk-in playhouse, free-form climbing apparatus with gymnasium mats, a large bounce-back toy, and an observation booth with one-way viewing mirror. He added that a counseling office in the elementary school should provide mirrors, a sink, painting easel, and open shelves with an assortment of small toys suggested by the nondirective therapists.

In another article reporting work in a school setting, Schiffer (262) described a room set apart in the school building for the exclusive use of the play groups. It was furnished with tables, chairs, work benches, sand box, and sink. Materials provided for the use of the children included doll families, doll furniture, paints of various types, easels, sand, clay, paper, toys, and games.

An elementary school guidance center in North Dakota was described by Butts (47). He listed the toys described by the nondirective therapists, and in addition, telephones, portable tape recorders, and toy hand puppets.

Materials for a hospital setting.--Davidson (68) recommends the establishment of a playroom in a hospital setting. She selected toys according to their facilitative nature as well as their adaptive nature for the hospital child with limited mobility. Table I presents Davidson's recommendations.

TABLE I*

DAVIDSON'S RECOMMENDATIONS ON MEDIA

Toy	Type of Patient	How Used
Dolls	For boys and girls	In family groups, mother, father In hospital groups, doctor, nurse As patients dressed in gowns, etc.
Dollhouse	For boys and girls, for bed patients, for ambulatory	Small enough for bed table; reproduce home and hospital furnishings.
Doll beds	For bed patients especially	Small enough to be used on bed equipped with dolls to fit representing hospital beds
Fist puppets	Suitable for all ages, both sexes	Child supplies conversation; nurse makes story about hospital
Clay plasticine	For bed patients	Use on aluminum tray
Crayons	For bed and ambulatory children	Use with newsprint; avoid coloring books
Paints	For bed and ambulatory children	Finger paints; use aluminum tray; provide apron; use newsprint

TABLE I--Continued

Toy	Type of Patient	How Used
Chalks and blackboard	For ambulatory	Never use in presence of respiratory disease
Games and puzzles	All ages	
Books	All ages	
Music	All ages	Record player, rhythm band

*Source: 68, p. 139.

Despert (75), in an article describing the use of a playroom in a hospital setting, states that it should be removed from the regular playground so that the child will not be affected by past associations of play. It should be equipped with a table, child and adult chairs, and toilet and water basin with running water. The necessary toys would include a set of dolls of the different family members, house building equipment, elementary furniture, nursing bottles, water basin, locomotion toys (car, plane), guns, soldiers, plasticine, and drawing materials. With children under four, she suggests that the most commonly used materials are plasticine, nursing bottles, and containers for filling with water and pouring it out.

Cassell (51) reports the use of brief puppet therapy with children in a hospital setting. The children were awaiting cardiac catheterization. He suggests that this form of work relieved the child of some of the anxiety accompanying the awaiting for surgery.

Materials used in structured therapy.--In describing his technique of structured play therapy as a diagnostic as well as therapeutic procedure, Conn (58) suggests the use of dolls. They should represent various characters such as parents, teachers, siblings, and toy furniture. However, in treating fearful children, no attempt should be made to arouse antagonistic or hostile tendencies (61). Guns, pistols, knives, soldiers, etc. are not included in the play materials.

The therapist assumes the role of the friendly, informed adult. This adult allows the child to express his thoughts and feelings through a medium of the dolls, as if they were responsible for all that was said and done. The child is an impartial spectator and can view objectively what is going on as well as participating in an intimate discussion of his own attitudes. The child is able to project fears, anger, jealousy, and hate onto the dolls. Other materials used in this technique involve toy furniture. Situations are structured to provide stimulus for individual cases.

In another article, Conn (60) describes the play interview technique in working with a timid child. He stresses that this technique allows the child the opportunity of viewing himself objectively while working through the dolls. Conn suggests that this technique allows the child to see "himself in action." Random play is eliminated. The child realizes that he has not come to play or to be entertained, but to participate as an equal who has something to contribute as well as to learn.

The therapist assumes many roles during the play interview. He may speak directly or for one of the dolls in order to inquire why another doll character acted in the way it did. In addition, he may present the "voice of experience," or he may introduce a different direction to the conversation.

Mann (195) suggests that in equipping the setting for persuasive doll play, the therapist should provide

> . . . an adequate and varied set of miniature dolls, representing members of both sexes and of various ages and occupations: complementary materials such as toy furniture scaled to the dolls, a doll house, various vehicles such as trucks, cars, and fire engines (195, p. 15).

Solomon (278, 279, 280, 283) discusses the use of the play technique diagnostically, therapeutically, and in research. The media discussed by Solomon in all his work are dolls. These dolls, usually like those described by

Levy and Conn (279), are used to symbolize the child and various members of the family. In addition, Solomon has added a doll to represent the therapist in his work with the child (280, 283, 278). He suggests that the doll to represent the therapist offers the child an opportunity to work out his feelings toward the therapist in a safer way. It is easier for the child to express anger, hostility, and love to the doll than it is directly to the therapist. This is especially true in the beginning stages of treatment and when the feelings are strong.

In introducing the new doll to represent the therapist, Solomon tells the child, "This doll is Dr. Solomon." In this way, the child learns he can express his feelings to the Dr. Solomon doll and finally to Dr. Solomon. Later, the child is able to express feelings onto dolls representing other persons and finally to the persons directly (280). The use of dolls and the active role of the therapist in playing with the child aids the therapist in learning about the child. Further, it aids therapeutically, in that the symbolism is clear. Although doll play may be interesting to the child, in the beginning he must be allowed to express himself through any medium he chooses. Solomon suggests that clay, finger paints, crayons, or other materials may be the "means of entering the child's fantasy world" (278, p. 409).

According to Levy (178), the playroom should have materials which allow the child to "get into" the structured situation. In addition, he advises the use of certain materials for certain situations. Some of those described are "new baby at mother's breast" in which the child is allowed to work through feelings of sibling rivalry. This involves the use of the mother doll, a baby doll, and a self doll. The child is encouraged to make a breast on the mother doll. The child is then asked to place the baby on the mother. Various dimensions of feeling are explored. Levy devised specific situations to represent specific traumas in the child's life. Each specific situation requires the use of a certain set of material.

Materials useful to facilitate the working through of specific problems are described by Hambridge (116). For example, in order to help a child work through genital difference problems, he suggests the use of water, balloons, and baby bottles with nipples. Using these, the child can play out his fantasies regarding the function of the organ. Another situation Hambridge discusses is the "invisible boy (or girl) in the bedroom of his parents." This type of play requires a mother doll, a father doll, a self doll, and a bed for the parents. Hambridge does not introduce furniture at this time but allows the child to choose it if he likes (116, p. 604). The "birth of a baby"

episode calls for a hollow rubber doll with a pelvic opening and a baby doll. Other stressful situations would require specific materials which the therapist would structure so that the child would be able to express and release his feelings.

Puppets as play material.--Bender and Woltman (32, 308, 309) describe their use of puppets in a children's observation ward of the psychiatric division of Bellevue Hospital. The ages of the children ranged from two to sixteen years. Behavior problems were the chief psychotherapeutic problem presented. The authors suggest that the use of puppets in this situation was ideal in that symbolic characters can give free expression of aggression without causing anxiety and fear in the child. Children can also freely express love through a puppet.

In this situation, Casper was the puppet used; however, Woltman reports that in England, this puppet would be Punch; in France he would be Grugnol; in Germany he would be Casper; in Czechoslovakia he would be Casparek; and in Russia he would be Petrushka (307). These characters possess the human characteristics of curiosity and sociability. They are naive, yet knowledgeable and fearful yet brave. They are uninhibited and immune to any real harm. In the end, after numerous difficulties, they find the solutions to their problems. Boys and girls both can identify with the life experiences of these puppets.

Pinocchio was used by Machler (193). Children with social and emotional difficulties can easily identify with Pinocchio because of the distressing social, educational, and peer problems he had. Pinocchio was punished, and in the end, he emerges whole and in better shape than he was before he went through his trials. Machler suggests the Freudian theme of the characters in the Pinocchio play and correlates them with the needs of children in a play setting. This theme allows a child to work through his psychosexual difficulties.

Grant (112), an Australian psychotherapist, discusses her use of the puppet, Kasperl, and his sister, Greta, in her work with children. This character and his sister originated in Vienna and were used in Europe widely after the war for educational purposes.

In her work with puppets, Grant makes up her own stories which bring out situations which children generally have to deal with. The stories have to do with feelings, difficulties, alternatives, and decisions. The plot is kept flexible, and the children are allowed to interact and redirect the process if they so choose. In this way, they become participants in the life process and not on-lookers to the solutions and explorations for alternatives.

Jenkins and Beckh (137), following the idea of Bender in puppetry at Bellevue, used rubber balls for the

heads of the puppets, and allowed the child to paint the face on if he so desired. They suggest that these are puppets the child can play with himself. The resources in finger puppets lie in the flexibility and dynamic types of dramatization made possible by them. The child can dramatize problems on an impersonal basis, yet the therapist at opportune times in the play therapy process can personalize the problem presented.

Jenkins and Beckh (137) also used masks in the play therapy setting. The forming of the clay, which is a pliable, flexible material, is therapeutic in itself. The child is able to form, destroy, and reform at will with no fear of failure. The physical experience allows for emotional release. The authors stress that care must be taken not to place value judgments on the outcome nor should the product be interpreted. There is a discrepancy at this age as to the ability of the child to produce a finished mask which would be what he wanted to project. Because of this, interpretation is likely to be inaccurate.

The use of puppets has been described widely. A Swiss therapist, Rambert (241), recommends using puppets as an extension of play therapy. In addition, Marcus (196), a therapist in Paris, discusses his use of puppets both diagnostically and therapeutically in his work with the child. Wall (296) has compiled an entire book on the

use of puppets. Hawkey (124) describes the use of puppets in child psychotherapy. She uses them in individual treatment with a child but never uses them exclusive to other media. Puppets are kept in the playroom with sand trays, paints, paper, chalk, crayons, water play materials, dolls and dollhouses, building blocks, sewing materials, trains, cars, and guns. Hawkey suggests that puppets are valuable because they are suitable for the expression of fantasy and are popular with children of varying ages. Most of the children use the puppets themselves, making up their own dialogue and using the therapist as an audience. At other times, the child requests that the therapist make the story with the puppets, which she does. Hawkey used the case study method in her description of the benefits of the use of puppets with various ages of boys--twelve, eleven, and six years of age. Her work is not limited to boys, however, because in another article (123), she describes the use of puppets with a young girl.

Hawkey (124) stresses that puppets offer the following advantages:

1. They are valuable if the child has difficulty in expressing fantasy because he feels too old or because play is too childlike.

2. They allow the child to formulate the fantasy. Puppets are quite versatile, and some children feel the fantasy but have difficulty putting words to the feelings.

3. The use of puppets also allows the child to act out his bad fantasies without feeling guilt. He can project these feelings of guilt onto the puppet which is not permanently harmed by bad deeds.

Other materials.--Interpretations of the art of children across cultures and time have been made by Lowenfeld (189). She has shown similarities in reference to stages of development and personality characteristics. Bender (29) wrote on the value of the use of art in the treatment of mental disturbances of children, and Roland (253) describes the use of art, painting, and finger painting in play therapy with children. Cashdon (50) reports the use of the drawings produced by a child in evaluating process in play therapy. The use of art and play in therapy was described by Gordor (109). He suggests that if we want to help the child, we must first find out what is wrong with him. Art, he contends, offers the child an unlimited amount of freedom. What the child is not permitted to express in words, he can express in drawings. He is able to express experiences and convictions about them which he is unable to verbalize. Gordor suggests that different children behave in different ways in the art experience. The therapist is able to identify many characteristics in the child by observing his use of the material, his freedom, his reluctance to use his own ideas, or his initiative.

Gordor indicates that a child will project his feelings into his art, and further will project his perceptions of the world into the art experience. As the child is able to put the distorted picture down in tangible form, he and the therapist are able to rid the child of the misconceptions he has carried. The art experience allows the child to be "magical" or "giant-like" in the world of the picture he draws. He has magic power in that he can control what he draws and the way he draws it. He can put his inner wishes and desires in everything he creates. This allows the therapist to understand the needs and wishes of the child he is unable to verbalize. The therapist is also able to understand the child's social and family concepts through his drawings. The child will draw himself in relation to the family. He will show likes, desires, hidden wishes, and dislikes in his placement or omission of the persons in his art.

Nickols (226) recommends the use of darts, suction-cupped projectiles, air pistols, and appropriate stimulus background materials in an effort to ascertain a child's feelings in reference to family, peers, and self. He feels that this aggressive material allows the child freedom of expression of his anger. In another article, Nickols (225) describes specifications for a multipurpose play therapy and examining table which is functional and

economical in space. The underside can be used for a chalk board. The top has a place for dollhouse framework and a flat surface for testing. The legs are folding, and the table is built to child specifications.

Goldings (108) has written on the use of books in the playroom. He suggests the use of bibliotherapy as a valuable tool in working with children with emotional difficulties. Books within a library are listed according to situational difficulties the child in the book has had to endure. The concept of bibliotherapy involves giving the book to the child to read, or in some cases, reading the book to the child. This gives the child a nonpersonal character he can identify with.

The use of psychodrama as a technique performed in a playroom setting has been discussed by Marcus (196) and Drabkova (78). Marcus discussed the use of costume play in the treatment of an underachieving effeminate boy. He encouraged the child to make up a play with various costumes. Through the use of this technique, the child was able to express conflict and to resolve the feelings generated.

Selection of Material: Research

Lebo (159) discussed the need for a formula for selecting toys for nondirective play therapy. He stated that toys should be selected for the play room rather

than accumulated for it. Toys should be selected objectively rather than inferentially.

Lebo developed a verbal index formula based on the number of statements made while a particular toy was actually used and the expressive variety of the statements. A rank order of the twenty-eight best toys, based on their obtained verbal index, are

> dollhouse, family furniture, poster paints, brushes, paper, easel, paint jars, sand box, blackboard and colored chalk, cap guns and caps, coloring books, hand puppets, balloons, nursing bottles, films and viewer, water in basin, pop guns, bubble gum, coffee pot, cord and rope, animals, wood, balls, crayons, baby dolls, bow and arrows, clay, cars, checkers, shovel, masks, toy soldiers, and water colors (159, p. 24).

These toys are suggested as the toy nucleus of a nondirective playroom.

Lebo (160) conducted a study including the recommended toys of the nondirective therapists which are supposed to cause the child to be more creative and release more feeling. He also included a list of nonrecommended toys in this study. These nonrecommended toys were structured in nature and consisted of rubber balls, bubble blowing equipment, checker games, coffee pot, coloring books, comic books, cord, filmstrips, fireman's helmet, ladies' hats, handcuffs, hoe, marbles, play money, paper pumpkin, rake, ladies' shoes, stand-up-figures of Peter Rabbit

and Farmer Brown, man's sweater, thumbtacks, washboard, and a whistle. The recommended toys (nondirective therapist) and the nonrecommended toys were all available in the playroom for each session.

Lebo used 4,092 statements made in sixty individual nondirective play therapy sessions by twenty normal children ages four to twelve. The data indicated that the use of toys suggested by nondirective play therapists did not seem to encourage children to express themselves verbally to a greater extent than did nonrecommended toys or even when toys were not used at all. Lebo (160) suggested that the nondirective play relationship might not require the creative or dramatic toys of the Freudian diagnostic play relationship. The power is in the relationship, not the toys. In summarizing, he quotes Hartley (121), who states that "for each child, the materials he uses have unique values dependent upon associations with his past and on his ability to project meanings and use symbols" (160, p. 147).

Lebo (163) investigated the question of the value of toys to play therapy by examining 166 pages of original play therapy protocols. Six judges were involved in examining the protocols for significant and nonsignificant statements made by children during the play therapy. Twenty-five statements regarded by three or more judges

as being significant were randomly selected. In addition, twenty-five statements which none of the judges had regarded as significant were randomly selected. The original protocols were re-examined to determine what toys the children were playing with when they made significant or insignificant statements. Lebo concluded that the findings suggest that there is no difference in statements made by children when playing with toys or not playing with toys. He contended, however, that toys do have a place in the therapeutic playroom, as they may serve to make the therapy hour more pleasant from the child's point of view.

In a study describing the use of miniature life toys and puppets, Hartley and others (122) found differences in the use by well-adjusted and troubled children. One hundred and eighty-six records were made describing the play sessions of seventy-nine children ranging in age from two to five years. The researchers summarized the overall differences between the two groups as follows:

> 1. Response to symbols of aggression. In general, troubled children showed four types of reaction to the snake or the knife; they refused to recognize it; were afraid of it; seized on it as a weapon; or conspicuously avoided it. Well-adjusted children were much more casual about these items, though it must be remembered that they may have a focal problem which can be touched off by such objects.
> 2. Response to nursing bottle. The happy, healthy child looked upon the bottle with mild interest, commented on its large size as compared to the dolls, sucked on

it experimentally, or used it as a water carrier. The child who had been deprived of babying would often pounce on it and suck it during the whole session to the exclusion of other toys. Sometimes he would make a derogatory remark about it at the beginning, but this false front usually broke down if the observer did not interfere.

3. Investigation of the doll's clothing. Almost all the children were interested in raising skirts or removing trousers, but some glanced at the adult furtively or turned their backs while investigating. The very young children were likely to be unconcerned about this interest and ask for help in undressing the dolls.

4. Creativity of play. About ten percent of the children seemed unable to play with the toys in any creative fashion but were also unable to refuse. They moved the toys about without rhyme or reason, constantly asked the observer what to do with them and ended up in monotonous repetition or hopeless confusion.

5. Content of the creative play. The play of troubled children who were unable to work at all creatively abounded in chaos, catastrophe, and sudden death. People were run over, cut in half, caught in burning houses, and abandoned to their fate. Well-adjusted children, on the other hand, tended to play out calmly the various aspects of everyday living such as bathing and feeding babies, having people go on trips, sailing boats, washing clothes.

6. Use of water. This was one of the most revealing clues. Untroubled children used water as they needed it in the play; children with special problems either seized on it avidly or treated it gingerly as if it might explode. The symptomatic use of water included wantonly and aggressively pouring it over everything in sight, including the observer, or wiping up every drop that fell outside the intended vessel. Somewhere between these two extremes were the released responses of older inhibited children who played enthusiastically,

> creatively, and even daringly with toys only after water was introduced.
>
> 7. Amount of aggression shown. Aggression was frequently exhibited--indeed, we would be surprised if it were totally absent, since one of the functions of this play is precisely to help children express aggression in a protected environment and in a way which hurts no one else. However, the amount varied widely. Only about seven out of the total sample of seventy-nine spent a considerable time in destroying, threatening or attacking. Of these, five turned their hostility against people and only two--both known to be extremely disturbed--set out to wreck the toys. One of these children poured water over the toys, threw them down and crushed them underfoot, and was heard to say pathetically, "I break and I break and I don't know why I break" (140, pp. 44-45).

A study investigating the relation of the play interests of children to their economic status was conducted by Boynton and Wong (40). They found that there is some evidence of economic status effecting children's preference in certain particulars. There is probably more evidence that children of any economic status prefer games and activities which require a certain economic outlay. This does not hold true with the child under five.

Homefield (133) investigated the use of role playing as therapy for stuttering children with special reference to the use of masks. He found this media to be effective in working with stuttering children. He observed that when children played the authoritarian role, the fluency increased.

The play patterns of three groups of children--psychotic, defective, and apparently normal--were investigated by Loomis and others (185). Initially, the toys were presented one at a time to the children in fixed sequence for a minimum period. Toys were then increased to pairs in order to force choices. Next, the toys were arranged in three corners of the room: a construction-transportation center, a doll corner, and a junk corner. The junk corner contained such small items as clay, a toy telephone, and peg boards. The transcribed protocols of the observer were then subjected to three different scoring approaches. While the results of this study were not conclusive, preliminary indications suggest that play patterns are consistent for any one child or group of children on re-examination. One of the major differentiating features between the severely psychotic child and the normal child was the inability of the severely psychotic to organize toys into various levels of complexity linked with the construction potential of toys.

Vance and McCall (294) report a study designed to help in identifying preschool children's preferences for play materials. The child was shown pairs of pictures, and he pointed to his preference. This might be a useful technique, but the results are questionable. Because of lack of experience, a young child may fantasize that

a toy would be desirable until he had an opportunity to play with it.

The effect of three anthromorphic models on the social adjustment of children was observed by Schall (26). She paired eighteen subjects on the basis of social adjustment and overt aggression. One member of each pair was exposed to two different treatment methods for twenty-one sessions. The child was asked to play individually for twenty minutes in a play therapy room. The second group had the same opportunity. Added to this setting, however, were two adult-sized anthromorphic figures representing male and female and a child-sized figure. Schall concluded that the children who experienced the treatment in the room with the anthromorphic figures had a significant decrease in overt aggression.

Pulaski (238) investigated the hypothesis that young children would show greater freedom and imagination when engaged in fantasy play with unstructured materials than with highly realistic toys. She used matched groups of boys and girls who ranged in age from five to seven. They were selected for high and low predispositions to fantasy. The treatment involved four play sessions in which the children were presented two related sets of playthings in counterbalanced order (one as structured as possible, and one as unstructured as possible). Pulaski found

that the less structured toys elicited a greater variety of fantasy themes, but the expected interaction between fantasy predisposition and degree of structure of the playthings did not appear to occur. Children with high predispositions to fantasy showed more creativity regardless of type of toy.

Kidd and Walton (145) report a study in which ten aggressive boys were encouraged to throw darts at photographs of individuals toward whom they had expressed verbal hostility. The dart throwing significantly reduced overt aggression toward nonfamily members but not toward family members. (The author noted that he felt that, in order for a child to be able to express hostility toward a family member, he would have to have established sound rapport with the therapist. This is an area of high risk for a child.)

In describing the results of a study involving forty children (approximately 150 to 300 drawings per child were collected and organized), Despert (74) reported definite patterns. The author explained that the drawings of psychotic children show evidence of regression, while the drawings of neurotic and behavior-problem children show no evidence of regression (predominance of characteristics which belong to earlier developmental levels; preservation and automatism are present to a marked degree). In the

drawings of the neurotic child, there is evidenced the underlying conflict through the "theme." Despert suggested further studies which would involve comparing drawings with primitives and with normal and psychotic adults.

Beiser (33) described a study involving the controlled use of toys by 100 children through the use of diagnostic interviews. The children were given free choice of toys from a wide variety which were grouped categorically. The categories included were doll play, motor, pattern, mechanical, and unstructured. Table II shows the toys receiving highest rankings, while Table III indicates toys receiving lowest rankings.

Beiser concluded that the potential for the use of a toy depends far more on the child and his unique use of it than on the toy itself. He offers this information as being helpful in setting up a playroom. He suggests that, for the inexperienced therapist, a simple and standardized play setting is advisable.

This standardization allows the therapist to compare with his own experience the behavior of different children in the same setting and in relation to the same toy stimuli. He further suggests that the toys in the study were not necessarily the only toys which could be used, but they have been found to be useful and inexpensive. They are adaptable to any room and could be easily transported to any physical setup.

TABLE II*

HIGHEST RANKING TOYS

Popularity	Communication Value	Fantasy Stimulation	Dynamic Spread	Combined Total
64% doll family	1.41 Nok-Out Bench	55% doll family	11 doll family	doll family
62% soldiers	1.14 doll family	54% paper and crayon	10 animals	soldiers
60% gun	1.13 gun	48% clay	9 planes	gun
55% Nok-Out Bench	1.00 soldiers	46% blocks	8 clay	clay
51% trucks	0.88 paper and crayons	43% planes	8 trucks	paper and crayons
50% goose	0.83 clay	39% soldiers	8 gun	animals
46% telephone	0.79 large baby doll	35% animals	8 Nok-Out Bench	planes
46% animals	0.65 animals	29% trucks	8 goose	Nok-Out Bench
46% planes	. .	29% furniture	. .	trucks

*Source: 36, p. 763.

Research on materials: sex differences.--Some research has been done on sex differences in the use of media. The research presented is not concerned with the use of toys in

TABLE III*

LOWEST RANKING TOYS

Popularity	Communication Value	Fantasy Stimulation	Dynamic Spread	Combined Total
3% pencil	0.0 pencil	0 pencil	0 pencil	pencil
8% scissors	0.2 crayons (only)	0 ball	1 paste	paste
9% paste	0.26 furniture	9% Nok-Out Bench	3 scissors	scissors
13% blocks	0.26 telephone	11% paste	4 blocks	ball
13% ball	. .	. .	4 ball	. .

*Source: 36, pp. 761-770.

play therapy per se, but it concerns general differences in use of toys by boys and girls. Such information is valuable to the play therapist in the interpretation of a child's use of toys in the playroom.

Erikson (85) studied the differences in toy configurations built by boys and girls. Two hundred children who were aged eleven to thirteen were given blocks, toy furniture, small dolls, toy cars, and toy animals for construction in free play settings. The differences noted in the constructions produced by the boys and girls were quite obvious. The outstanding configurative design by

the boys was height and downfall; motion and its channelization and arrest were also prominent. The constant configuration produced by the girls, however, was that of static, open interiors, simply enclosed or blocked and intruded on. Erikson related these differences to the differences in the position and significance of the genital organs in the two sexes. For example, in boys, the genitalia are external, erectible, and intrusive in character. In girls, the organs are internal with or without access.

Clark and others (53) found that girls spent more time in activities involving fine motor manipulation. Boys engaged in activities that require gross motor movement.

Ackerman (1) investigated the constructive and destructive tendencies in children, and Robinson (247) investigated the form and the imaginative content of children's block buildings. He found that boys exceed girls in the time spent and in the height of constructions. Boys more often embellish their constructions with tower and use enclosures as accessories. Girls more often build simple enclosures, particularly floor plans and furniture.

Rosenberg and Sutton-Smith (254) sought to investigate a comparison of male and female differences in game play activities. A checklist yielded eighteen items differentiating boys from girls, and forty items differentiating girls from boys. In light of their findings, these researchers suggest that it seems probable that an extension

of the female role perception occurs in games. The masculine role appears to have become confined, yielding fewer, widely acknowledged ways of seeing the self. Although modern boys spend as much or more time at their play as did their predecessors, the variety of their games has been considerably reduced. The authors feel that their investigation supports the conclusion that girls show greater preference for boy play roles, and that, in addition, the girls also retain their girl play roles. This seems to be a result, not of sex convergence in the area of play interest, but possibly of female expansion of interests. This study does suggest that we cannot continue to rely on data defined a decade ago, but must reidentify male/female interests in light of changing perceptions and awareness.

Differences in male and female roles in children's play as well as differences in black and white children's play was studied by Graham (111). Of the seventy-four children involved in his study, Graham found that differences do exist in the play patterns between boys and girls in both Negro and white children. The differences noted included girls showing more stereotyping than boys. Girls showed more affection in the doll play than did boys. Boys showed more aggression with the dolls than did girls. Girls put more demands on the dolls than did boys.

Moore and Ucko (209) investigated free play in children in a study involving 115 normal children aged four to six. In using the London Doll Play Technique, they found that a comparatively high proportion of boys were unable to respond freely to the play situation. They showed signs of emotional conflict (aggression, inhibition) which precluded constructive solutions. Girls tended to show more themes of punishment in their doll play than did boys.

McDowell and Howe (191) investigated the creative use of play materials by preschool children. They found that there were no significant differences between boys and girls either in the frequency of choice or in the degree of creative attainment with blocks. Girls not only elected to use paint more frequently than did boys, but they displayed a greater degree of creativeness in their use within the definitions of the term applied in this study. Girls chose to use plastic clay more frequently than did boys, but there was no difference between the degree of creativeness displayed by the two sexes in the use of this material. The authors concluded that age was positively correlated with the degree of creative ability with which the preschool children used each of the three play materials--blocks, paints, and clay. The investigators also concluded that the intelligence quotient of the children was correlated positively with the degree of creative use of all of the play materials of the study.

Research on material: age differences.--Research has been reported on the variable of age as it affects the use of toys or the behavior in play therapy. While this material is not comprehensive, it is beneficial in that it acquaints the reader with the methods which are being used to assess this variable. It also indicates that there is reason for exploring this variable as it affects process.

In a study investigating the preferences of eighty-seven three-, four-, and five-year-old children for block shapes and sizes which were used or unused in building construction, Moyer and Gilmer (219) found that the preferences of the subjects were not related to age. On the basis of the results of this study, the investigators discount past assumptions that children pass through stages in their selection and use of blocks. They contend that this is not necessarily related to chronological age. They found that three-year-old children made their decision about selection and use of the blocks in essentially the same ways as did the older subjects. Individual differences in the design of structures were just as great within any given age group as those between the different age groups. The investigators concluded that the subjects' preferences for block shapes and sizes were made on the basis of their utility in being combined together for building.

Robinson (247) investigated the form and imaginative content of children's block buildings. The purposes of her study were (1) to indicate the range of block building performance which is characteristic of children between the ages of three and ten; (2) to develop methods for ordering block building data so that comparisons can be made; (3) to determine what differences in block building performance may be related to differences in age, sex, and intellectual level.

Five boys and five girls were used at each of two levels of intelligence (100-115 and 135-160) and in four age groups (three years, five years, seven years, and ten years). The eighty subjects each built three free choice buildings and one prescribed construction. Photographs of the constructions and verbatim reports of the verbalizations provided material for the study. The analysis shows that as children grow older, they tend to use more blocks, to build for longer periods of time, and to build larger and taller constructions. Boys exceed girls in the time spent and in the height of constructions. At every age, the variance among children on these quantitative measures is large.

It was further found that younger children build simpler structural types such as piles and serial arrangements. Older children no longer build these. Enclosures

appear early and children throughout the age ranges built them. Roofed buildings predominate in the constructions of five-year olds. Combinations of roofed buildings and enclosures are popular at seven and ten. Boys more often embellish their constructions with towers and use enclosures as accessories. Girls tend to build simple enclosures, particularly floor plans and furniture.

Verbal accounts revealed further differences. Younger children most often build a house or a bridge and seldom add many details. The seven- and ten-year-olds often build public buildings and describe their constructions in vivid detail, frequently placing them in geographical or historical perspective.

Updegraff and Herbst (293) report a study which was an attempt to observe experimentally the aspects of social behavior stimulated by certain play materials in young children. The study involved twenty-eight children, seventeen boys and eleven girls ranging in age from two years to four years and two months. Age differences found included the fact that two-year-old children paid less attention to their partners than did three-year-old children. The older children made more verbal suggestions to their partners, accepted more suggestions positively, held more conversations, were more sociable, and were more cooperative.

Lebo and Lebo (166) conducted a study in which they investigated the problem of aggression and age in relation to verbal expression in nondirective play therapy. They hypothesized that children would manifest their aggression in their verbal behavior and, also, that aggression would be reduced in older children because of the process of socialization. Subjects were selected on the basis of chronological age, intelligence test scores, and aggressiveness. There were twenty, twenty-two, twenty-four, and twenty-three children who were aged four, six, nine, and twelve, respectively. Twenty-six, twenty-seven, and thirty-six children fell into aggressive, intermediate, and non-aggressive categories, respectively. Ratings of aggressive behavior were obtained through the use of the Beller Scales, which are teachers' ratings of student classroom behavior. Children found to be chronologically and intellectually suitable for the study were given three one-hour, individual, nondirective play therapy sessions with the same therapist in the same room. Twenty-two of the 644 pages of verbatim records made during the play therapy sessions were categorized by three experienced play therapists using Finke's revised categories.

Lebo concluded that the outstanding findings of this study were that aggression and age exert a marked influence on the amount and variety of speech produced by normal

children in nondirective play therapy. The results of a one-criterion variance of the relation between category usage and age revealed significant differences regarding a majority of categories. Aggressive children made more aggressive statements, threats to playroom rules, expressions of decision, and exclamations than did non-aggressive children. The speech of aggressive children contained more story units than did that of other children. The aggressive child made more favorable statements about himself, evidenced more interest in the counselor, and made more attempts to establish a relationship with the counselor than did non-aggressive children. Six-year-old children made more aggressive verbalizations than did any other age group. Younger children made more attempts to relate to the therapist and made more favorable comments about themselves than did the older children. Twelve-year-old children employed fewer story units than any other age group. The six-year-old children employed more story units than any other age group. Lebo further concluded that the process of nondirective play therapy, judging from verbalizations, does not seem to be the same for all children. The amount of aggression and the age of the child can predict the way children respond to play therapy.

Lebo (158) stressed the need for experimental evidence on the matter of age and suitability for nondirective play

therapy. He hypothesized that twelve-year-old children will make fewer statements while using toys than will children at younger age levels. The experimental data consisted of 4,092 statements made by twenty normal children, ten boys and ten girls aged four, six, eight, and twelve. Each child was seen for three play sessions. Lebo held constant the toys, room, and therapist, as well as the therapeutic role. After finding that fewer statements were made while playing with toys at the twelve-year level than at levels four to ten years of age, Lebo concluded that nondirective play therapy toys seemed to restrict the verbalization of the older children. He further suggested that toys other than those generally recommended by nondirective therapists might make children who are twelve years or older feel more at home in the playroom.

In another study, Lebo (165) investigated the relationship of response categories in play therapy to age. Using Finke's (Borke Scale) categories, he studied the relationship between the age of a child and the type of statements he makes in play therapy. The study involved twenty children who were matched intellectually and in reference to social adjustment. The children were seen in three play therapy sessions by the same therapist in the same room. Five age levels--four, six, eight, ten, and twelve years--were represented with two boys and two girls at

each age level. When fifteen pages of verbatim notes were categorized and analyzed, it was found that maturation, as represented by chronological age, accounted for definite trends in the types of statements made by children in play therapy. Older children discussed their decisions less with the therapist, tested fewer limits, played more independently, and verbalized likes and dislikes more readily.

Lebo (164) gives as a reason why play therapists with the nondirective orientation have neglected attending to age differences in planning for the playroom situation for children the fact that this philosophy suggests taking the child "where he is." Lebo contends that this refers to psychological or emotional set, rather than to the maturational needs of the child.

Case Studies in Play Therapy Process

In an effort to describe the process of play therapy as it applies to working with specific children, many authors have presented case studies of their experiences with individual children. These case studies are generally presented by including excerpts of strategic sessions. Axline (12) and Baruch (26) have each written a book devoted entirely to the description of individual boys in the play therapy process. Other material found consisted of articles in which the author uses the case study method for demonstrating his particular use of play therapy.

Fraiberg (89) describes her theory of working with a young child with a behavior disorder. The child, a four-year-old boy, was seen in long-term analysis by Fraiberg. She follows the teachings of Anna Freud, but she suggests that the analyst should be relieved of the educative responsibility Freud stresses. In addition, Fries (92) reports success in working with a case study using the analysis as described by Anna Freud.

The use of nondirective play therapy in the case of a ten-year-old timid boy was reported by Andriola (6). She did not discuss involving the mother, but gave a complete description of the case study. Her method of reporting was to supply excerpts from the play therapy sessions. Holmer (131) used play therapy with a three-year-old deaf child. Since the child was nonverbal, Holmer indicated that play therapy was the most effective mode of treatment.

King and Ekstein (147) use the case study of a nine-year-old boy diagnosed as schizophrenic to demonstrate the effectiveness of play therapy. They stress that general play requires a certain maturation of ego organization. Playing, they stress, is a stage in the ego development which lies between impulsiveness of the id and the secondary process, thinking. They suggest that this case clearly shows a progression from disorder exhibited

by the schizophrenic personality to the beginning of rudimentary ego-control at the end of the play therapy treatment.

A case study of a ten-year-old girl, whose presenting problem was school phobia was reported by Machler (193). The play therapy setting and the puppet Pinocchio were used. The use of this puppet is described in the media section. Hellersburg reported the successful use of play therapy in the description of two case studies. In addition, Styrt and others (287) describe the case study of a young girl six years of age who worked out her problems in a play therapy setting.

Pothier (236) describes George, aged eight, who was seen at a state hospital clinic. The goal of the therapy was to provide a concerned, consistent relationship for the child. It was assumed that this would allow him to establish a trusting relationship with an adult which would allow him to begin filling his needs. George was seen by a psychiatric nurse, and in addition, intensive work was done with the family. The method of treatment for George was play therapy. Pothier contends that in this particular case, play therapy was a valuable technique for helping the child. Baruch (26) describes a boy, Kenneth, with whom she worked in a play therapy situation. She uses the case study method to describe the work she did with the boy and the parents. She stresses that

working with the parents is critical in the progress with the child.

A shy ten-year-old boy was seen in play therapy by Miller (205). She stresses that the use of nondirective play therapy for children with emotional problems is a useful technique.

Axline used the case study method for reporting her work with various children. She has described her work with Mary Ann, a four-year-old girl, and a young boy, Billy (20). In her book, Dibs: In Search of Self (12), she reported her work with a severely emotionally disturbed boy.

Literature Dealing with Types of Children Seen in Play Therapy

A survey of the literature shows that play therapy has been used in a wide variety of situations. This section gives an overview of the use of play therapy in the correction of specific difficulties and of the use of play therapy with differing age groups. The bulk of the work done in this section is theoretical in nature. However, some research was found and is included.

Type of Children Seen by Major Theorists

Anna Freud developed her technique primarily to be used for infantile neurosis. She reported working with phobic children, obsessional children, hysterical children,

and those with neuroses and anxieties (90). Klein reports working with very young children (151). One child she discusses was two years and nine months old (149). Klein stresses that all children could benefit from analysis and suggested that it should be a regular part of the work of the educational system. She indicates that all children have suffered from improper rearing in one form or another, or at one stage or another. Therefore, she concludes, analysis should be provided universally (149, 150).

Conn discusses working with a variety of types of children. He discusses using the structured interview play technique with the fearful child (61), the timid, dependent child (60), the child with castration fears (57), and the anxious child (62).

Conn (57) describes the method of play interviews as it is applied to the specific problem of castration fears in children. In working with a thirteen-year-old boy with castration fears, he used a specific technique which he arranged for this particular problem. The child was a passive and dependent boy. Conn encouraged the boy to talk about his fears through a doll to other dolls. Conn worked with the boy in fifteen-minute play sessions. He reports that after a fifteen-year follow-up, the young man is now twenty-nine and has assumed a masculine role.

In the article, "The Treatment of Fearful Children," Conn (61) indicates that the attitudes, feelings,

imaginations, and motives of the child are closely associated with his life situation and actual experience. He has used these life realities in planning a series of play interviews which give the child an opportunity to express himself. The procedure uses the capacity of the child for self-scrutiny and provides for a personal re-orientation and synthesis of hitherto unrelated experiences. For the first time, the child can view the whole story and see himself as others see him. Conn stresses the importance of allowing the child to find and express himself in the presence of an appreciative adult. This adult can listen to the parents and yet continue to like the child. There is no attempt to arouse antagonistic or hostile feelings. Guns, pistols, knives, and soldiers are not included in the play materials. Conn tells the parents to stop their criticism and nagging.

Solomon (280) discusses types of children who would benefit from treatment. He differentiates the type of treatment these "reaction-types" are likely to need. The "aggressive-impulsive" group includes those children who show overt hostile or overt affectionate behavior. They clown and try to get attention. Solomon describes these children as being potential delinquents and stresses that they need carefully defined and restrictive limits.

The "anxiety-phobic type" presents a predominant emotional tone of fear. These children have weak ego structures and suffer from strong superego demands and strong id impulses. Since the parents generally are punishing, something should be done to lessen the pressures at home. The child is anxious and guilt ridden. Care in the imposition of limits has to be maintained, or else the child will become more repressive. He describes the third group as the "regressive reaction-formation group." This group includes those cases where the "original anxiety is replaced to a great extent by various types of defense mechanisms" (280, p. 409). The fourth group is described as "schizoid-schizophrenic." Solomon suggests that play techniques furnish a method for breaking through these "autistic barriers" (280, p. 409).

Moustakas (215, 211, 214) discusses his work with the following types of children: the disturbed child, the normal child, the adjusted child in conflict, the creative child, and the handicapped child.

The disturbed child is one who has lost touch with himself. He no longer knows who he is or what he can do. Through the process of the safety of the relationship, the child is able to experience his real self for the first time and so to begin to find himself again.

In describing his work with normal children, Moustakas stated that the process of the therapeutic relationship with an insightful adult offers the child a unique opportunity for growth. The child is allowed to become more aware of himself and explore his feelings in reference to himself and others. The normal child generally begins testing limits and examining the setting immediately and expresses his negative feelings clearly and directly. The full enriching experience provided by this type of hour offers him a concentrated time with an adult. This is different from his other relationships with adults in that they are generally too rushed and busy to "be" with him (215, 211).

The adjusted child in conflict is one who is generally normal, but who, because of a stressful situation, needs help in working through it. Such conflicts as divorce, new baby in the family, or death can be worked through effectively because of the relationship with the therapist. Moustakas feels that the technique provides the child with an opportunity to work out temporarily disturbing feelings and so removes the possibility that these feelings will be repressed. If not dealt with, these feelings lose their identify with reality and eventually even damage the self by pervading it with free floating anxiety.

Moustakas indicates that the therapist-child relationship can be a very enriching experience for the creative child.

The handicapped child is described by Moustakas (211) as a child who needs to be worked with using all the basic principles of child therapy. In addition, the process must be adjusted for the child's handicapping condition. The therapist must be willing and flexible enough to believe that the child is a whole person of immeasurable potential. The therapist cannot be beneficial in the relationship if he does not perceive the child as a whole in spite of the apparent physical handicaps.

Axline describes the use of play therapy with a wide variety of children in reference to difficulties as well as age. She reports working successfully with the retarded reader (15, 16), the handicapped child (22), the child with speech problems (22), the depressed child, the emotionally disturbed child (12), the socially maladjusted child (17, 18), and the retarded child (14).

Axline (22) reports the case of a child who had difficulty in speaking due to a constriction in his throat (anxiety). The child's teacher acted both as a teacher and as a teacher-therapist. Axline concluded that it would be possible for a person to be both teacher and therapist to a child.

Play Therapy in the Treatment of Speech Difficulties

Some articles have been written about the usefulness of play therapy in providing remedies for speech difficulties.

This material consists of three articles which are theoretical or case studies and one article dealing with research.

A case of a seven-year-old child whose problem was a stuttering speech defect was presented by Reynert (244). He reported that as a result of nondirective play therapy, the child was able to successfully overcome the stuttering.

Dupent and others (80) suggest child-centered therapy as a treatment method for delayed speech, where emotional disturbance is considered a causative factor. In a study which involved two therapists, the investigators conducted forty-one interviews over a year. The therapists' observations of the child indicates improvement in emotional adjustment, and in intelligibility of speech. The improvement in the mechanics of speech occurred without speech instruction because the child received no speech therapy. The authors suggest that the results reinforce the hypothesis that child-centered therapy can be an adequate treatment for some types of delayed speech. They further suggest that there is evidence of the potential value of further research.

Homefield (133) investigated the effect of creative role playing as therapy for stuttering children. His basic hypothesis was that catharsis could result from a limited re-exposure of the disturbed child to the types

of emotional situations with which he had been unable to cope. The function of masks in this procedure was also studied. Eighteen stuttering boys of elementary school age were divided into three groups which met once weekly for hour-long role-playing sessions. One group never used masks; one used masks during the first weeks only; and the other group wore masks during the second eight-week period.

As a test procedure, the children were shown pictures and were asked to tell what they thought was happening. The investigator established that the permissive atmosphere provided a situation in which creative role-playing could provide catharsis. Homefield contends that most children speak more fluently during role-playing than during their regular speech. This fluency is increased if the child plays an authoritarian role or one in which he engages in bodily motions. Masks used in the initial stages of role-playing accelerate the actor's ability to sublimate his identity and to approximate the character of the role.

Sokoloff (277) compared the gains in communicative skills resulting from group play therapy and individual speech therapy among a group of non-severely dysarthric, speech-handicapped cerebral palsied children. He concluded that group play therapy was more effective than individual speech therapy on the factors measured. Twenty-four

children were divided into two groups. The experimental group received thirty one-hour sessions of group play therapy. The children in the control group received thirty one-hour sessions of group play therapy as well as thirty half-hour sessions of individual speech therapy. It was found that the children in play therapy made significantly more improvement than did the children in speech therapy in the areas of speech and communication, social development, and personality factors. Sokoloff concluded that play therapy aids the development of communicative skills without formal speech therapy.

Play Therapy in the Treatment of Learning Disabilities

Landreth and others (157) suggest the use of a team approach in working with the learning disabled child. They state that

> present research indicates that certain physical deviations, brain injuries, and defects, speech and hearing defects, emotional problems, and reading difficulties all frequently occur concomitantly (178, p. 83).

They suggest that a multi-faceted disability requires a multi-faceted approach to remediation and describe the team approach employed at the Pupil Appraisal Center in Denton, Texas. This involves staff development and interdisciplinary sharing. Work with the child includes thorough diagnosis, staffing by the different members of

the team, and finally, treatment. Speech therapy, reading therapy, and play therapy are all available for the use of the staff. These treatments may be employed individually or in combinations according to the recommendations of the staff.

The play therapy as described by Landreth and others is within the frame of reference of the nondirective therapist. Within an atmosphere of acceptance and broad limits, the child is allowed to use his most natural medium of communication, play. This allows him to express his feelings, both positive and negative, explore new ways of reacting to himself, to others, and to his environment. He learns to be responsible for his feelings and his actions at home, in the playroom, and at school.

Siegel (274) investigated the effectiveness of play therapy with other modalities in the treatment of children with learning disabilities. He used a variety of treatment experiences with a sample of children diagnosed as having learning disabilities. Primary intervention experiences, such as a special class or tutoring, were educational. Secondary intervention experience, such as play therapy, parent counseling, combination of play therapy plus parent counseling, or neither, was psychotherapeutic. The hypotheses of the study were designed to examine the effectiveness of the primary and secondary intervention.

Forty-eight children in grades two to five were selected. It was found that children in the special classes improved more than did children who had tutoring. However, in comparing the effectiveness of the secondary intervention, it was found that the high levels of therapist-offered conditions provided to parents and children was the critical variable. Whether the therapy was directed towards the child, the parent, or the combination of child and parent, significant improvement on all three factors was found when this group was compared to a group who did not receive counseling.

Play Therapy in the Treatment of Blind Children

Rothschild (257) discussed his work in play therapy with blind children at the Service Bureau for Blind Children in Brooklyn, New York. The parents of these children were seen by social workers in a rather formal manner. He suggests that working with blind children in play therapy requires certain modifications in facilities and media. The range of materials which can be employed is reduced, since many toys require vision for manipulation. Since locomotion is often more difficult with impaired vision, the area of the playroom should be smaller.

The medium of play is not as natural a medium to the blind child as it is to the sighted child; therefore, the

therapist must first spend time in an introductory phase before play. Peacefulness in play is essential in working with a child. Often the blind child has not developed this peaceful feeling in playing with toys. This presents the therapist with the task of helping the child to overcome the inability to play, and further enabling him to solve problems in play in the context of his relationship with the therapist.

Rothschild suggests that the fully nondirective approach may not be the best approach for the blind child because of the nature of the physical handicap and the imposed limitations. A considerable amount of direction on the part of the therapist is indicated. The therapist has to establish himself as a helpful and kind companion in the child's world through interested participation in the child's play. The child gradually learns that this is a new and different relationship from any he has had before.

Because thorough understanding of the effects of blindness on the child is critical, much preparation on the part of the therapist is needed prior to his beginning therapy with the child. Blindness continues to pose limitations and deprivations throughout the child's life. It affects the way the child perceives the environment, and the way the environment reinforces the child. Release therapy is not appropriate for this type of child. The

child needs support as he tests and experiments with his environment. He needs instruction in the development of skills and interpretation of his environment which allows him to gain insights to the world (257).

Raskin (242) suggests that work with blind children in play therapy is basically the same procedure as that of work with a sighted child. The therapist has to view the child as a person with his own individual right to development. The therapist gives the child the right to express himself and to grow in his own unique way. It is the responsibility of the therapist, in as nondirective a way as possible, to allow the child to experience and feel. He is further responsible to the child to limit actions which would interfere with the child's safety and the comfort of others. The child should be given the opportunity to find himself and to grow on his own terms.

Jones (142) describes his experiences in working with blind children at the Perkins-Institute for the Blind. He suggests that the study of play therapy in its adaptation to work with blind children is necessary. Evidence seems to point to the fact that handicapped children are subjected to different parental attitudes (overprotection or rejection) much more frequently than are physically normal children. He presents two case studies to show his permissive approach in working with blind children.

Play Therapy in the Treatment of Psychotic Disturbances

Non-speaking children in play therapy were described by Jackson (136). Two of the cases she described were childhood schizophrenic. At the end of the play therapy experiences, Jackson reported that the children were showing trends in a positive direction.

Jackson also describes two cases of neurosis or severe behavior disorders, a five-year-old child and a four-year-old child. Jackson attributes much of the success she describes to the intensive work done with the parents by a psychiatric social worker. Jackson does not indicate that the children were "cured" but that the condition was reversed. She suggests that the evaluation of the process could only occur as one watched the way these children dealt with the future tests of adolescent adaptation--choice of a career and of marriage--without a major breakdown.

Rosenzweig and Shakow (255) discuss the rationale for using the play technique for adult schizophrenia and psychosis. They indicate that the justification would be that the immaturity found in the schizophrenic is "child-like" in that his behavior is characterized by egocentricism and irresponsibility. He is dependent mainly on more mature adults. Since these adults tend to function more like children and have less verbal skill, the authors

suggest that the use of play media would facilitate the process in work with them. The authors contend that the play life depicted would be regarded as representations of the fantasy life and as a sample of their intellectual function. The play could also be used diagnostically in order to find the level of construction at which the patient is working. Another benefit would be therapeutic. The experience would provide catharsis and an opportunity for social re-education because in play, the entire world of social experience can be represented.

Rosenzweig and Shakow describe the levels of play normally found in working with children as falling within the following categories:

1. Spontaneous constructive play in which the experience is happy and creative. Clinically, children are well-adjusted and socially acceptable aggressiveness is exhibited.

2. Compulsive constructive play which is characterized by rigidity and no fantasy. It is stereotyped. The child involved in this play is generally found to be moderately well-adjusted, timid, fearful, and has deeply inhibited aggressiveness.

3. Ineffectual constructive play in which the behavior presented consists of pretense, dawdling at constructing which occasionally culminates in success, but usually

pretense ends in failure. It is suggested that the type of child exhibiting this is one with psychopathic symptoms and is passive aggressive.

4. Constructive play sublimating aggressive impulses occurs when the child verbalizes the destructive tendency while overtly being creative.

Rosenzweig and Shakow (256) report a study in which they tested the applicability of the play technique in working with schizophrenic and psychotic adults. It was expected that the results would involve a description of the form of construction rather than an interpretation of the content of material used. The method involved the use of a specially designed playroom which was divided into three parts, including a table with toys, a table for construction, and a room for observation. A one-way mirror was used. The adult subjects consisted of ten paranoid schizophrenics, ten diagnosed as hebephrenic schizophrenic, and ten normal individuals.

The findings indicate that the schizophrenic patients responded favorably to the form of play technique used. Typically different patterns were discernible for the three groups of subjects in respect to the general characteristics of their constructions. The researchers contend that individual cases yielded some material of psychiatric interest even in a single session. They indicate that this can be

used productively, not only diagnostically, but also therapeutically with psychotic adults who exhibit child-like behavior.

Play Therapy in the Treatment of Psychosomatic Disturbances

Miller and Baruch (206) report the use of play therapy with six children in order to treat the symptoms of allergy. The young children had failed to respond to medical treatment and were selected for play therapy. Miller and Baruch report,

> As patients blocked the outflow of troubled feelings, allergic symptoms increased. As feelings were brought out, symptoms decreased. At least five of the six children showed improvement in therapy (206, p. 14).

Jessner and others (139) cite case studies to support their theory that play therapy can be used effectively to treat children with asthma, ulcerative colitis, and other psychosomatic disturbances. The children treated were aged five and one-half. They had above average intelligence and were capable of verbalizing, although anxiety made verbalizing difficult for them. The authors suggest that play therapy was the treatment of choice.

The effective use of play therapy for the treatment of warts was investigated by Dudek (79). He based his research on his contention that suggestion is the most important fact in the treatment process. The study was

used to identify factors in the relationship between the medical doctor and child which develops in the process of curing warts. Twenty cases were used which included twelve boys and eight girls. All the children were given a placebo (red ink) and play therapy.

Group A received therapeutically-oriented play combined with the statement during the second interview, "If the warts don't begin to disappear by the next visit, I will have the doctor cut them off." This introduced the factor of conditional acceptance of the child in the relationship. Group B was never threatened. Contact was supported and play was therapeutically-oriented. Unconditional acceptance was established.

There was a much higher percentage of cure in Group B than in Group A. It is hypothesized that the adequacy of rapport was a relevant factor in effecting one. Because of the lack of careful control in the study, it was not clear what part the placebo played in cure.

Play Therapy in the Treatment of Reading Difficulties

The case study method to describe the treatment of a reading problem through nondirective play therapy was used by Bixler (37). Through the reporting of a series of twenty interviews, the author shows success in helping the child to overcome a reading problem through the use

of the nondirective play therapy technique. No reading instruction was given.

In articles on understanding and helping reading problems in children, Axline (15, 16) presents case studies of children of above average intelligence who had reading difficulties. Two of the children had reading problems, and one substituted the fantasy world of reading for friends. Axline reports that during therapy it became apparent that the children's emotional problems contributed to their reading problems. She stressed that if the child is given the opporutnity, he can and does help himself. She indicated that the play therapy experience enhanced his chances for helping himself.

In an article describing four alternative ways for helping a child learn to read when he is having difficulty, Mehus (201) stresses that care must be taken so that no relapse occurs in the progress in reading. She contends that if a child has failed using one method, then a different experience for remediation is required. She indicates that psychotherapy can be effective in preparing a child to accept learning to read. Often, when this stage is reached, the child has yet to acquire techniques of reading and in order to do so, he has to return to the same unacceptable environment, thus generally regressing. Mehus proposes that rather than preparing

a child to read through psychotherapy and then having him tutored, an alternate plan would be to provide the two simultaneously by the same therapist.

According to Mehus, there are generally two types of children having reading difficulties. In one type, emotional difficulties have prevented the child from accepting reading, and in the other type of child, the technical difficulties of reading have proved too much, and he has become emotionally involved so that he projects disturbed feelings on to his inability to read.

Mehus suggests four approaches in working with these children:

1. Alternative one would be to apply play therapy and allow the school to teach the child on his own level (providing the school individualizes to this degree).

2. The second alternative would involve the use of play therapy in developing responsibility in the child. The child is then given help in reading orientation, while play therapy is allowing him to be comfortable in his environment so that when reading is introduced by the therapist, he will not be afraid to try to read.

3. In the third alternative, reading and therapy are carried out simultaneously. The therapist provides both services.

4. The fourth alternative would be to provide supportive therapy in the reading situation.

The effect of nondirective play therapy on maladjusted junior high school boys was investigated by Plumbery and Elliot (239). The eight socially-maladjusted boys were of average intelligence but were retarded in reading progress. Modifications in adjustment and reading attainment both at the end of therapy and on follow-up one year later were measured. A limited number of play therapy sessions did not produce a significant overall improvement in social adjustment. However, on a one-year follow-up, eleven of the sixteen students in the experimental and control groups combined had improved in adjustment. There was no significant improvement in reading attainment in either group at the end of treatment.

Bills (34) reports a study designed to assess the relationship between personal adjustment and reading achievement. Using a group of eight poorly adjusted, eight- to nine-year-old retarded readers for his study, he designed the experiment so that each child was his own control by dividing the period of ninety school days into three blocks of thirty school days. This included four testing sessions. Reading tests were given six weeks before beginning therapy, immediately before therapy, immediately following therapy, and six weeks after therapy. The gains made on reading scores by the therapy group during the six weeks after therapy were significantly

greater than during the initial control period. He concluded that significant changes in reading occurred.

In another article, Bills (35) reports repeating the study using a group of well-adjusted readers. He hypothesized that therapy would not improve the reading ability of a group of children who exhibited adequate emotional adjustment. As a result of the findings in both studies, he suggested that the gains in reading achievement in the first study (involving poorly adjusted children with reading difficulty) were related to the child's improvement in personal adjustment. He further concluded that play therapy may be helpful to retarded readers who are emotionally disturbed but probably is not necessary for all retarded readers.

In discussing the effectiveness of play therapy in helping poor readers, Axline (15) reported a study of fifty second graders listed as poor readers by their teachers who were given a reading test. The thirty-seven children who received the lowest scores were placed in a special class. The group consisted of eight girls and twenty-nine boys whose intelligence scores measured by the Stanford Binet ranged from 80 to 140. These children had all their school work in one room with the same teacher. The reading problems were considered to be a part of the whole child. The children were given the opportunity for

ample emotional expression, and their feelings and attitudes were accepted and clarified. No remedial reading instruction per se was given. At the end of the semester, three and one-half months later, intelligence and reading tests were administered. Axline reported that twenty-one children gained more than the maturationally expected 3.5 years in words. Four subjects were reported to have gained in reference to the intelligence score.

Winn (302) investigated the influence of play therapy on personality change and the consequent effect on reading performance. The data was collected through the administration of pretest and posttest on twenty-six children. The children were randomly assigned to two groups of thirteen each, with the experimental group being given weekly individual play therapy for sixteen weeks.

Results indicate that the experimental group showed a significantly greater improvement in personality change than did the control group. However, the experimental group did not show significantly greater improvement in reading than did the no-therapy group. Possible explanations could be that personality change has little or no bearing on reading improvement. The author suggested that possibly the existence of reading skills in children has a bearing on the degree of reading improvement brought about by personality gains.

Play Therapy in the Treatment of Retarded Children

Maisner (194) theorizes that there is a circular relationship between intellectual and emotional functions in the retarded child. The child is not only having difficulties in the three "R's" but is also having difficulty in an additional "R," relationships with others. Maisner suggests that "underlying the motor, or symptomatic manifestations of each of these inefficiencies is the child's inadequate perception of his physical or social world" (219, p. 236), and she contends that the play therapy experience can help these children "reorient their concepts of themselves in relation to the institutional community and the school in order that they might more effectively use the growth producing resources at their disposal" (219, p. 237).

Maisner discusses an attempt made at a training school which was labeled "Special Personality Re-education Program." This program involved a psychologist who attempted "to establish close rapport with a given child and to help him use this relationship in learning how to relate more effectively to the rest of his environment" (219, p. 238). This special intervention method is considered to be a "wedge" in that its aim is to get an "in" with the child and to reverse the vicious cycle of his negative responses. This enables the constructive cycle to begin

so that the rest of the training at the school can be effective.

As a part of this program, play therapy is used in individual sessions. The sessions are conducted in a building set apart from the school in a room which is large enough to accommodate the movement of hyperactive children. Maisner describes the re-educative process in two steps: (1) the development of acceptance and rapport and (2) the clarification of feelings and desensitization. During the first stage, the therapist is nondirective. However, during the second stage, the therapist becomes more directive. He involves himself in the child's play, clarifies feelings, and yet, at the same time, maintains the reassurance of a calm acceptance.

Leland and Smith (170) recommend the use of the unstructured play therapy experience using unstructured materials with brain-damaged, retarded children. They suggest that this is a positive therapeutic practice in that the needs of these children seem to be in three primary areas: the need to establish a level of self, the need to establish impulse control, and the need to establish social interaction. The authors feel the play therapy setting in which the therapist uses unstructured materials and loosely structured procedures gives the child opportunity to meet these needs.

The unstructured nature of the materials teaches the child that he gains acceptance for using his imagination and creating play activities. This allows the child more avenues for carrying this learning to his environment than does the limited structured toy. Included in the therapeutic concepts is the process of conditioning which is closely in line with the theory of the learning theorists. Leland and Smith (170) suggest the use of unstructured media within the play therapy setting in contending that the first goal is the process of conditioning the patient to the idea that his behavior, his ideas, and his reactions to stimuli are his and that they have originated in him. He is responsible for them. This occurs in an unstructured play therapy setting where acceptance is unconditional. The second phase is based on conditioning the patient to organize his behavior around his cognitive associations. This implies that impulse control is closely related to development of communication between the therapist and the child. Once the child has in the first phase been conditioned to know that his behavior is his, it then becomes a necessity for him to learn that the more acceptable behavior is that which has positive cognitive associations. Leland and Smith describe the third phase as the process of conditioning the child to organize his behavior around mutual cognitive associations. The behavior of the therapist

falls into three categories: cognitive stimulation, reward, and punishment. In the playroom, this can be seen as the permission the therapist gives the child to be himself, to be active. At times, the therapist will block activity, will set limits. This the child begins to see as punishment.

The importance of unstructured materials for this type of therapy lies in the patient's greater ability to control, create, change, and develop play activity with them. Thus, the child can learn that he is a person capable of creating and controlling materials and things. This paves the way for learning that he can control himself and interact with others. He learns that he is not necessarily a dangerously destructive person, and he sees that his impulses, which have been destructive, are primarily destructive to himself. He learns that his ideas and efforts can produce tangible differences in reality. He learns that he can destroy and construct. In this way, he gains control over his environment and himself.

Miller (204) also describes the successful use of play therapy with retarded children in an institutional setting. She stresses that the provision of play therapy is a necessary part of the total program.

Axline (14) reports examining stenographic therapy protocols of fifteen six- and seven-year-old children who

were in play therapy because of behavior and speech problems. The children were seen in eight to twenty sessions. On the basis of the pre- and posttest therapy scores, the children were categorized into three groups (1) children who showed no significant change in intelligence scores after therapy; (2) children who showed significant gains in intelligence scores after therapy; and (3) children with average intelligence both before and after therapy.

Axline does not state the conclusions of her study explicitly, nor does she answer the question posed by her title, "Mental Deficiency, Symptom or Disease?" She does, however, point out that the retarded children who showed no gains in intelligence score did not complete their therapy, while those who gained in intelligence score did complete it. She does not claim that play therapy raised the intelligence of these children but rather that the emotional relief attained in therapy enabled them to express more adequately their true capacities. The children in group three who had average intelligence before and after therapy were included in the study to indicate that behavior problems stem more from emotional deficiency than from mental deficiency.

Subotnik and Callahan (288) conducted a pilot study in short-term play therapy with institutionalized educable mentally retarded boys. Eight boys, eight to twelve years

old, nominated for treatment by teachers and cottage parents, were given a short-term series of individual play therapy sessions. Several quickly administered tests, such as Children's Anxiety Pictures, Auditory Memory for Digits, Vocabulary, Draw-a-Person, and Bender Gestalt, were obtained from the subjects at intervals. Improvement during the therapy period and during the therapy plus follow-up period were compared with improvement during the eight weeks without treatment. Results on all tests were negative. In addition, behavior ratings on six categories were obtained at the beginning and the end of therapy. Differences during this period also proved non-significant. The obtained data serve to point up some methodological problems inherent in evaluating psychotherapy.

Play Therapy in the Treatment of Older Children

Some material was found suggesting that techniques of play media can be used effectively with the older child. Some of the authors suggest that adaptations should be made in the types of media used with the older child. Other articles were simply written in support of the use of play media with the adolescent. No research was found in this area.

Ginott (98) suggests that different materials should be used for older children. He recommends painting, model

building, woodwork, leatherwork, and similar activities for fearful and withdrawn older children. The pugnacious older child can effectively use a play therapy setting which allows for safe and respectable expression of aggression. Otherwise, they are likely to be very destructive. Ginott reports Slavson's recommendation that the older child be provided with media such as penny arcade machines, rifle galleries, table bowling, and boxing machines. He further recommends that an activity room be designed for the older child which includes machines, tables, etc. This room should be five times the area of the furniture necessary for work.

Schiffer (262) suggests that a room of about 600 square feet is optimal in size, and materials suggested are a rectangular table seven feet by three feet, an isolate table three feet by two feet, a round table, a woodwork bench with two vices, a cabinet for supplies and for storing unfinished projects, and a pegboard for tools. In addition, there should be hammers, nails, saws, clamps, files, planes (for woodwork), wooden mallets and ashtray molds for metal work, tools for leathercraft, and a typewriter and paper.

Schiffer (262) further suggests that in working with the older child in a school setting special materials should be provided. He suggests woodworking tools and

games designed for older children. He would also include the traditional toys recommended by the nondirective therapists.

Mendes and others (203) describe their work with a group of preadolescent girls in Lisbon. They see play as a symbolic language and look for the free floating communication through the play themes and conflicts having a manifest and latent content. The authors discuss the application of group analytic concepts to play therapy. They use permissiveness and support only as a means of uncovering unconscious and repressed content.

The girls seen in the play group consisted of a group of six who had behavior problems and school difficulties. The facilities consisted of a former kitchen which had been divided into two rooms. One room was furnished with adult furniture, a couch, chairs, and tables, and was attractively decorated. The other room was furnished as a playroom with toys and preschool material. No structure was placed on the group as to where it would meet. For the first thirteen months the girls used the playroom exclusively; then gradually, they moved to the outer room and became a verbal group. During the period of transition, there was a good deal of movement between the rooms. The therapist followed the needs of the group as to the setting. While the group worked in the playroom,

they acted much like younger children. They never verbalized situational problems. Play was characterized by sudden motor outbursts, fantasy play, and nonverbal expression of primitive impulses. The therapist began interpreting the play and indicated that the turning point into the meaningful material began at this point. Gradually, the girls moved to the "adult room" and began verbalizing their situational difficulties. The group became a talk group. At this point, more mature behavior was noted in the members in their interactions.

The dynamics and needs of the latency child are unique according to Meeks (198), who stresses that children in this stage of development like games which are organized in nature, which are competitive, realistic, and have definite roles. The child at this stage has a need to improve his skill and tries to win. Meeks contrasts the latency period with the period which immediately precedes it, the Oedipal. During the Oedipal period, the play has as its aim the granting of the child's wish to do as the adult he so envies. The play of the Oedipal is fanciful, charming, and unrealistic. Meeks added that the games of checkers, chess, and card playing offer excellent media for the child in the latency period, since he is trying to overcome the fantasy of the Oedipal and move toward realism.

Often the therapist will work with a child in the latency period who has suffered such a loss of self-esteem at earlier stages of development that his behavior is compensatory. This is particularly evident with the child who has experienced school failures. A child with lack of self concept is so fearful of loss of self-esteem that instead of competitively trying to win according to the rules, he practices cheating. Meeks stresses that this will occur after good rapport has been established. The child exposes his typical way of handling other experiences in his life. Every time the child has an opportunity to develop new skill, he is so frightened at losing self-esteem that he bluffs or cheats his way out so that he can maintain the false stance of omnipotence. In this way, he continues to deny himself the opportunity for developing skills and thus the ego strength which accompanies this skill. Meeks contends that it is important to allow the full elaboration of the cheating before the therapist intervenes. If the therapist intervenes too early, the child will stop because of superficial conformity, and the underlying fantasies and meaning will then be lost to his understanding. The therapist's goal in the situation is to increase the child's realistic awareness of his capacities and his limitations. In so doing, the child can learn to assess realistically where his skills lie in

a given area. From this knowledge, he will be able to move forward.

Loomis (184, 185) suggests that for the older child the use of a checker game is an excellent way for him to be able to play out and disclose his resistances. Hawkey (124) contends that the use of puppets is particularly valuable in working with older children who feel that playing with toys is babyish. Puppets allow the child to express fantasy when he feels "too old" to engage in toy play because the older child can project his feelings onto the puppet and does not have to acknowledge them as his own.

Literature Dealing with Parental Involvement As Influencing Process and Outcome in Play Therapy

Numerous articles were found which consider the significance of parental involvement as it affects the process and outcome of child therapy. Most of the major theorists (220, 90, 280, 60, 116, 5, 13, 26, 291) in the area of child therapy have included their views on the importance of working with the parents as they work with the children. The orientations range from suggestions that children should not be worked with unless the parents are involved in therapy to suggestions that it is beneficial but not necessary to see parents as well as the child.

Included in this section is a discussion of the organization of family services in a clinic setting by Ginott (99). In addition, various other methods for working with parents are presented. The use of and the training of parents as delivery agents is presented by Guerney (113), Guerney and others (115), and Andronico and others (8).

Most of the material included in this section is pragmatic in nature. The philosophy, however, is presented in some situations. Some research is presented.

Parental Involvement: Position

Anna Freud involved the parents of the children she saw from the very beginning. She obtained an intensive, detailed case history of the child from the parents (220). In her earlier statements about parents, Anna Freud wrote that children should not be seen unless their parents have been in analysis or are in analysis. However, she later added a fourth stage in the therapeutic process which includes counseling with parents in preparing them for the changes in the child and in educative procedures. This will help them to be healthy enough to handle the child without contributing further to his neurosis. Something must be done to "change" the outlook of the parents because it would be dangerous to turn the responsibility for the newly liberated "instinctual life" over to them.

There is a great risk that the child will be forced to repression and neurosis again since it was with these same parents that he began the original neurosis (90). In situations where the parents did not have personalities with analytical understanding, it would be more economical to omit the analysis of the child (90).

A combination of working with parents and child in the therapeutic process is recommended by Solomon (280). He emphasizes the importance of working with parents whenever it is possible, especially as it is reflected in the handling of the child. The problem in the very young child often dissipates when the parents develop wholesome attitudes. Even the older child will change when parental attitudes alter. However, there is a stage in the development of the child when a fairly fixed pattern of disturbed thought develops and simply working with the parents will not affect the child enough to cause the needed change.

In this situation, the therapy is focused on the child. It is not always the relationship between the parent and the therapist which causes change in the parents. When the parents take the step of calling for help, they begin to assess themselves because they realize that they may be "objects of discussion between the child and the doctor" (280, p. 402). Parents can be sources of valuable information in that they can give the therapist another view of the activities of the home (279, 281).

Conn (60, 61, 62) works with both the parents and the child. The child accepts the parent-physician-patient relationship as a natural procedure. The parents are usually seen just before the child is seen. The parents are given the opportunity to tell their side of the story and also are praised for doing their best in the "light of their present understanding" (60, p. 93). The parent can be invited into the playroom while the child "reviews" what he has learned. From the first the child is commended for expressing his feelings, both loving and hostile, in reference to his parents and siblings.

The importance of involving the parents so that they will be able to assist in the treatment process is stressed by Hambridge (116). Parents are informed of the expected increase in aggressiveness of the child as a result of treatment. The family is told to maintain the usual restraints at home. The therapist's task is to pace the treatment so that the parent's ability to handle the child at home is not overtaxed. This affects the direction of the work with the child, the intensity of the work, and further aids in the diagnosis of the child (116).

The importance of parental involvement is stressed by Allen (5, 213). Mother and child come to the child guidance center together, and both are worked with at the same time. This is beneficial in that they are together,

yet differentiated. This is a start in the growth process of the child. The child is seen by the play therapist while a case worker sees the mother.

Therapy might move faster if the parents were involved in counseling or therapy themselves, according to Axline (19). But, she adds, "it is not necessary for the adults to be helped in order to insure successful play-therapy results" (19, p. 68). The child sees his environment in a different way, and as he relates to it in a different way, the environment will relate to him differently. The circular pattern becomes positive, he is accepted more, and he responds positively. This causes more acceptance by others. Axline points out, however, that in the case of a handicapped child, the parents should be more directly involved. These parents have difficulty in accepting the handicapped child, especially in the case of mental retardation. The parents have to work through their own feelings of guilt and inadequacy before they are able to change their perception of the child.

In another article, Axline (13) discusses the value of group therapy as a means of self-discovery for parents and children. Often, the therapist is too forceful in his own philosophy and in his own value judgments. The use of group in working with a family has many advantages, one of which is that self-disclosure within the family group

offers an opportunity to experience self in many different ways within the family since the family has often lost its individual family identity.

Many children have benefited from play therapy without concurrent parent therapy, states Dorfman (77). Success in working with children where parent counseling is not a requirement for treatment is disproving the old assumptions.

Therapists need to be alert to factors which usurp the intelligence of a family group and destroy independent thoughts and actions within the family. Such usurpation obstructs the development of the family's own moral values. Conformity that suffocates self-discovery is thrust on them when the unit is broken down and each member is treated individually by the therapist. The group offers the opportunity for the family to have a choice of participation and a system of checks and balances in the face of a strong therapist. Within the group, both the parent and child can be involved in the constructive relationship. This occurs when the group has built-in checks for errors in interpretation and perception of the actions by the different family members.

Axline suggests putting the child and the parents all in the playroom setting because it allows the child the medium of expression he best knows. It further allows him to begin verbalizing within the family in a comfortable setting.

Fuchs (93), the daughter of Carl Rogers, describes a problem she was having with her young daughter in reference to proper bowel elimination. She wrote her father for suggestions in working with the child, and he suggested a play therapy treatment at home by the mother. Rogers advised her to read Axline's book on play therapy and then to get furniture, dolls (which represented family members), a toilet, potty chair, clay, and toilet paper. By providing the child with media and by accepting and reflecting the child's fears, she would be able to help the child to overcome the difficulty. It becomes a learning experience for a mother when she really begins to watch her child's play and learns to listen to what her child is saying. Not only is the mother able to assist the child in problem solving, she is also able to develop observational skills for herself (93).

Baruch (26), in describing her work with a child named Kenneth, states that the parents were also closely involved in the process. In elaborating the case study of the boy, she described in detail her work with the parents.

Moustakas (214) feels that the best results can be obtained if the therapist works with the parents as well as with the child. He does not indicate who should see the parents, only that "someone" should see them. The

alleviation of the child's psychological tensions, the resolution of his problems, and his self-perception as a worthwhile individual are goals which are achieved more completely when the parents participate in the experience (214).

Moustakas and Makowsky (217) present two cases from their clinical records to demonstrate their work with parents. One problem in working with the parents is that often the parents do not see the problem as a reflection of their own conflict and confusion. They are intellectual about the problem or else have it poorly defined in a vague way. They like to see the problem as only belonging to the child, and they come to the counselor for authoritative advice on "how to handle" the child. Often, when they do not get direct advice, they terminate the contract. One way to work with the difficult parent is first to focus on the presented problem and then gradually to move to the real problem. Moustakas and Makowsky present three tentative principles for parent counseling which include the following: (1) When the parent can see the difficulty as focused on himself and his own feelings, then the traditional nondirective approach should be used. (2) When the parents feel that they need advice, the therapist should modify his approach and then try to lead the process back to the main issues (dynamics within the family).

(3) In all cases, the client-centered philosophy should be maintained.

Ginott describes differential treatment using groups (97). He identifies the four types of groups as guidance, counseling, psychotherapy, and psychoanalysis. He suggests that the aim of any type of group is to effect change; however, each of the groups is the method of choice for specific persons. Group guidance is a method of choice for parents who are without serious personal disturbances yet have difficulty in getting along with their children. The group guidance experience gives the parents an opportunity to go over their troubled feelings with sympathetic group members who are in the "same boat." Pent-up emotions and guilt-charged conflicts are diminished by ventilation, while ego strength is enhanced by satisfying relationships with the leader and the other parents. This emotional relief is designed to free parents to face problems and "opens" them to accepting guidance.

The basic technique generally involves a group of from eight to ten parents. Sometimes it involves both parents, but it generally involves only mothers. Two basic types of composition are used, heterogenous and homogenous. The homogenous group involves parents who have children of like ages or similar difficulties. The heterogenous group involves parents with varying ages

and difficulties. The groups are problem-centered and child-centered. The mothers learn to be aware of the effects of their own attitudes and behavior on the behavior of the child. They begin to see that the child is a reacting individual with rights, feelings, and cravings, and they are helped to realize that the problem lies in the relationship between the parent and the child and not just in the child.

The way in which a child guidance clinic began a new service of group screening which was necessitated by the tremendous number of persons seeking service was described by Ginott (99). The aim of the group screening was to render immediate initial service to those who called the clinic for help. The method used was to schedule the parent who called in for help into a group. The parents sat in a small group with a leader and gave their complaint. Based on the difficulties presented and the recommendation of the group leader, a decision was made as to whether the child should come individually, the parents should come individually, or the parents and child should both be seen. According to Ginott, the following advantages are offered by the group screening:

> (1) It enables applicants to be seen for an initial interview without delay. If there is any waiting, it occurs after the first appointment. Such an interview given at a time most urgent from the patient's point of view, "strikes the iron when it is hottest."

> (2) It enables parents to establish some relationship with the clinic. When they subsequently come for the individual intake or for the parent education group, they already are acquainted with the workers and, consequently, are less tense, less defensive, and able to utilize their appointments more productively.
>
> (3) There is considerable decrease in broken intake appointments. Very few individual sessions are canceled after a group screening.
>
> (4) Parents seem to get much support from each other and from the idea that they are not alone in their difficulties.
>
> (5) Group screening can be offered without drastically increasing the personnel or the budget of a clinic. Only the training of the staff might have to be enhanced (99, p. 409).

Ginott (100) describes a measure used at the child guidance clinic as an attempt to combat the increased lag between request for services and the delivery of those services. Group screening and parent education groups were developed. Parent education groups differ from group psychotherapy in that group therapy is aimed at bringing permanent changes in the intra-psychic balance of selected patients grouped for the therapeutic effect they have on each other. Parent education groups are designed to improve the everyday functioning of parents in relation to their children. They are helped to a better understanding of the dynamics of parent-child relations and of the basic facts of child growth and needs. This is done through "sensitizing parents to the needs of children, increasing their awareness of the role of feelings in

human life, and promoting understanding of the latent meanings of children's activities, play, and verbal expression" (100, p. 83).

The parent education groups are composed of twenty to twenty-five mothers who meet for ninety-minute weekly sessions for a period of ten weeks. The groups are generally homogenous--mothers of children of like ages and similar problems are grouped together. The first meeting generally consists of all the mothers telling their "problem." After all parents tell their "problem," they are asked to tell their remedy or those remedies which they think might work. The group is then asked to attempt to form reasons why they think these measures fail. At this point, the members of the staff refuse to give answers or to relieve the anxiety which mounts in the group. The skilled leader functions mainly in a nondirective way.

Gradually, as a result of the interaction, the mothers begin to acknowledge that children have feelings just as adults do, that these feelings are both positive and negative, and that the expression and acceptance of feelings is more healthful and more helpful than their rejection and denial. The mothers begin to grasp the value of non-critical empathetic mirroring of feelings. "Therapeutic understanding and reflection of feelings cannot be taught but it can be 'caught' by individuals who experience them"

(100, p. 85). Ginott concludes that the most significant effect of the group was the reported decrease in tensions and greater harmony between the mothers and their immediate families.

Ginott reports the main advantages of parent groups to be the following:

> (1) Parents become aware of the existence in themselves and in their children of an inner world of feelings and of its significance in making or breaking happiness.
>
> (2) For the first time in their lives parents take time to think through and wonder about the right of people (including themselves and their children) to have negative as well as positive attitudes, and they become aware of a new freedom--the freedom to feel.
>
> (3) Parents learn new methods of relating to children. They become sensitized to children's expressions of attitudes and learn to accept and reflect rather than rejoice or deny troubled feelings.
>
> (4) Parents acquire, if not digest, a large body of factual information concerning the nature of child behavior.
>
> (5) Parents become aware of, even if they do not fully assimilate, the meaning and value of non-critical acceptance and genuine respect.
>
> (6) Parents learn to be more objective and less ego-involved in their everyday relations with their children and gain an ability to handle daily problems with more confidence and less guilt.
>
> (7) Parents learn many new methods of dealing more adequately with the specific problems of their children.
>
> (8) Finally, parent education groups enable even a minimally staffed agency to provide extensive services to the community. Under competent therapists the parent education group can become a potent tool in helping a selected group of parents

> modify old attitudes and beliefs, develop new values and sensitivities and bring about a greater enjoyment of family work and life (100, p. 86).

A study designed to determine why people fail to carry out plans for treatment after having gone to the trouble of contacting the agency was conducted by Ginott (103). Because of the tremendous demand for clinical services, it is expedient that there be a way that nonattenders can be identified. In the Duval County Child Guidance Clinic, it was noted that at least one-third of the applicants did not arrive for their initial appointment in the group screening, and in addition, a considerable number of parents attending the screening procedure did not continue. The purpose of the study was to answer the following questions:

> (1) What accounts for nonattendance after an appointment is accepted by the parents? More specifically: Do negative feelings toward a group meeting account for nonattendance at the initial interview?
> (2) What accounts for the failure of some parents to carry out the next step in the intake procedure, namely, returning the completed medical form? More specifically: Does the initial attendance in a group setting arouse negative feelings in the parents so that they fail to continue contact with the clinic (103, p. 315)?

The method of the study involved contacting the two hundred parents who failed to keep their initial group appointment and the one hundred parents who attended a screening group but did not follow up on their commitments.

Table IV presents the reasons given by parents for failure to attend the initial interview.

TABLE IV*

REASONS GIVEN BY 200 PARENTS FOR NOT ATTENDING THE INITIAL INTERVIEW

Reasons Given	%	Number of Times Reported
A. Difficulties in getting to the clinic	23.5	47
a. sickness, deaths or divorce in the family		18
b. Time of appointment not convenient because of work or school hours		11
c. transportation or baby sitter difficulties		11
d. out of town on day of original appointment or rainy weather		6
e. had guests at the time of appointment		1
B. Parent's attitude toward problem changed	21.0	42
a. decided they "did not need" clinic services, "nothing wrong with child" or no longer worried by symptoms		20
b. decided it was parents' problem, not child's		9
c. felt they could cope with the problem by themselves		4

TABLE IV--Continued

Reasons Given	%	Number of Times Reported
d. consulted relatives or neighbors and found that the child or his problems were quite normal		3
e. decided to try scouts and dancing lessons instead of clinic services		2
f. decided to wait a while		1
g. decided that the clinic was for mentally disturbed people, not for their child		1
h. accepted the fact that the child would always be slow		1
i. "got to thinking that maybe the child is unhappy, but he has it a lot easier than mother had as a child"		1
C. Problem alleviated	20.0	40
a. problem "cleared itself up," "straightened out" or "under control"		20
b. special symptom disappeared, e.g., "talked child out of burning matches," "put child in ful-sized bed and he stopped wetting," "coughing habit disappeared," "child stopped pulling his hair"		6
c. child adjusted to school		5
d. child is "somewhat better" or "started improving"		5

TABLE IV--Continued

Reasons Given	%	Number of Times Reported
e. child improved so much that mother "hated to waste the clinic's valuable time"		3
f. "turned into a different girl overnight--stopped smoking, drinking and running around and started going to church"		1
D. Received help from other sources	15.0	30
a. advice or care received from physician		10
b. child changed schools or teachers, or received help from his present teachers		11
c. child put in foster home or sent to relatives		4
d. received help from Juvenile Court		2
e. received help from County Health Nurse		1
f. parents found local TV program on psychology helpful		1
g. "child was hit on head by a retarded child, since then problem disappeared"		1
E. Forgot time of appointment, forgot reason for nonattendance and other reasons	12.0	24
a. could not remember reason, e.g., "I declare, I just can't		

TABLE IV--Continued

Reasons Given	%	Number of Times Reported
remember to save my life why I did not come"		9
b. forgot time of appointment		8
c. "just did not keep it"		2
d. expected clinic to call them		2
e. thought clinic fees would be too high		1
f. husband made appointment and did not tell wife		1
g. mother objected to need for parent to be seen in clinic when problem was the child's		1
F. Child or husband objected to clinic referral	5.5	11
G. Was advised that the child has no need for clinic services	2.0	4
a. by physician		2
b. by teacher		2

*Source: 103, pp. 316-319.

Table V presents the reasons given by parents for failure to return the medical form.

TABLE V*

REASONS GIVEN BY 100 PARENTS FOR NOT RETURNING THE MEDICAL FORM

Reasons Given	%	Number of Times Reported
A. Parents' attitude toward problem changed	23.0	23
a. decided problem was not "big enough"		11
b. decided they themselves should be able to cope with child's problem		4
c. decided the problem would take too long to solve		3
d. decided it was a "normal adolescent problem"		2
e. group gave parents self-confidence		2
f. felt mother, not child, needed help		1
B. Problem alleviated: "situation improved," "symptom disappeared," "problem cleared up," etc.	19.0	19
C. Received help from other sources	17.0	17
a. advice or care received from physician		6
b. child changed schools or teachers		5
c. got help from other psychological services		2

TABLE V--Continued

Reasons Given	%	Number of Times Reported
d. advice from relatives		2
e. child given up		1
f. child sent to reformatory by court		1
D. Difficulties in getting to the clinic	14.0	14
a. transportation and baby sitter difficulties		5
b. illness		4
c. doctor delayed returning forms		3
d. working hours		2
E. Vague reasons	9.0	9
a. "just didn't have it done"		2
b. "just not able to have it filled out right now"		2
c. "just never got around to it"		2
d. "does not remember getting a medical form"		1
e. "plans to return it sometime"		1
f. "thought clinic services would be free"		1
F. Was advised that child has no need, or is not ready for clinic service	7.0	7
a. by doctors		4

TABLE V--Continued

Reasons Given	%	Number of Times Reported
b. by school		2
c. by relatives		1
G. Medical examination	4.0	4
a. could not afford medical examination		4
H. Child refused to come to the clinic	4.0	4
I. Negative attitude toward the group meeting	3.0	3
a. felt that the "women in the group were not on the same moral, social, physical or any other level" with her		1
b. did not like the "type people" in the group		1
c. was "embarrassed and mortified" in the group because hers was a stealing problem		1

*Source: 103, pp. 316-319.

Jackson (136) describes her work through the case study method with nine children who successfully responded to treatment. She attributes much of the success, however, to the work done with parents by a psychiatric social worker. Jackson suggests that the mother of a severely

disturbed child needs to exercise special skill and tact in "reconciling the child to the world." Often the mothers of such children lack this skill, knowledge, and intuition. They need warmth and support as they develop them. The mother has to be educated in awareness to the special difficulties which a child with unstable heredity may encounter in early years. The treatment and support of the parents helps to prepare them for the future difficulties which are likely to arise in the lives of these children, since Jackson indicates, they are not "cured."

Rothschild (257) suggests that in providing the play therapy experience for the blind child, work with the parents is critical. In the case of blind children, the need for "disentanglement" between the mother and child is of primary importance if the child is to learn to feel and function in his own right. Therapy with the child has to include changes in the relationship between mother and child before changes in the child can occur. This is possible often only through the simultaneous therapy of both mother and child.

The use of a playroom setting for diagnostic family interviews in which play therapy and family interviewing techniques are incorporated is described by Orgun (227). By using this method, the diagnostic team can accumulate valuable diagnostic data on the family, while causing the

least discomfort and stress to the child by using the playroom and play materials. After having used this technique, the author suggests that it can be a useful procedure in family therapy when working with young children.

The purpose of therapy with children is to correct the patterns resulting from previous trauma or parental mishandling or to provide a release of energy from repression according to Gerard (95). Treatment can be carried on entirely through the medium of guiding the parents in the application of healthy training methods or in the treatment of the mother's neurosis. The neurosis of the child is closely related to the neurosis of the parent. The parent cannot make good use of the learning experience unless her own neurosis is resolved. However, if the pattern of behavior is fixed in the child, the child should be worked with.

In an article describing therapeutic effects of a play group for preschool children, Burlingham (44) states that parents should be worked with closely. Parental work is necessary in understanding the needs of a child. Leland and Smith (169, 170) see working with parents of handicapped children as a necessary part of the process for the child. The handicapped child has particular difficulties in self-perception, while their parents have particular difficulties in self-acceptance.

In Cameron's (49) view, parental guidance should be a part of the total process of child therapy. Since the child's problem is often the consequence of a disturbed parent-child relationship, both parties must be involved in the process if effective change is to occur. The mother, because of her own neurosis, often tends to relive her own traumatic childhood during the infancy and childhood of her child. If, however, the mother is truly interested in her child, willing to look at herself, and accept her own role in the parent-child struggle, she will be able to allow her child to grow as a result of the therapy. Some mothers resent the attention given to the child in therapy and will become a deterrent in the growth process. This constitutes one of the major reasons why the parent should be involved in the process. When parents are involved, they themselves will begin to take pride in the work and feel themselves to be a part of it. Cameron believes these services to parents should be delivered by a psychiatric social worker who is a member of the clinic staff (49).

Withall and Reddenhouse (303) claim that no therapy can be really effective for a child if all members of the family are not involved. And Katz (144) stresses that in working with emotionally disturbed children, parental education and guidance is more important than is individual psychotherapy with the child.

Methods used to create participation by parents were reported by Ganter and others (94). The treatment contract involved forty-seven severely disturbed children who were in residential care. The methods of group therapy, parent casework, and family contact were used. The investigators concluded that parental attitudes changed, since thirty-one families offered to pay for the service after the work was done with them (94).

Dawley (69) discusses the interrelated movement of parent and child in therapy. He stresses that the child's self is a composite of his inner forces and those external elements that make up his life. The degree of external influence is more intense in the child than in the adult. The parent comes in to the therapy setting when he is ready to do something about the difficulty with the child and the struggle they are in. The parent and child are united in this struggle. When the parent goes outside of this parent-child unit, he is breaking up the unity. Seeking help is seen as a positive shift by the parent. He begins the positive process when he breaks into the negative unity by using an outsider. Parent and child are both seen in the weekly clinic sessions. Since an outer force enters their relationship in the clinic, both the parent and child come to a new experience and begin to build a new relationship. In other words, the outer forces can be used to get

more quickly at the problem and strengthen the process of reorganization within the child.

The problems involved in parental work was discussed by Bruch (41). The therapist has to be aware of her own fright of the parents. She may be fearful that she will not be able to live up to the parental expectations. When the therapist acknowledges this insecurity in herself and deals with it, she will be able to work more openly with the parents. One danger is that the therapist often over-identifies with the child and neglects the parent. In an effort to work constantly with the parents and to overcome some of the problems before they start, she gains a detailed summary of the parents' expectation of treatment at the beginning of therapy. She assesses their awareness of the child's problem, identifies areas of resistance, and discusses their expectations.

In working with the parents, Bruch limits her work to areas which enter significantly into the relationship and into the handling of the child. She stresses that if the parents need treatment, it should be postponed. The parents should choose to enter therapy, not for the child's sake, but for their own sakes. One must respect the parents of the child. The child cannot grow if he feels the therapist believes that he has sprung from inferior stock. Bruch sees her role (whenever possible) as that of helping

the child learn to find love and affection from his parents and to feel that they are "good" people.

Pechy (228) discusses work done at the Meyrick Bennett Children's Medical Centre, in Durban, England, with mothers and children. He writes that in examining the cases treated there, the staff concluded that the success with the young child in therapy seemed to depend, not on catharsis nor abreaction but on lasting changes in the familial relationships. These changes tend to occur as a result of two factors: (1) the freeing of the growth process in the child through a permissive, accepting relationship with the play therapist and (2) an application of the insight into the needs of the child and his problems gained by the parents. Since this involved the treatment of the parent and the child separately, it posed difficulties which could be avoided. One of the difficulties was that a common experiencing of the child was not available for both therapist and parent. It was difficult for the therapist to understand the home dynamics and for the parent to make good use of the insights gained by the therapist.

The major theory of the staff was that maladjustment was the consequence of blocks and obstacles, more or less internalized, to the natural development of the child. They proposed that these blocks had arisen from disturbances

in the relationship between parent and child. Therapy had as its goal the removal of these disturbances by freeing the child through play therapy, and in addition, the development of parental insight through increased awareness of the relationship between the parent and child. Using these concepts, the staff developed a technique where the parent, usually the mother, and the child were observed together, and the parent was trained in working with the child.

During the first part of the treatment, the mother was seen alone. The therapist functioned as an objective, sympathetic worker. The mother initially was given time to express feelings, fears, and attitudes. Later she developed a sense of responsibility in the process. The mothers generally went through about the same stages. The first part of the time was generally spent on a concentration of the symptoms and a search for nonpersonal causes. Gradually, the mothers tended to move toward the expression of guilt feelings and acceptance of a personal responsibility for the difficulties. Finally, they began to show signs of interest and eagerness to search for the disturbing factors in the relationship.

When the mother reached a stage of rapport and active participation, she was put with the child, who had been undergoing a series of diagnostic tests with another therapist. The child and the mother were observed through

a one-way mirror during all of the sessions. The mother was instructed to allow the child to play any way she wanted him to, just as she would play with him at home. After each thirty-minute session, the therapist worked with the mother in helping her to understand the dynamics of her encounters with the child.

Basing his conclusions on numerous case studies, Pechy suggests that the benefits from this method include the following:

> 1. Observed parent-child play sessions can provide a method of dealing directly with the relationship problems which are of such vital importance in the development of neurosis. The technique can be varied considerably as occasion demands, and is valuable diagnostically and therapeutically.
> 2. As a method it places the responsibility where it belongs and gives the parents a direct opportunity of remaking their own failures.
> 3. Because it deals with the parent-child configuration without breaking it up, it has a continuity with ordinary effect, and at the same time allows what is really a continuous form of therapy to take place. The steps taken up in the sessions are naturally followed by the parent and child in all their contacts.
> 4. It is particularly appropriate for the younger child and may lose its value for the pre-adolescent and adolescent child.
> 5. It has been used successfully with children between the ages of three and a half and ten years who showed a variety of problems (228, p. 112).

Guerney (113) and Guerney and others (115) describe the development and implementation of the technique in parent work which they label as filial therapy. Andronico

and others (8) further discuss the relevance of the combination of didactic plus dynamic elements in the training of parents for filial therapy.

Guerney (113) and Guerney and others (115) describe filial therapy as a new psychotherapeutic method that "extends specific Rogerian approaches to the training of parents for treatment of their own young emotionally disturbed children" (115, p. 8). They base their assumptions on the effectiveness of this treatment method on the facts that (1) the parent has more emotional significance to the child, (2) anxieties learned in the presence of parents can be most effectively extinguished in the presence of parents, and (3) the parent can be actively involved with the child as he reassesses his original perceptions and with the help of the parent makes an accurate re-synthesis of the original material. The parents can be taught in effective ways to deliver the services to their child and to grow themselves as a consequence.

Another desirable consequence of filial therapy is that it makes for a more efficient utilizatin of the professional therapist's time by extending portions of his role to a nonprofessional. In addition, there is less chance that the parents will be threatened by the therapist-child relationship if they are actively involved and, in fact, are the deliverers of the service. The parents do

not maintain the guilt and hopelessness since they are actively involved in the remediation of the difficulty. And lastly, the parents develop new behaviors at the same time the child does. In this way, the entire family dynamic structure is influenced with the same amount (or less) of the therapist's time.

Andronico and others (8) describe the methods involved in the training of parents for filial therapy. This process is defined as a "method of teaching parents of emotionally disturbed children to relate empathetically to their children for prescribed periods of time" (8, p. 11). The goal of the play periods which eventually will be conducted at home is to enable "the child to work through his emotional problems via play in the therapeutic atmosphere of parental empathy (8, p. 11). Didactic as well as dynamic elements are used in the educationaand training of the parents involved. Initially, the didactic method is employed. The parents meet for eight to ten weeks and are taught the techniques of play therapy based on the client-centered philosophy. The major principles stressed are

> (1) The child should be completely free to determine the use he makes of the time and materials.
> (2) The parent's major task is to empathize with the child, to understand the intent of his actions, and his thoughts and feelings.
> (3) The parent's next task is to communicate this understanding to the child

> by appropriate comments--if possible by verbalizing the child's experiencing to him.
> (4) The parent is instructed in the setting of limits (8, p. 11).

In addition, the parents are given a format for evaluation of each of the sessions they do with the child. During the initial weeks, the parents work with their own child or children of others in supervised play therapy sessions. Thus, the dynamic part of the training is introduced.

This combination of didactic plus dynamic elements is a valuable way of working with parents. The parents' ability or inability to explore their own and others' feelings are generally critical in whether the treatment process succeeds or fails. The parents are given the opportunity to explore these capacities in themselves in a homogeneous group. Since it would be more comfortable for the parent to focus entirely on the subject matter of the home sessions, traditional therapy often fails. The group process gradually involves all the parents at the feeling level, and thus many continue who otherwise might not.

Parental Involvement: Research

Stover and Guerney (286) used the concepts of Guerney (113) and Guerney and others (115) and Andronico and others (8) in attempting to evaluate the efficacy of training procedures for mothers in filial therapy. This

research was designed to assess the feasibility of training mothers for the desired reflective, empathic role in conducting weekly half-hour sessions with their own children. It was hypothesized that the mothers in the trained group would increase their percentage of reflective statements and decrease their percentage of directive statements. Also included was an attempt to see whether the child's behavior would reflect such a change in role behavior even as early as the first few training sessions.

Structuring for mothers included asking the mothers to participate with their children in an observed tape-recorded, one-half-hour play session in a playroom. They were asked to play with the child in any way they liked and to use the materials in any way they liked. On the basis of the diagnosis, the mothers were divided into three groups, two experimental groups and one control group.

Training for the two experimental groups began with a discussion of the benefits of the coming experiences for the child and the parents. These mothers observed demonstrations and were encouraged to model their own behavior after that of the group leader. They were encouraged to attempt specific techniques and to try to express empathy toward their child. The parents were provided supervision as they worked with non-clinic children

and then began working with their own child. They received feedback from other mothers and from the trainer. During these discussions, they had opportunity for discussing their feelings in relation to their child.

After four sessions, it was found that the children in the experimental group revealed significantly more verbal negative feelings than did the control group children. The trends which began to emerge showed a definite change in the mothers' behavior. The investigators suggest that parents can learn to modify their pattern of interaction with their own emotionally disturbed child in the role behavior of client-centered therapist. In addition, it was noted that children quickly responded to the change in role in the parent.

In further research using filial therapy, Andronico and Blake (8) investigated its effect with parents who have children with stuttering problems. They report that this method is more difficult for parents of stutterers to use in that these parents tend to want to focus only on the problem. The parents were urged in this case to focus their attention on the total personality of the child rather than just on his stuttering. The investigators report that when the parents shifted their focus, the pressure was removed from the child, and his stuttering pattern subsided.

Marshall and Hahn (197) report an experiment designed to determine a cause of correlations between parent and child behaviors obtained earlier by Marshall. Twelve matched triads of preschool children were trained in doll play fantasy, in the use of toys, or were given no training. Frequency of dramatic play before and during training were the dependent variables. The results indicated that if an adult engages in fantasy play with a child, enacting topics commonly used in children's dramatic play with peers, the child will increase the frequency of his dramatic play with peers. Training in dramatic play was the critical factor.

The influence of the mother's presence on children's doll play aggression was observed by Levin and others (174). Twenty children were observed in two sessions of doll play. The first session involved the child and an experimenter. During the second session, the child's mother was an audience for one group, and an adult female, not previously known to the child, watched the sessions of the second group. Each of the ten children observed by their mothers were more aggressive in the second than in the first session. Eight of the ten children watched by a stranger decreased their aggressions in the second session. The findings are discussed in terms of modifications of the displacement theory of aggression.

Schiffer (261) in a study designed to evaluate the effectiveness of play therapy, included in his design two groups whose parents were involved in parent group therapy and one group whose parents were not. He reports no significant difference between the progress of the children whose parents were involved and in those whose parents were not.

An investigation on the effects of high levels of therapist-offered condition on parents and children was conducted by Siegel (273). Whether the therapy was directed towards the child, the parent, or both parent and child, the conditions of therapy was the critical variable, not whether parents or parents and children were both involved.

Dorfman (76) assessed the outcomes of client-centered play therapy. She found that therapy improvements occur without parent counseling despite the emotional dependence of children on parents.

When parents are provided with high quality counseling or when parent counseling and play therapy are combined, each or both become an effective method of treating learning disabilities in children, Baker discovered (23). Forty-eight students were divided into two groups of twenty-four each. For one group of twenty-four students, there were two special classes of twelve each which involved reading and other learning instruction. The other students in the

study received tutoring. These two groups were further divided to determine the effectiveness of counseling on the academic and other performances of the students. As a result of the treatment methods, Baker concluded that high level therapy was instrumental in causing a change in the parent-child relationship to a greater extent than was either the tutoring or special class situation singly. The counseling of the parent or play therapy with the child, or a combination of the two, proved to be a valuable treatment as an adjunct to the services of either the special class or the tutoring.

Prestwich (237) described a study investigating the influence of two counseling methods on the physical and verbal aggression of preschool American Indian children. The purposes of this study were (1) to investigate the influence of anthropomorphic models as a therapeutic vehicle to help five-year-old Indian children to appropriately handle, and thereby decrease, physical and verbal aggression and (2) to investigate the influence of group counseling with Indian mothers as it affects aggression in their preschool children.

Subjects in the eight-week study included thirty children randomly assigned to three groups. In group I, children were placed in a controlled environment with human-feature life-sized dolls. Mothers of group II met for

ninety minutes weekly to see films and participate in group discussion/counseling sessions. The counseling model used was perceptual modification through verbal reinforcement. Group III was the control group. Pre- and post-test observations and ratings were made for the subjects on an experimenter-designed instrument which measured quantitative aggression responses. Study results revealed no significant differences in physical, verbal, or total aggression between experimental and control groups before or after treatment. Indian mothers significantly increased verbal output during treatment, but results indicated that this change bore no relationship to children's aggressive behavior at preschool.

The importance of parent treatment to the successful outcome of therapy with their child was studied by Levi (172). It was hypothesized that the successful outcome of children's therapy is related to the concurrent treatment of their parents. The sample consisted of 314 cases. It was found that there is no relationship between parent treatment and outcome of the child's therapy. The data imply that the most important factor in the outcome of a child's therapy may be the identity of his therapist. Length of treatment was also found to be a factor in treatment. While the superior therapist achieved as much success with his briefly-treated cases as with cases that

remained for a longer time, the other therapists achieved much better results with cases who remained for relatively long periods.

Literature Dealing with the Setting As Influencing Process and Outcome

School Setting

Some material was found in which the use of the play therapy technique in a school setting was discussed. These articles tended to be philosophical or pragmatic in nature. Only one article, by Hume (135), presented research.

Demaago (70) described the use of client-centered play therapy for use in an elementary school. Following the concepts of Carl Rogers, she points out that play therapy offers a child an opportunity to play out his feelings, explore his thoughts, and describe his experiences. The counselor's role is described as that of a nondirective participant, reflecting, recognizing, and clarifying the child's feelings. She describes two types of playrooms which are appropriate to a public school setting, and she suggests that teachers should be trained in the techniques of play therapy. The method of play therapy could be adaptable to the classroom through the use of creative activities and the recognition of the child's feelings by the teacher-therapist.

Waterland (297) describes the use of play therapy in an elementary school guidance setting. She follows the

philosophy of Axline in reference to rationale, selection of materials, structure, and technique and uses the case study method to illustrate the use of this technique in the elementary school.

In an article on school-centered play therapy, Alexander (4) stresses the relationship-therapy approach as described by Moustakas. He gives a case study to demonstrate the application of relationship therapy to actual situations. Since no playroom was available, the counselor carried the toys in a suitcase and used a quiet room for the sessions. He stressed the importance of working very closely with teachers as a necessary part of the total service to the child.

Moustakas (210) believes that in providing play therapy experiences for school children in the school setting the therapist must project his accepting attitude toward the teacher's experience. The therapeutic relationship between the therapist and child can act as a catalyst in the relationship between the teacher and child. The therapist has as one of his goals that of providing support to the teacher in her struggle to accept and understand the child. The child, he suggests, is helped to make an emotional reorganization in his school environment as a step toward emotional growth at home and in his other environmental situations.

A study involving twenty children is reported by Hume (135). The most effective means of intervention in working with the emotionally handicapped child was the use of play therapy in combination with inservice consultation for teachers. Play therapy alone was found to be an effective approach, but more gains were observed when this was combined with work with the teachers.

A summary of research about play therapy in a school setting is given by Seeman (267). He surveys the approaches to child therapy and also discusses applications of child therapy in practice and research. He concludes that play therapy not only has a place in strictly clinical settings but also has a place in the field, where workers are finding ways of making a therapeutic approach directly relevant to the educational scene. He cites research by Seeman (268, 269), Bills (34, 35), and Moustakas (210).

Hospital Setting

Some articles (all but one dealing with theory) have been written on the value of including a provision for the emotional needs of children within a hospital setting.

Davidson (68) recommends a playroom with a trained counselor for a hospital setting. It should be designed to meet and serve the needs of the child while he is in the hospital. Davidson contends that the hospital has a deep obligation to provide for the emotional needs of the

child who is under stress in order to lessen the possibility of permanent emotional trauma as a sequel to physical illness. She bases her philosophy on the assumption that unique insecurities develop in a hospital which should be dealt with at that time. Good nursing care should make provision for adequate experiences in all areas of the child's needs. However, this play program should be directed by a person qualified in child guidance techniques.

It is the responsibility of a hospital to provide for the total needs of the children who come there, emotional as well as physical, suggest Whitted and Scott (301). The emotional needs of the child can be provided for through the use of facilities for play and a "play lady." The "play lady" possesses personal skills which allow her to understand and be helpful to both the child and his parents. She offers fun, relaxation, comfort, and enjoyment. In this particular hospital setting, both indoor and outdoor facilities are provided.

McPherson (192) and Kimmel (147) have written on the value of the play technique in meeting the needs of children in a medical setting. Chalmers (52) wrote that play is valuable in nursing severely subnormal children. She suggests that nurses working with these children should be trained in play techniques.

The functions of a hospital playroom were described by Despert:

> (1) The playroom provides the child an outlet for motor activity under unrestrained, uncensored, nonorganized conditions.
> (2) It allows the child an opportunity for abreaction of affects of the traumatic experiences often accompanied by separation; the fright involved with illness; and the other uncertainties involved with being in a strange place.
> (3) It allows the child to gain insight.
> (4) It allows for sublimation of stress into constructive activities (74, p. 679).

Richards and Walff (245) describe a play group which functions within a Medical Clinic setting. The group is open in that the children use the group on the mornings they are scheduled for regular medical services. Play materials are provided for the younger children and handcrafts are provided for the older children. The playroom is supervised by a trained worker.

Cassell (51) reports a study investigating the effect of brief puppet therapy upon the emotional responses of children undergoing cardiac catheterization. The study involved forty children between ages three and eleven who had been admitted to a children's hospital for cardiac catheterization. Twenty of the subjects were randomly assigned to an experimental group which received puppet therapy before and after the operation. Twenty of the children were placed in a control group which was not given therapy but received the same treatment in other ways. The author reports that children who received therapy were less disturbed during the operation and also expressed to

their parents more willingness to return to the hospital for further treatment. The post hospitalization behavioral expectation of the study was not supported. Both groups showed slight improvement in their emotional behavior following hospitalization.

Literature Dealing with Therapist Variables As Influencing Process and Outcome

Smolen (276), in an article on the nonverbal aspects of therapy with children, emphasized that therapy with children is an "action cure," not a "talking cure." The therapist talks because of his own insecurity and not for the benefit of the child. In observing the nonverbals of a child, the author states that one must place the behavior in the context of this session and of the total history of the child. In addition, one must evaluate the significance of the behavior in terms of the psychodynamic implications before verbally responding to it.

Arthur (11) suggests that the therapist should be completely passive during the nondirective play therapy relationship. She suggests that while the child plays, the therapist should be engaged in something. This will induce the child to play independently. She goes so far as to suggest knitting as a counselor activity.

Adams (2) presented an article in an attempt to initiate consideration by therapists of their hidden and/or

open racism, as it bears on psychotherapy. He discusses the racial distortions which develop between a white therapist and a black client. He suggests the following measures as helpful strategies:

> (1) Open discussion of racial issues with the patient.
> (2) Independent cultural education, including community involvement; study of pertinent social data; and a hard, honest look at cultural issues.
> (3) Fuller personal analysis of therapists' own susceptibility to racist distortions and negative countertransference.
> (4) Salutary personal contact with black people on the part of the white therapist. This is beneficial both in childhood and later in the life of the therapist in what might be called "personal action research" (2, p. 42).

Adams suggests that if a person is not willing to look at himself in this way and grow, then he should not participate in biracial therapy.

Many authors have dealt with the variable of counselor integrity. Engebretson (84) discusses the role of interaction distance in therapeutic interventions. Since that nonverbal coding of behavior is learned early in life, the therapist should be cognizant of the child's nonverbal language as expressed by distance. Stressing the relationship approach, Newell (224) wrote that for therapy to be of value to a child he must have the experience of relating to and of talking with a therapist who has a different attitude towards him and his problems than have his parents.

Sometimes the relationship which develops between the therapist and child represents the child's first experience with an adult who respects and accepts him as he is. The importance of the personality of the therapist as it influences the process of play therapy was discussed by Tallman and Goldensohn (292). The therapist must be able to get "rid" of his own superego in order to allow the child to "loosen up" in the session. This allows the child to get past barriers within himself. Withall and Reddenhouse (303) suggest that even though nondirective play therapy may superficially appeár to be simple, it is not. It should not be attempted by a novice. A person should have thorough training before attempting to work with a child in a play therapy setting.

Siegel (273) conducted a study in order to investigate changes in the client's behavior during the course of play therapy. The function of differing levels of therapist-offered conditions was observed using sixteen children, second and fourth graders who were diagnosed as learning-disabled. The Porke Process Scale of play therapy and the empathy, warmth, and genuineness scales as described by Carkhuff were used. Sixteen play therapy sessions were conducted by the same therapist. Four children receiving the highest level responses were correlated with the four children receiving the lowest. Statistical significance

was noted in the change of behavior which occurred over time as a function of differing levels of therapist-communicated conditions. High-conditioned children increasingly made more insightful statements and positive statements about themselves than did low-conditioned children. Occurrence of a modeling effect was noted in the children receiving high conditions of communication.

Subotnik (288) investigated the variable of transference in client-centered play therapy in a study involving one child and the child's parents. He made an effort to identify those variables onto which a client transfers with the therapist. His hypotheses and the results are the following:

> (1) The child's perceptions of the therapist as goal object will , as observed during the course of therapy, reach a point of significant similarity to the child's perception of the parent as goal object.
> (2) If the child's perceptions of the two parents are clearly differentiated, his perceptions of the therapist will more closely resemble his perceptions of the like-sexed parent.
> (3) During the course of therapy, the child's perception of the therapist will be modified in the direction of approach and equilibrium.
> (4) At the conclusion of therapy the child's perceptions of his parents will be modified in the direction of approach and equilibrium.
> (5) Modification will be greater in the relationship with the parent of the same sex as the therapist.
> Results indicate:

> Hypotheses one, two, and five were supported by the research.
> Hypotheses three and four were unsupported (288, p. 5).

The effect of permissiveness, permission, and aggression in children's play was observed by Siegel and Kohn (272). The study involved two boys to each group in a playroom. One session involved the presence of a permissive adult and one session involved allowing the two boys to be in the playroom alone. The authors found that the children in the presence of a permissive adult tended to be more aggressive than they were when they played alone.

Moustakas and Schalock (218) describe a study conducted at the Merrill Palmer School designed to examine the nature of the interaction of therapist and child in a play therapy situation. Two groups of children, one with serious emotional problems and the other without such problems, were used. A total of eighty-two child categories are included in the schedule. These categories were constructed on the assumption that adult-child interaction involve reciprocal stimulation. The subjects were selected from four-year-old children enrolled in the nursery school. Group A included three girls and two boys, and Group B included four boys and one girl. Each subject was seen by the same therapist for two forty-minute play sessions. There was an interval of three days between each session. For a report of their conclusions, see Appendix D.

Mehrabian (200) conducted a study on the relationship of attitude to seated posture, orientation, and distance in an attempt to investigate the functional relationships of a communicator's posture, orientation, and distance from his addressors to his attitude toward that addressor. The subjects played the role of the communicator with a hypothetical addressor. The latter's sex and the subject's sex and liking for the addressor constituted the independent variables. The dependent variables were eye contact, distance, head, shoulder, and leg orientation, arm-leg openness, and measures of hand, leg, and body relaxation. The findings of the study indicate that eye contact, distance, orientation of body, and relaxation of body (as angle or backward lean and by his sideways lean) are significant indexes of subject's liking for the addressor. The remaining measures did not yield any significant relationships to liking.

Siegel (271) reports a research project investigating the hypothesis that the verbal behavior of adults will vary as a function of the linguistic level of children. Two adults were assembled in a series of permissive play therapy-like sessions. Eight children were classified as high verbalizers and eight children were classified as low verbalizers. All were labeled as retardates. The adults were told that the children were retarded and that

they could use whatever technique they could in order to get the child to express himself. Simple toys were given them to use in a playroom setting. An overall Low Adult Mean Length of Response was observed through the use of recordings and typed manuscripts of the sessions. This was hypothesized to indicate that the adults prejudged the verbal level and ability of the children. They consequently stereotyped them all into one category.

Stollak (285) reports a study in which undergraduates were trained as play therapists using the didactic procedure. This procedure included didactic lecturing, group discussion, practice, and being observed in actual play therapy sessions. The members were trained in the nondirective techniques of a client-centered therapy. The author found that undergraduate students do significantly change their behavior during the sessions, increasing their reflection of content and clarification of feeling statements. These statements, the author felt, effected an increase in the expression of negative feelings and leadership behavior of the children. Stollak states he feels prognosis for training undergraduate students to work with children is very good. He feels their youth and malleability, their openness to suggestion, and their eagerness to learn are obvious positive characteristics. These undergraduates acted maturely and competently. They were in the fullest

sense of the word "therapists" attempting to bring about change.

A study conducted by Linden and Stollak (181) was designed to assess the changes in behavior of undergraduates trained to be reflective, noninterfering, and empathic with children. Two training procedures were employed. Forty-eight volunteers were selected from undergraduates. The setting was the clinic playroom at a university. The playroom was twenty feet by forty feet and contained a sandbox, chalkboard, dollhouse, and toys as described by Axline. Two training procedures were used--didactic and nondirective.

In the didactic training procedure, the Axline paradigm of play therapy was used. The trainer told the student the principles of nondirective play therapy. He demonstrated the principles through role playing and observed each student in a series of play therapy sessions and gave feedback.

The nondirective training experience involved telling the students that they were being used in an attempt to answer the question, "Can twelve intelligent college students--by playing with children, observing each other, and discussing among themselves what had been done--be able to figure out an ideal sensitive way to work with children?" The leader summarized, integrated discussion, and reflected comments and questions as this group met together for discussions. No lecture was given. The students worked

with children and discussed problems in the nondirective discussion group.

The results indicated beyond a reasonable doubt that students trained didactically reflect significantly more feeling and content of behavior in play therapy. They gave less direction and unsolicited help and asked fewer questions and restricted the child less than did the other group. Other training implications would be that undergraduates and lay persons can be trained if the proper methods are used.

Kranz (152) reports that because of the lack of available personnel in the United States trained to provide adequate psychological guidance to school children in early grades, he initiated a program where teachers were trained to work with students with emotional difficulties. The teachers were given a ten-week theoretical course covering process. After this course, they began a practicum which lasted ten weeks. Each teacher worked with one child in direct therapeutic contact while under supervision. The teacher saw the child for two hours per week.

After the training program, the therapeutic experiences began in the schools. The teachers met with a psychologist one time per week for case presentation, discussion, and feedback. They were gradually more open with themselves and with the children. The teachers reported more spontaneity, genuineness, and authenticity. They indicated

that this growth was exhibited in the playroom as well as in the classroom.

Guerney and Flumen (114) suggest the use of teachers as psychotherapeutic agents for withdrawn children. They feel that the teacher is a logical person to provide therapeutic services to a child because she already knows the child and has more access to him.

The authors hypothesized that withdrawn children would become more assertive in their classrooms when seen in therapeutic play sessions by their own teachers. In addition, the progress of the child would be correlated with the effectiveness of the teacher in her client-centered role as therapist.

The children used were eight boys and seven girls from the first, second, third, and fifth grades. The teachers were trained using filial therapy procedures in training sessions which lasted twenty weeks for one and one-half hours each. They were trained in Rogerian theory underlying the play therapy technique. They saw demonstrations of individual play sessions conducted by professionals and had opportunity to role-play sessions. Each teacher met with her child weekly for forty-five minutes for fourteen sessions. She was supervised during the time she worked with the child.

The results indicate increased assertiveness and significant correlation between the teacher's therapeutic role performance and the child's improvement. A need for further research in the area of delivery of services to children is indicated.

Schiffer (264) reports a situation where he was called in as a consultant in order to train volunteer teacher therapists to lead play groups within a public school setting. Interested teachers volunteered to spend one hour per day leading a play therapy group for the children within the school needing a therapeutic experience. The teachers were given one hour per day release time from their classroom duties for this work.

Schiffer provided training and consulting through the use of seminars in which the teacher-therapists presented play group meeting reports which they had written after each session. In the beginning, Schiffer reported that the teachers were very dependent on the consultant for insight and interpretation. One of his goals was to help the teachers to learn to look beyond the superficial behavior of the child. The consultant tended to become less active in the seminar discussions as the teachers began to feel more confident in their assumptions. Schiffer stressed that not only the teacher-therapists and guidance workers benefited, but the referring teachers who were also a part

of the seminar group learned to intensively study child behavior.

The training and use of teacher's aides in a headstart program was described by Andronico and Guerney (9). They used the techniques they developed for training parents in filial therapy to train teacher's aides to work with children in play therapy sessions in the program. They discuss one of the aides who had been trained in filial therapy to work with her own child. She was a high school graduate in her late twenties who had been trained in client-centered techniques. She achieved a high degree of success with her own child and later in the headstart program, consistently with other people's children.

Members of the staff provided further supervision and training. They suggest that in training paraprofessionals for this filial "type" therapy, the aides should be taught

> (1) to try to understand how the child presently feels;
> (2) to accept the child's feelings no matter what they are;
> (3) to allow the child always to take the lead in determining how he uses his play time;
> (4) to enforce the rules of the session with complete firmness while remaining empathic and noncritical; and
> (5) to demonstrate to the child that his needs are indeed being understood and accepted, by making appropriate but brief statements like "That gets you angry," i.e., reflecting feelings (9, p. 16).

The treatment of two seriously disturbed children by their teachers in a playroom was reported by Hargley (121). The children were seen in an institute and it is reported that progress was noted in each case. Volunteer teachers were trained to be used as play group therapists in play groups which met one hour per day in a school setting by Schiffer (262). The principal arranged for these volunteers to be given one hour per day for the purpose of leading the therapy groups. Schiffer was used as a consultant whose responsibility was the training and supervision of these teachers.

Literature Dealing with Outcome Research in Play Therapy

The following articles were concerned with the reporting of research which had been conducted in order to evaluate outcome of the play therapy process.

Seeman, Barry, and Ellinwood (268) investigated the interpersonal assessment of play therapy outcome in a study involving 150 children. The children were aged eight to nine years and were in an upper middle class school. Their behavior was classified into categories of high adjustment, aggression, and withdrawal. The sixteen lowest ranking children on composite adjustment scores were divided into two groups who were matched for age, sex, and aggressive or withdrawn patterns of behavior as indicated by the test

results. Each child in the experimental group was given individual play therapy at the clinic for as long as was required according to the judgment of the therapist. The median length of play therapy for the group was thirty-seven sessions. The tests were repeated seven months after therapy began, and finally, one year after the second testing. The interval from first to last testing was nineteen months.

It was concluded that children involved in play therapy were perceived by others as significantly less maladjusted after therapy. The findings in this study suggest that a significant reduction in aggressiveness may result from non-directive play therapy experiences and that children as young as seven or eight may change in the absence of systematic environmental alteration.

Levi and Ginott (173) investigated the effectiveness of therapy with children by comparing the improvement rate of a group of treated children with the remission rate of a control group of untreated children. Included in the research were 314 children who were treated in a child guidance clinic. Fifty-five per cent were considered to be improved and 45 per cent were unimproved at the close of treatment. Improvement was defined as the disappearance of presenting symptoms.

The control group consisted of 300 children whose parents failed to complete intake procedures. Fifty-nine

of these parents reported the reason for their defection as the alleviation of the child's presenting symptom. In other words, the remission rate for this group was 20 per cent. A comparison between the improvement rate of the treated group and the remission rate of the control group was considered a measure of the effectiveness of therapy.

An investigation to determine the significance of client-centered play therapy on a short-term basis was reported by West (300). He used twenty-six children from grades one through five. The children had normal intelligence and had been diagnosed as having emotional problems, learning difficulties, and behavior problems. The children were randomly assigned to three groups which were experimental, placebo, and control. Individual play therapy sessions were conducted for one hour each week for ten weeks. Five hypotheses were formed in reference to the effect of the play therapy group. The variables examined were intelligence scores, self-concept, social adjustment, and perception of school adjustment. All hypotheses were rejected. This was an indication that the experimental group which was exposed to play therapy did not benefit significantly from the experience.

In reporting a study investigating the personality outcomes of client-centered child therapy, Dorfman (76) hypothesized: (1) personality changes occurred during a

therapy period; (2) they did not occur in the same child during a no-therapy period; and (3) they did not occur in the control group. She used psychological tests, therapist judgments, and follow-up letters in order to investigate the outcome. The basic experimental design consisted of the pre-test and post-test variety. The design involved observation during three time periods for the therapy group of twelve boys and five girls. (These children were aged nine to twelve, had average intelligence, and were considered to be maladjusted by their teachers.) They were tested over three time periods which were pre-therapy or control period, therapy period, and follow-up period. The experimental group was tested four times: (1) thirteen weeks before therapy; (2) immediately prior to therapy; (3) immediately after therapy; and (4) a year to a year and a half after therapy.

Dorfman found that reliable test improvements occurred concommitantly with a series of therapy sessions. She also found that time alone did not produce reliable improvements on tests.

Two secondary hypotheses were also supported: (1) effective therapy can be done in a school setting and (2) therapy improvements occur without parent counseling in spite of the emotional dependence of children upon parents.

Cox (65) investigated the nature of interpersonal relationships and individual adjustment before and after play therapy in a study involving two groups of orphanage children. There were nine children in each group, matched individually for age, sex, residential placement, adjustment, Thematic Apperception Test scores, and sociometric measures. Both groups were chosen so that they would be a representative sample of the orphanage population. The experimental group was given ten weeks of play therapy. The control group received no therapy. At the end of therapy and again fifteen weeks later, both groups were retested. The adjustment scores and peer ratings of about half of the children in the experimental group showed improvement. The control group showed no gains.

Forty cases of children aged four to thirteen were reviewed by Gitelson and others (106). Of the total cases reviewed, thirteen showed much improvement, eleven showed significant improvement, and sixteen showed no improvement. The design for the survey was not described. The information was based on his cases.

The effectiveness of nondirective therapy with maladjusted fifth-grade pupils was investigated by Quattlebaum (240). The purpose of the study was to determine if the self-concept of these students could be improved through the use of play therapy or counseling.

The study involved three groups of maladjusted fifth-grade pupils. One group received no therapy; a second group received individual counseling; and a third group received play therapy. This was done in order to assess the effectiveness of play therapy and counseling in contrast to no treatment. Nine students were involved in four months of treatment.

Based on the results, Quattlebaum surmised that

(1) there is a substantial number of maladjusted elementary students and from all indications, teachers are quite reliable in categorizing them.

(2) even though overall significant differences were not found in the three treatment effects, individual children did improve as a result of treatment.

Pelham (230) investigated the use of group and individual play therapy in increasing the social maturity of kindergarten students who had been identified as socially immature. The study involved seventeen children in the experimental group, nine of whom received group therapy and eight of whom received individual therapy. The control group consisted of eighteen other children. All of these children had been identified by their teachers as being socially immature in terms of classroom behavior. Each child in the experimental group received six to eight forty-five-minute therapy sessions held at the university. One investigator conducted all of the sessions.

Based on the results of the pre- and post-test evaluations which included the Missouri Children's Picture Series, the Children's Self-Social Constructs Tests, and the Behavior Problem Checklist, it was concluded that few significant differences in social maturity could be found between the experimental and control groups. The experimental group was shown, however, to have developed more complex self-concepts, but decreased in maturity as measured by the Missouri Children's Picture Series. No differences could be found between the children who had received group therapy and those who had received individual therapy.

The effects of play therapy and behavior modification approaches with conduct problem boys were compared by Perkins (231). Twenty-seven subjects were randomly assigned to one of three conditions. These conditions were the control group, the play therapy group, and the reinforcement therapy group. They were assigned to one of three therapists. The subjects were seen over a three-week period of time for nine twenty-minute sessions. The therapists were found to be significantly more effective in increasing responsiveness to social reinforcement in a reinforcement therapy condition than in the play therapy or the no-treatment control condition. Perkins contended that the play therapy condition did not differ from the no-treatment controls in its effect on responsiveness. Social reinforcement

therapy procedures produced greater behavioral improvements than did play therapy.

Herd (130) investigated the relationship of play therapy to behavioral changes in interpersonal relationships, mature and desirable behavior patterns, more adequate use of intellectual capacities, and improved adjustment. Subjects ranged in age from six to eleven, were of at least average intelligence, and were identified by their schools as having behavior problems. The subjects were randomly placed into three groups: (1) an experimental play therapy group, (2) a play group, and (3) a control group. Little statistical significance was found on the measuring data to support the hypothesis that positive behavioral changes would occur as a result of play therapy. There were evidences, however, which did support the hypothesis. These were interviews with parents and teachers, letters and statements, and observations made by the therapist.

Levitt (176) surveyed thirty-five reports of child therapy outcomes. Two-thirds of the children examined at termination of therapy and three-fourths of those seen in follow-up showed improvement. Approximately the same percentages of improvement were found in groups of untreated children. Levitt concluded that the published figures "fail to support the view that psychotherapy with 'neurotic' children is effective" (176, p. 195).

In a later study, Levitt (177) combined the results of a number of studies to include nearly 10,000 child patients. Of those who received treatment, between two-thirds and three-quarters were improved, but a similar improvement rate occurred in those who were not treated.

In a study conducted in Great Britain, Barbour and Beedell (24) report that they found no difference in outcome between treated and untreated children. They also report no difference between short-term therapy outcome and long-term therapy outcome.

Flint (88) reported a program designed to rehabilitate infants and preschool institutionalized children who were emotionally and culturally deprived. An experiment was conducted in the children's home, which involved using volunteer mothers in addition to daily provision of play therapy for the children. The children gradually showed emotional, social, and speech development and became more competent in self-help skills. After fifteen months, forty-four children had been returned to their parents or placed in foster or adopted homes. Results indicated that an institution could promote healthy development by recognizing the individuality of the children, providing close relationships with other people, encouraging initiative, and being consistent in care and discipline. Flint included five case histories to show the trend of development as a result of the provision of the increased services.

Variables affecting child therapy outcome were investigated by Levi (172). The variables investigated were type of parent, identity of therapist, length of treatment, age, sex, and symptoms of the child. Of these variables, only the identity of the therapist and the length of treatment were found to be related to outcome. The children who were seen by one particular therapist had a much higher level of success more quickly. Other therapists, less able, achieved success, but it took them a longer length of treatment.

Rogers (248) describes a survey on the outcomes of three different treatment methods used in child therapy. He surveyed and discussed the methods which were used in the Child Study Department at Rochester. The decision for the type of treatment used with a particular child is made on the basis of a staff decision. The first method described involved a complete change of environment for the child. This might consist of placement in foster homes, institutions, and other settings. The second method used was to work with the family. The staff stressed changes in parental attitudes by education. They taught methods of child management and recommended physical changes in the family style of living. Included in these patterns would be work and rest patterns, housing, neighborhood, and family interaction. The third method involved therapy for the child.

Rogers' survey indicated that treatment should be selective. It points to the fact that in treating children we must use social, educational, and medical therapy as well as psychotherapy. He suggests using definite types of therapy for definite types of children. He further suggests that we should welcome all methods which give promise for help of children, but therapists should recognize that some of the techniques are applicable only in certain cases.

The level of experiencing in a child as a predictor of short-term play therapy outcome was used by Eme (83). Twenty-four boys between the ages of eight and twelve participated in twelve one-hour individual play sessions. Eme attempted to predict therapeutic outcome by using pre-therapy measures of level of experiencing and level of adjustment. Level of experiencing was assessed by the Rotter Incomplete Sentence Blank Test using Dorfman's modified criteria. The level of adjustment was assessed by the subjects' responses on the Incomplete Sentence Blank Test. In addition, parental reports and target complaints were used. None of the statistical tests used after treatment showed the necessary significance to indicate that the level of experiencing is a favorable predictor of play therapy outcome.

Subotnik and Callahan (289) investigated the outcome of play therapy for institutionalized educable mentally

retarded boys. Based on the data gained from their study, they posed such questions as (1) who needs treatment, (2) how can the need for treatment be quantified, and (3) what is treatment? There seems to be a need in assessing psychotherapy and a better formulation of the goals of psychotherapy reflected in the selection of subjects for treatment. In addition, there need to be more holistic methods of evaluation compatible with the complexities of personality. There should also be more sophisticated expectations of change which allow for individual variations.

Duration As It Affects Outcome

Eisenberg and Gruenberg (82) found short-term treatment as intensive as long-term psychotherapy. Phillips and Johnston (233) report an attempt to evaluate the effectiveness of short-term therapy as compared with conventional treatment. Short-term therapy consisted of a stated number of interviews in which treatment was directed "not at retrospective self-examination, but at the child's pattern of interaction in current situations" (233, p. 267). Of sixteen short-term cases, two were considered successful and the rest improved. Of fourteen conventionally treated cases, one was considered successful, eight improved, and five failed. Of the thirty control cases, four were considered successful, nineteen improved, and seven failed. The authors concluded

that the similarity in outcome between short-term and conventional methods was great enough to warrant further study.

Phillips (232) did a follow-up study comparing short-term and conventional therapy. To do this, he obtained ratings from parents of the thirty children seen in conventional therapy and of the parents of the twenty-seven children treated in short-term therapy in a guidance clinic. He also obtained information from fifty-two children seen in short-term therapy in private practice. The criteria involved assessing growth in reference to the areas of improvement in original complaint, parental ability to handle the child, and the child's behavior at home, school, and with peers. As a result of the information gathered, Phillips suggested that the short-term therapy was more effective than was the depth therapy. He suggested that for some cases, it is possible to evolve procedures which shorten therapy without jeopardizing results.

Hare (118) reports a study designed to evaluate a shortened method of treatment at a child guidance clinic in order to compare the results obtained with other similar studies. The study involved 119 consecutive cases carried out by one psychiatrist in the clinic. The average number of attendances per case was 6.3, and the median number of months under treatment was 3.8. A follow-up assessment

was made about two years after discharge. Adequate information was obtained on 95 per cent of the cases. At discharge, 49 per cent of the cases were recovered, and 23 per cent improved. At follow-up, 75 per cent were recovered, and 24 per cent improved. Outcome was better in girls than boys and in older than in younger children. Outcome was best in neurotic cases and poorest in conduct disorders. The improvement rates compare favorably with those of other studies. They add to the evidence that short methods of treatment are as effective as longer conventional methods.

Follow-Up Research Studies

The research discussed in this section is work which has been done to assess the long-range effects of the play therapy experience. There is a wide range in type of study and effectiveness of study included.

In a follow-up study involving a group of fifty children who had been exposed only to diagnostic study, Witmer and Keller (304) found that there was little difference between the later adjustment of the successfully treated children and the untreated children. The children were chosen to constitute a control group for the children described in the study by Shirley and others (270).

The adjustment found in the follow-up of the "diagnostic" group was as follows: 48 per cent made successful adjustment;

30 per cent had improved but still were somewhat maladjusted; 22 per cent remained unimproved. They found that by late adolescence or young adulthood, a majority of maladjusted children outgrew their problems. Those who missed therapy in childhood did about as well as those who were successfully treated.

Shirley and others (270), in a follow-up study of child guidance patients, assessed children twelve years after termination of treatment. Of the thirty-five treated subjects considered to have had successful treatment, 60 per cent remained well adjusted, 23 per cent displayed some problems, and 17 per cent were definitely maladjusted. Of fifty children considered as unsuccessfully treated, 56 per cent remained unimproved, 20 per cent had improved, and 16 per cent were well-adjusted. In other words, when treatment was successful, the chances were six out of ten that the patient would still be well-adjusted years later. When treatment was unsuccessful, the chances were only two out of ten that the patient would be found well-adjusted.

A follow-up study involving forty delinquent children of school age was reported by Rexford (243). One therapist saw all children. At the end of treatment, thirty-three of the children were rated as improved and fifteen as unimproved. At the follow-up, two to seven years later, nine of the unimproved were found to be delinquents, while only

seven of the improved were delinquents. When treatment was successful, the chances were only two out of ten that the patient would be found delinquent, while when treatment was unsuccessful, the chances were six out of ten that he would still be delinquent years later.

Lehrman and others (168) report a follow-up study conducted involving fifty-three children who were seen in a child guidance clinic in play therapy. Of these children, 34 per cent were considered improved, 21 per cent partially improved, and 45 per cent unimproved at the close of treatment. A comparison between the status at the close of treatment and at a follow-up a year later showed an increase in successful adjustment and a decrease in failures. The investigators question how much of this can be attributed to therapy and how much to maturation or to the effects of time, because they did not have a control group.

They did use a control group of defectors and of the twenty-six untreated children; 19 per cent made successful adjustment, 50 per cent made partially successful adjustment, and 31 per cent were unsuccessful in their community adjustment. The comparison shows a greater proportion of partial successes in the untreated group, a greater proportion of complete successes in the treated group, and an equal proportion of failures in both groups. When the cases were divided into the categories "improved"

and "unimproved," differences between the treated and the untreated groups vanish. At follow-up, both groups show about two-thirds improved and one-third unimproved.

Eight children (four boys and four girls) were followed by Clay (54) thirteen to twenty-two months after termination of therapy. Both the children and their mothers were in treatment for a period of at least six months and termination was by consent of both mother and therapist. At the time of termination, seven of the cases were considered successful, and one was considered a failure. Clay measured the degree of sustained improvement on a scale that compared mother's evaluations of the child's adjustment at the intake interview to that at the follow-up interview. He found that six of the children, three boys and three girls, sustained their improvement. One girl did not. The boy who was rated at termination as an "outright" failure was worse than he had been at the time of referral to the clinic.

Cunningham and others (66) report a five-year follow-up of 420 patients. They found that 63 per cent remained satisfactorily improved, although they were able to contact only one-half of the cases.

Axline reports the follow-up of twenty-two children whose therapy was deemed successful and whose parents did not receive treatment (18). She used the following interview procedures: the therapist met the child and asked

an introductory question, "Do you remember me?" There were no probing questions nor suggestions. Those who could not be contacted personally were reached by mail. Axline found that the twenty-two children were still successfully adjusted a year after termination of treatment. She does not discuss her criteria for adjustment.

Axline (15) reports a sharp gain of functioning in the case of Billy in a follow-up assessment. Upon entering play therapy, his intelligence quotient was measured at sixty-five, and upon retest, it was sixty-eight. He was tested again in six months and was evaluated at ninety-six. A year later, he scored 105. Axline uses this as an example to attest to the lasting effects of play therapy.

Conn (57) reports a follow-up done after fifteen years on a young man now twenty-nine who was treated for castration fears. He states that the man now has a masculine orientation.

Literature Dealing with Material and Information Related to Play Therapy

This section includes information and material which is related to play therapy, yet is not considered to affect the play therapy procedure.

Methods Used for Evaluating Process and Outcome in Play Therapy

Included in this section is a discussion of the methods which have been used in evaluating the process and outcome

of studies in play therapy. The material found in this area consists of pre- and post-test measures. It includes methodology of research. In addition, mechanical devices for recording process are described and discussed.

Testing procedures.--Mehlman (199) reports the use of the Stanford Binet and the Haggerty-Olson-Wickman Behavior Rating Scale in an effort to show growth in group play therapy with retarded children. He stressed that both scores would show improvement and that there would be a correlation between raised intelligence and better behavior.

Pelham (230) used three instruments in his investigation of the outcome of play therapy on socially immature kindergarten students. These instruments were the Missouri Children's Picture Series, the Children's Self-Social Constructs Tests, and the Behavior Problem Checklist.

Subotnik and Callahan (289) report that they used tests administered at varied times before, during, and after the play therapy sessions in their research. In the study designed to evaluate outcome of play therapy for institutionalized mentally retarded boys, they used the following tests: Children's Anxiety Pictures, Auditory Memory for Digits, Vocabulary, Draw-a-Person, and Bender Gestalt.

Herd (130) used the following tests in her assessment of play therapy outcome: California Test of Personality,

Vineland Social Maturity Scale, The Haggerty-Olson-Wickman Behavior Rating Schedule, school grades, and a sociometric measure. Quattlebaum (240) used the Rorschach, Thematic Apperception Test, and the Draw-a-Person in investigating the effectiveness of nondirective counseling and play therapy with maladjusted fifth-grade pupils. She used the assessments for pretest and after four months of treatment, for a post-test.

Bucur (42) used a modified version of Bower's Sociometric Index and a teacher's rating scale in his investigation of the effects of nondirective group play therapy with aggressive boys. West (300) used the Wechsler Intelligence Scale for Children, the Goodenough-Harris Draw-a-Person Test, the Self-Esteem Inventory, a sociometric measure, and the School Apperception Method in his study evaluating the effectiveness of play therapy.

In a study investigating the effectiveness of play therapy with other modalities in the treatment of children with learning disabilities, Siegel (273) used The Observation Rating Form. Each teacher was evaluated in the study in order to quantify aspects of the teaching process. Truax Scales were applied to excerpts of the therapy tapes in order to assess the level of therapist offered conditions. Siegel also used the Borke Process Scales in order to compare the clients who received the highest

offered conditions to the clients who received the lowest offered conditions.

Seeman, Barry, and Ellinwood (268) report a study concerned with play therapy outcome in the treatment of aggression. The Tuddenham Reputation Test was used. In addition, teachers of the children completed the Radke-Yarrow Teacher Rating Scale. These instruments make possible the classification of behavior into categories of high adjustment, aggression, and withdrawal.

Johnson (140) investigated the clinical use of Raven's Progressive Matrices to appraise potential for progress in play therapy. The children, institutionalized mentally and educationally retarded, consisted of twelve boys and six girls. They were aged from nine to sixteen years old. The measures used as pre- and post-test to play therapy were the Stanford Binet, Authur, and Raven. Johnson reported improvement in every instance in which the Raven Z score was higher than the Binet Z score. This was evidenced in thirteen children. Twelve of the thirteen showed improvement in interpersonal relationships and a reduction of symptomatic behavior. No improvement was noted in the five children who had a lower Raven Z score than the Binet Z score. In addition, Johnson used sample histories of the play therapy responses in terms of the criteria of projection, insight, and working through to illustrate and support findings.

Johnson (141) investigated the sensitivity of Raven's Progressive Matrices as a clinical predictor of play therapy progress conceived as a function of superego potential by using the Rorschach Prognostic Scale of ego strength. Prognostic scores were computed for a group of fifteen children who had previously been reported as improved or unimproved in psychological treatment according to clinical and social criteria of behavior. As a result of the findings, Johnson concluded that while the Raven may be a more accurate predictor of play therapy responses, the use of it is incomplete. The Rorschach Progressive Scale more reliably estimates the level of improved behavior obtainable in short-term clinical treatment.

No attempt will be made here to evaluate the rationale for the use of the various measures described in the above section. However, the choice of instruments is critical to the research done. A researcher must be able to support the rationale of his selection. The selection should be contingent on the type of data dealt with, the variables in consideration, and a thorough understanding of the validity and reliability of the instrument used. The reader is referred to Oscar K. Buros, Tests in Print (46) for information concerning the psychometric measures used in this section.

Other research contributions.--As discussed elsewhere in this paper, Finke (86) made a worthwhile contribution in the study of process in play therapy. She derived categories to be used in the assessment of the process as it occurs in the work with children. Because of her marriage, her scales are now labeled the Borke Scales (see Appendix A).

Rogers and L'Abate (251) developed a bibliography for use by persons researching the areas of play therapy, emotionally disturbed children, child development, and handicapped children. The references are comprehensive and are inclusive from 1928 to 1968.

Lebo (161, 162) wrote on the status and quantification of research in the play therapy process. He summarized in a very usable way the research which was of note in the area of play therapy up to 1955. This material is valuable in that it furnishes a critical summary in a field which has been somewhat lax in quantifying. Lebo pointed to the fact that statements based on philosophy and emotionality in reference to the treatment were not enough to prove professionality in the area.

Heinicke and Goldman (127) have made a major contribution by reviewing the child therapy research. They presented a detailed study of the method of comparing outcome research in the area of child therapy. They noted the difficulties of a model of research in evaluating the

effect of play therapy and suggest that the clearest observation of the benefits of child therapy will be offered when research is done in the dimension of process.

Levitt (176, 177) has made a contribution in the area of child therapy in that he, too, has pointed to the fact that quantification is necessary. His work is mainly negative towards psychodynamic philosophies and techniques. However, the stimulation he has caused in the field is healthy.

Documentation of play therapy.--Many studies suggested that verbatim records were kept of the process in an effort to identify strategic areas as well as growth stages. These records were kept by observers through the use of tape recordings and through video equipment.

Mende and Kauffman (202) investigated the effects of video tape replays on behavior of culturally different children. They used a video tape procedure of a physical education lesson which was played back to the children immediately after the lesson. The subjects were three boys and one girl who were four and five years old and enrolled in a preschool program. The daily program consisted of three fifteen-minute instructional lessons and an eight-minute language lesson. Criterion measures used were teacher perceptions and frequency of inappropriate

behavior. The Adapted Devereaux Child Behavior Rating Scale was completed for each subject by four teachers and behaviors were counted. The results were significantly favorable toward appropriate behavior. A video tape replay may be used to change human behavior. When this technique of observation is used with young children, some consideration must be given to specific replay techniques which facilitate the attainment of the desired therapeutic goals.

Lovaas and others (187) describe an apparatus and a procedure which have been developed to facilitate recordings in child observation studies. The apparatus consists of a panel of twelve button switches connected to an Esterline-Angus pen recorder. An additional piece of apparatus was developed for training observers and for insuring inter-observer agreement. Various behaviors of the child and the attending adult were defined. Each behavior corresponded with a designated button on the panel (or pen on the recorder). The apparatus kept a running account of both frequency and duration of each of these behaviors. The procedure can be used for analysis of interrelated behaviors of the child as well as for studying covarying relationships between the child's behaviors and those of the attending adult.

The authors also describe a series of studies performed on (1) reliability of the observations, (2) assessing the

effect of experimentally controlled variables on various behaviors, (3) quantifications of behavior changes over time, (4) analyzing temporal relationships between various behavior from the child, and (5) comparing the behaviors of normal and autistic children. Lovaas and others suggest that by the use of the apparatus, they have been able to reliably record frequency and duration of several coinciding behaviors of children at the time of occurrence. In addition, it includes in the record the context in which the behavior took place.

Lovaas, Baer, and Bijou (186) describe a procedure which has been designed to overcome some of the limitations associated with traditional doll play. The apparatus centers on dolls, puppets, and motion pictures. These have been designed to exemplify certain social stimulus functions such as affection and aggression.

Cline (55) describes his use of video tape as a documentation of behavioral change in children. He felt that the tape offers an opportunity to reobserve every behavior of a child during the therapy session. He contended that after initial interest in the lights of the taping procedure, the clients eventually failed to pay it any attention.

Haworth (125) reports the use of a standard play interview situation which was developed as an aid to the

differential diagnosis of young nonverbal children. The individual sessions were recorded on video tape which permitted immediate and repeated playback for data analysis. A six-pen multi-event recorder was used to measure duration and frequency of a variety of behaviors. Checklists were developed which included negative and positive behaviors which might occur during each play sequence. An inventory of mannerisms were also used. Satisfactory interscorer and intrascorer reliabilities were obtained for each procedure.

The use of playroom laboratories.--L'Abate (154, 155) described an automated playroom which was designed for and is in operation at the Child Development Laboratory at Georgia State College in Atlanta. It is designed for boys seven to twelve years old, since most of the referrals received at the Child Development Laboratory are boys in that age range.

The Monitored Playroom Laboratory consists of a control booth and two connected playrooms, one with aggressive toys and games and the other with constructive toys and materials. The control booth contains dials which total the amount of time the child spends in each room and also the time spent with various toys and materials in each room. This material is fed to a computer automatically. The control booth is also an observation booth which is equipped

with earphones and has one-way mirror panels. Microphones are mounted in the ceiling of the playroom. The design of the rooms is based on a slot machine model. As the child picks up a toy from each position, the timing begins in the control booth and is fed to the computer. The child is taken on an exploration of the two rooms during the first session. The therapist shows the child how each of the machines works by demonstrating. Thereafter, the child is allowed to choose where he will spend his time.

This playroom is probably most useful in the area of research. Rogers (249, 250) and Golden (107) have made contributions in the area of play therapy using this laboratory, and other studies are in progress.

In a paper presented at the American Psychological Association in September, 1969, Golden (107) presented the rationale for using the monitored playroom setting for research in play therapy. She stated that there are many unanswered questions about play therapy. Monitored play therapy is an attempt to discover answers to these questions. The main emphasis is on quantitative recordings and analysis of the process and outcome of play therapy. The strongest feature is the conceptual and physical separation of the stages of play into aggression and construction. The use of separate playrooms for aggression and construction eliminates problems.

However, because of its newness, monitored play therapy also has some weaknesses. Some of the weaknesses found in using this method are that the stimulus properties of the two rooms are always unequal and that all the activities do not take equal time for completion. Children differ in the amount of skill they have for playing different games in the playrooms. Too, there is little opportunity for the child to manipulate the aggressive materials in his own way. The child cannot destroy the objects or create his own outlet for aggression.

Rogers (249) described research which she did in the monitored playroom investigating the major stages which the children tended to go through in the process of development. She contends that through the use of the monitored laboratory, and the consistent stages which the children progress through, the therapist is able to ascertain and predict movement in the play therapy process.

A playroom designed for filming children while they play is suggested by Lee and Hutt (167). This room was used in a hospital setting and the children seen were often severely disordered and psychometrically untestable. The playroom was designed so that a close systematic observation could be made of such children with the use of hidden video cameras. The room was twenty-four feet by twelve feet and was divided into partitions to give a waiting room and an

observation-playroom filming cubical. There were windows along one wall of the observation room. The floor of the playroom was covered with alternating black and grey squared linoleum. This made for easy recording of movement within the playroom. A camera tunnel was built so that the camera could view the entire playroom. The construction of this tunnel has proved to be an economical and convenient method of obtaining film records of children. It solved the problem of filming children without in any way distracting them or unduly modifying their behavior.

Literature Dealing with "Armchair" Philosophy

Some information was found in the literature which was positional rather than theoretical. Even though the material is "armchair" in nature and lacks strength, it is included because of its being typical of a bulk of material found in this field. In addition, some of the material is insightful and adds dimension to the reader's informational base.

Fantasy communications as a technique in working with children during play therapy was used by Gordor (110). Many of the children seen in play sessions experience a world of fright which consists of characters of nightmarish quality. Children describe witches, devils, and other fears of the unknown. Through therapy, the child should be able

to express these fears. One technique used is that of allowing the child to express fears through art. The therapist must be aware enough of the fantasy language of each child to be able to understand his drawing and communicating.

Bower (39) stresses the importance of using play activities for children on the basis that young children need to learn to process symbols. Symbols are seen as representatives of things, action, relationships, and feelings. The quality of a child's education in managing and using symbols will affect his ability to work, love, and grow. Some major ideas in our conceptualizations of man and his development have been uprooted in the last thirty years. They include the concepts of (1) fixed intelligence; (2) predetermined development; (3) the brain as a switchboard; (4) the insignificance of early experiences; and (5) to learn requires conflict or pain. Play activities are seen as voluntary activities in which children can develop and test competencies. Ego development and mastery of social competencies can take place in the psychologically safe zones of play.

Buhlen (43) defines play therapy in a vocabulary which parents can understand. He indicates that play therapy is a valuable procedure to be used for children because it gives the child a place to "play-out" his

problems. In discussing play therapy in general terms, he suggests that material should be used which will give the child an opportunity to deform, amass, spill, spread, mold, and destroy as well as construct.

Amster (10) discussed the differential uses of play in treatment of young children and presented cases in order to demonstrate this theory. She stressed that play has both diagnostic and therapeutic value in child therapy. All uses of play aid diagnostically in that the counselor can learn more about the child through observing him at play. In addition, the child benefits from play since he learns to share himself and to re-enact, release, and re-live various experiences. The materials and the activity the therapist uses are determined by the personal dynamics of each child.

Five uses of play described by Amster are the following:

1. Play can be used for diagnostic understanding of the child. The therapist can explore the child's capacity to relate, his distractibility, his rigidity, his areas of preoccupation, his inhibition, the direction of his aggression, his perception of people and himself, and his wishes.

2. Play can be used to establish a working relationship. Amster suggests that this is particularly helpful with the young child who lacks the facility for verbal self-expression and the older child who shows resistance or inability to articulate.

3. Play can be used to break through a child's way of playing in his daily life and in his defenses against anxiety.

4. Play can help a child act out unconscious material and to relieve accompanying tension.

5. Play can help the child to develop interests which he can carry over into his daily life and interests which will strengthen him for his future life.

Blackham (38) discussed various strategies for behavior change in working with children. In his article on these strategies, he gave an overview of modeling as described by Bandura and play therapy as described by Axline and Ginott.

Cameron (49) believes that it is not the play itself which is responsible for the therapeutic effect in using the play technique. Play is the child's "talk." The use of the play technique comprises a "relationship" therapy in which toys are used so that the child will be able to use a medium of expression which allows him to feel comfortable in his self-disclosures. The use of the play technique is important in working with children in that it (1) furnishes a medium for expression which allows the child to feel comfortable; (2) is more primitive than speech, thus allowing the child to experience feelings which occurred before verbalization was developed; and

(3) provides a method of catharsis within a secure relationship.

The seven examples of uses of play techniques in psychoanalytically-oriented therapy given by Burns (45) are the following: (1) for ventilation so that the child will be able to reduce guilt and anxiety; (2) to aid the child in reducing anxiety; (3) to allow the child to work through his feelings; (4) to communicate his feelings and to develop an awareness of his problems; and (5) to help a child learn to modify his lifestyle.

The field approach to transference and its particular application to children in the counseling process is described by Colm (56). Her approach, she suggests, simply brings out into the open, into the child's field, an accepting other person in his life. She also proposes that the field involves the total therapist and the total child. This involves their collective past, present, and future.

Arthur (11) discusses the differences between psychoanalysis and psychotherapy with children. She suggests that, in general, the object of therapy is to allow the child to make unconscious feelings become conscious feelings. She stresses the importance of being passive and of allowing the child to produce the play activity for himself. She even suggests that in order to be sure the child uses his

own play in the play setting, the therapist could busy herself with an activity such as knitting.

Liss (183) contends that play therapy techniques allow the child a better medium of expression than has heretofore been used with children. Woltmann (305, 307), in his articles on concepts of play therapy techniques, presents an overview of various definitions of the value of play and of the various theoretical approaches in the field of play therapy. He presents a case study to indicate his own philosophy as to how the process helps a child.

In discussing the importance of technique in working with children, Buxbaum (48) suggests that when therapists know which technique is best suited for which particular disturbance, they will be able to make optimum use of constructive ideas on child therapy. The appropriate technique should be related to each case.

Frick (91) wrote a position paper describing his feelings about the use of food in the play therapy setting. He questions the indiscriminate provision of "goodies" which are made available by some therapists to their young clients. He stresses that this is especially harmful when the child's difficulty involves the use of limits which the family has never been able to set. Another difficulty is that parents use food with both hostility and affection, and the wholesale giving of food introduces uncontrolled

variables in the therapy. Some of these variables which might lead to the possible contamination of the relationship are the child's perception of the offering, the emotional significance of food, the personality dynamics of a particular child, and unknown uses of food in the home.

Katz (144) questions the value of individual therapy per se and specifically play therapy for most children. He indicates that few emotionally disturbed children need any type of personal direct or individual psychotherapy. Generally the only children who can benefit from play therapy would be those with character disorders. Most children can be best helped if the parents are provided education and guidance.

Diagnostic Procedures Using Play Media

The following material is not related to play therapy per se; however, it is included as an added section because of its relevance to research procedures in child therapy. Included in the material found were studies on the use of the doll play technique, The World Test, and the play interview.

Doll play technique.--Doll play has numerous variations, but essentially the child is presented with a set of dolls, generally a family, and a setting in which the dolls are to operate. The child is told to manipulate the dolls while

he tells a story. The child has the opportunity to talk for the dolls as well as to act for them.

Doll play probably had its beginnings as a clinical procedure. It was used by Melanie Klein (148) as a procedure both for the diagnosis and the treatment of disturbed children. Mann (195) suggests that doll play offers a "third person" approach which allows the child to feel safer in dealing with intense material. In this technique, the child is not confronted directly with his problem, but he is allowed to project his feelings onto the stage.

Levy, in his discussion of release therapy (178, 179, 180), Conn, in his discussion of the play interview (57, 58, 59, 60, 61, 62), and Solomon, in his discussion of active play therapy (278, 279, 280, 281, 282, 283), all use dolls in a planned way. They include this structured technique as a therapeutic method and also diagnostically. As in most play therapy, there is a fine line between diagnosis and treatment in the process of the relationship and activities.

Levy (179) uses a series of thirty-five case studies to describe the use of release therapy as a treatment/diagnostic method. The children described were aged two to nine. Levy suggests that this is a method whereby a frightening event could be restored in the child's play and thereby the child could release the anxiety he had been

unable to rid himself of. Suggested criteria for the selection of children for this procedure are (1) the difficulty was precipitated by a specific event, (2) the problem was not too long in duration; and (3) the problem results from a past trauma, not a present pathology.

In another article, Levy (178) uses the case study method in the description of his theory. He describes the two forms of release therapy as general release therapy and specific release therapy. Specific release therapy relies on various forms of restoring the situation out of which the anxiety and its accompanying symptoms arose. An example of a situation like this would be when a child has experienced a specific trauma such as the birth of a new sibling, a divorce, or a death. Specific release therapy is designed to allow the child to release the anxiety and pain of this particular experience. Specific sets of toys are used for each specific situation. General release therapy is used typically when symptoms have arisen because of excessive demands or prohibitions made on the child at an early age. In this situation, typically, the therapist would use the structured technique diagnostically. He would probably combine the structured technique with more nondirective techniques.

Levy (180) describes a standardized technique for assessing progress in play therapy. He based his diagnostic

procedure on his structured technique of play therapy. In this article, he describes shaping a situation wherein the child is able to express sibling rivalry in a standardized form. By using the same play material and the same stimuli words, the investigator is able to use play material both therapeutically and diagnostically. Levy indicates that this standardization does not interfere with the process of therapy.

Levy describes an experiment he conducted using this technique. It involved ten healthy children of average intelligence--six males and four females with age range from five to thirteen years. Their problems included rebellious behavior (five cases), sibling rivalry (one case, and other difficulties, such as feminine mannerisms, infantile behavior, stealing, and a mild assortment of behavior problems. All the difficulties were within the nondelinquent category. In structuring the situation, the therapist says to the child, "We are going to play a game, we will need a mother, a baby, and an older (brother/ sister). Mother must feed the baby, but she has no breast." The therapist then makes a breast and instructs the child to make a breast and place it on the mother doll. The child is then instructed to put the baby in the nursing position. The therapist continues the game by saying, "When the sister comes and sees the baby at the mother's breast, she . . . " (180, p. 273).

Based on the use of this standardized way of assessing the level of the child's functioning, Levy (180) has identified the following patterns of reaction:

I. Primitive patterns
  Primitive hostility
    Destruction of baby by biting, crushing, dismembering (primitive murder)
    Destruction of the mother
    Destruction of the breasts
  Possession
    Removing breasts and placing them on subject's own body
    Taking the baby and making it one's own
  Regression
    Putting subject to breast after removing the baby
  Self-punishment
    Primitive murder of subject doll

II. Modifications
  Of hostility to mother and baby
    Acts: Primitive murder is modified into simple murder, torturing, maiming, hurting, operating, causing accidental falls, kidnapping, simple riddance, annoying.
    Words: All items as noted expressed in words instead of acted out on the play material. Included also are derogatory remarks about baby or mother, and simply molesting the mother with questions.
    Acceptance with mothering, defending, tender acts or words by saying, "baby is changed; it is really my brother."
  Of hostility to breasts
    Modification of destruction of breasts, by simple removal (so the baby will die), by rolling them into "food."
  Of possession
    Various mothering activities of baby from feeding, dressing to teaching it lessons.
  Of regression
    Various activities with the mother after removing the baby, chiefly playing with her, being cared for by her.

> Of self punishment
> Of restoration of baby
> Simple resuscitation is modified by changing a series to a mild injury, of making the baby well again (180, p. 274).

Conn (58) describes the use of the structured play technique with a six-year-old girl, Barbara. He stresses using the natural tendencies of the child in allowing him to self-express during the experimental play situations. The play interview Conn describes is a regular part of the diagnostic work-up in each case treated. It is one of many procedures and is designed to supplement other methods. He feels that it contributes materials which deal with personal, emotional, and imaginative aspects of the child's behavior. The child's responses were accepted at face value. No attempt was made at interpretation, nor was transference encouraged.

Mann (195), following the philosophical base and techniques developed by Solomon, Conn, and Levy, describes his use of the structured doll play technique. He emphasizes that this is a useful tool for "symptom" therapy in that it allows the child to identify with his feelings in reference to a situation very quickly. This technique should be used with other, more dynamic, insightful methods in order to achieve the full effect. He further suggests that this method will tend to lose its effectiveness over a prolonged period of time if used at the exclusion of

other techniques. He contends that it is appropriately used where situational factors abound, where the child's conflicts are externalized, and in situations where the parents are amenable to change.

Structured puppet play therapy in an elementary school setting was used by Vittner (295). He suggests that this particular technique offers opportunity for the child to vent his feelings in grades kindergarten through six. This can be used effectively with children who have difficulty in verbalizing their feelings.

Lynn and Lynn (190) have used doll play as a projective technique. They suggest that its usefulness as a clinical play projective technique has relevance for children between the ages of three and eleven. In this procedure, dolls are used with a dollhouse, and a child is presented with a number of typical family and age mate situations. The work usually lasts from thirty to forty-five minutes. The authors presented two research studies which they suggested lent validity to the use of this media as a projective technique.

Kulla (153) describes a therapeutic doll play program with an emotionally disturbed child. The therapist used the method of storytelling where the experimenter's stories followed the theme of the child's and were also structured to broaden the possibilities for solutions and alternatives

to the conflicts presented in the child's stories. Kulla conducted twenty-nine doll play sessions spread over a period of two years and nine months. He concluded that the child showed more appropriate aggressive-responding, and increased self-initiated and solution-responding.

Doll play was used as a way of examining the chief divergences between play and reality in children by Moore (208). This author, after observing the way children tend to oscillate between fantasy and realism, saw this as a way for regulating the amount of affect admitted to consciousness for assimilation by the ego in its thrust toward maturity. Sample records are presented to show how different children respond to imagined absent objects and concern with size. Records also revealed how the same child may vary the likeness of action and characterize to serve different purposes. Three types of nonrealistic play are distinguished. The child's way of relating play to reality is discussed. It is suggested that the concept of flight, whether to or from reality, is often inappropriate to zestful play. An alternative interpretation is offered in terms of an oscillatory mechanism for regulating the admission of an affect laden fantasy to consciousness for assimilation by the ego in its thrust toward maturity. Both principles are shown to be useful in the interpretation of doll play in the individual child and for children generally.

Moore and Ucko (209) report that through observing doll play it is possible to gain insight into the feelings and fantasies that underlie behavior in areas of daily life which is producing difficulties or conflicts for the child or his parents. The authors developed the London Doll Play Technique which is a structured technique for providing an avenue for exploratory research into various aspects of the child's fantasy life. The technique involves presenting a doll family in a standard set of scenes and asking the child to indicate what will happen next. A group of 115 normal children were tested at four and again at six years of age. An investigation was carried out into the fantasies, feelings, and attitudes of boys and girls respectively concerning certain situations of everyday life. Investigation also included assessing the ability of the child to solve in play simple problems in interpersonal relationships.

The authors found differences on such variables as ability to cope, intellectuality, emotionality, degree and kind of affect, freedom of expression, degree of socialization, constructiveness and solutions among the different children tested. A comparatively high proportion of boys were unable to respond freely to these play situations. Many showed signs of emotional conflict (aggression, inhibition) which precluded constructive solutions.

Numerous researchers have investigated the variables to which the technique of Structured Doll Play lends itself. Phillips (234) investigated doll play as a function of the realism of the materials and the length of the experimental session. Pintler (235) investigated the variables of experimenter-child interaction and the initial organization of materials on the outcome. Linder compared the effect of verbal conditioning of aggression using nursery school boys in a therapy-like situation (182). Sears (266) investigated the influence of the method used as it affects the performance of the child.

In addition, Aderhold (3) investigated the behavior of children in a doll play situation in reference to their age. Marshall (197) examined the influence of experience as affecting the behavior of the child in the doll play situation. Robinson (246) investigated the influence of the presentation of different types of family constellations to the child in the doll play experience. Baruch (25) investigated the variable of aggression of children in doll play.

Levin and Wardwell (175) suggest that because of the flexibility of the materials used in doll play and the endless situational scenes which can be staged, this technique is highly useful in the area of child study. It is influenced by a number of variables such as the themes,

the composition of the dolls, the nature of the setting, the amount and kinds of interaction with the researcher, and the directions and structure presented to the child. The chief variables which have been investigated using this media are aggression, stereotype, and prejudice.

Sears and Sears have made major contributions in this area by researching the variables related to the structured doll play technique. Some of the research in this area is briefly presented here. However, for a complete discussion of this research, the reader is referred to the excellent article by Levin and Wardwell (175), "The Research Uses of Doll-Play."

Sears (265) studied the influence of sex, age, sibling status, and father's absence on doll play aggression in 150 young children of a nonclinical population. Sex differences in aggression were noted. Boys showed more frequent aggression and particularly were rougher than girls. Girls showed less aggression, and their aggressiveness tended to be more mischievious in nature. Differences in aggressiveness as influenced by age was shown. The differences were more distinct between sexes as the children grew older. It was found that older siblings are less aggressive than younger siblings or only children. Sears found that prolonged absence of the father affected aggression in boys but not in girls. He concludes that

in comparing the correlation between doll play aggression and real life aggression, the doll play experience reflects the broader habits of aggression. The children are more fanciful in their aggression in doll play than in real life.

Graham (111) reports a study using the doll play technique. He used the technique in order to design and standardize a projective doll play technique for studying the family fantasies of Negro and white primary school children and to isolate psychological factors which may contribute to the development of children's fantasies. Seventy-four children aged six years to nine years old were used. The theme of the play was a home which included either black or white dolls depending on the color of the child. Findings indicated that differences do exist as a result of age, sex, and individual development among children in their use of the dolls. For both races, the sexual differences tended to be the same. Girls showed more stereotyping than did boys, chose different locations in the house for play, and showed more affection with the dolls, while boys showed more aggression.

Play interview technique.--In addition to the type of play interview which is described by Conn (58, 59, 60, 61, 62), others have used the free play technique or the interview method in a less structured way as a diagnostic

procedure. The methods used in this procedure vary, but the focus is on allowing the therapist an opportunity for insight as the child expresses himself through the medium of toys.

Sargent (259) describes a case study in which the technique of spontaneous play was used diagnostically. A nine-year-old boy was given opportunity to play freely in a play setting which contained dolls, dollhouse, bears, and other toys. The therapist was a passive observer and allowed the child to play spontaneously. The author states that much highly relevant material can be observed in such a situation. A group of four-year-old boys over an extended period of time was observed by Harris (120). She also kept anecdotal records. She suggests that this is a useful method in seeing processes in personality dynamics as they develop.

Weiss and Frankl (298, 299) report the use of the play interview with nursery school children. They suggest that they focus not on the content, but on the behavior patterns of the child. This is a particularly useful tool in working with parents and teachers in a consulting role. After observing the child in a play situation, the counselor has a better understanding of the way he behaves. Thus, he has more insight into the child as he attempts to consult with parents and teachers. In the view of these

authors, a nondirective setting lends itself best to this procedure. The playroom should be equipped with blocks, crayons, clay, paper, dolls, cooking utensils, cars, trucks, and toy animals. The goal of the play interview is both educative therapy and diagnostic. Through his experience, the child can be observed in his many dimensions.

Holmer (131) suggests that the use of the play situation is an invaluable aid to diagnosis especially when the child is too young to verbalize. He stresses the fact that clinicians should avoid early diagnosis of children. They will be able to make a more accurate diagnosis if they allow the child to use his natural medium of expression and merely observe him while he plays.

The case study of a very young child who was unable to talk is described. In relating the case, the author described how, through the observations in play, he was able to arrive at more accurate decisions and allow the therapeutic process to begin. During the process of the play, the child began to verbalize. By setting limits during the course of the therapy, the therapist helped the child to begin to define reality. In this way, by using careful observation, and allowing the child to play, the therapist was able to conclude that the child was not retarded and so he avoided making an error in diagnosis.

Personality reactions of normal children ages two to five years in a free play situation were reported by Despert (71). A record of the verbal, motor, and affective behavior of each child was kept. The child expressed affective relations with his family in doll play and, to a lesser extent, in drawing play.

Howard (134) investigated the use of the play interview with young children. He saw it as being a technique of allowing disclosure of personal and social attitudes. The attitudes and interests of twenty-three kindergarten and twenty fourth-grade children were studied in a play interview technique. The average length of the interview was forty-one minutes. Materials used were mobile toys, house furnishings, human character figures, animals, and fish. Most of the children responded to the interview with fantasy which was told in story or drama form. The attitudes and interests revealed by the children concerned war, illness, and accidents, death, superstition, animals, and family relationships. The author concluded that the amount and the quality of fantasy material given spontaneously by the children of both age groups indicate that the play interview is an effective technique for uncovering attitudes and interests of young children.

Others writing about the use of the play interview or the free play technique as a diagnostic procedure include

Harms (119) who used the method as a pretherapy diagnostic procedure, Hayward who discussed the use a social worker could make of the technique (126), and Rucker (258), also a social worker, who described her work in this area.

Simpson (275) stressed the diagnostic usefulness of the procedure while Symonds (290) used the procedure for assessing learning readiness. Weiss (298, 299) and Conn (59, 62) use the procedure both diagnostically as well as remedially.

Baruch (27, 28) discusses a technique which can be used in child study. Forty children were each given fifteen minutes for free play with dolls. The observer was hidden. In the course of a very short span of time, much information in reference to the child's family, feelings, and self came out. Baruch stresses that this technique can be used in other settings for other purposes.

Haworth (125) reports a study concerned with the development of a play interview with a standard and a specified sequence of activities. This should be appropriate to the age level under consideration and would have the potential of discriminating between diagnostic categories. It could be videotaped for immediate and repeated playback for analysis. Toys were selected for interest appeal to both sexes. A standard play interview situation was developed as an aid to the differential diagnosis of

young nonverbal children. The individual sessions were recorded on video tape. A six-pen multi-event recorder was used to measure duration and frequency of a variety of behaviors. An inventory of mannerisms was also used. Satisfactory interscorer and intrascorer reliabilities were obtained for each procedure. Results were reported on a sample of thirty-four cases who were two to nine years old. Eight normal children and twenty-six clinical cases were used. Three patterns of play behavior emerging included (1) a highly interactive group characterized by older normals, adjustment reactives and familial retardates; (2) a group with variable inconsistent and immature reactions which was seen in the younger normals, sensory handicapped, and multiply handicapped children; and (3) a group marked with stereotypy of behavior, inappropriate affect, and reactions of withdrawal and disengagement. This group included childhood schizophrenics, psychotic, and autistic children.

Other diagnostic procedures using play material.--A particular use of toys is made by a group of investigators who use the toys in a very structured way for diagnostic purposes. One such technique is the Little World Test. This term refers to that structured procedure using Little World Toys in a free play situation by a therapist.

The procedure has a standard scoring for the outcome of the child's play.

Investigators differ in their use of this procedure, but it can generally be divided into three main groupings. Kamp and Kessler (143), as a preface to the discussion of their use of this technique, give a historical overview of the development of the technique. Lowenfeld's World Apparatus is discussed as providing the richest collection of materials and activities. They describe this test as including play with sand and water, building with blocks and molding clay in addition to arranging toys. They also overview The Scenes Test, which usually involves dolls and materials appropriate to the scene the examiner is using. This scene might be outdoors, indoors, or in any setting. The use the child makes of the doll in the scene is studied.

Another diagnostic procedure Kamp and Kessler (143) discuss is The Worlds and Villages Test. These materials are mainly used to ascertain the child's depiction of the external world. Some use is made of spatial relations projectively in this technique. Kamp and Kessler (143) report that their use of this procedure is to evaluate the end product of the child's play. They assume that the psychological state of the child during the test influences the final configuration to such a degree that it may be

considered representative of a major part of the subject's activity. They suggest that this procedure is most useful for the children between the ages of five and twelve. The procedure as they use it involves the use of 431 small toys or elements plus a table top. Most of the children, when given a free opportunity to manipulate the objects, build a world or construction.

The authors describe a study involving four groups of twenty children who were six, seven, eight, and nine years old in which they used the procedure. The toys were divided into ten categories which were presented to the child on different trays. The categories included soldiers, people, animals, buildings, trees, fences, blocks, vehicles, and indoor and outdoor equipment. The authors hypothesized that the configurations of the end product of play made by different children vary according to the developmental level of mental functioning at the time of the testing. Four categories of configurations were distinguished: juxtapositional, schematic, depictive, and realistic. The investigators describe the developmental scale of the four stages which is used to score the end products and report the influence of chronological and mental age on the developmental level of the end product of The World Test. In addition, a number of other factors are explored which influence the child's performance.

Leton (171) discusses a study involving the use of a standardized School Play Kit. Previous studies have shown the kit to be a useful tool in identifying the need for autonomy and the need for structure among first-grade children. The judgment as to whether these emotional needs were frustrated or satisfied in their classroom situations was also made on the basis of the school play responses. The School Play Kit is a set of toy materials designed to represent the average classroom. It includes teacher and pupil dolls, desks, tables, chairs, blackboards, bulletin boards, books, pencils, and other representative materials. The pupils' behavioral reactions and verbalizations during structured play situations are recorded on a diagnostic record form.

Bender and Woltman (31) indicate that the use of plasticine clay is a useful tool in the diagnostic areas. The examiner sits with the child and tells him to use the clay and make anything he wishes to. The examiner carefully observes the process the child goes through in the construction. He is not as concerned with the finished product as he is with the way the child forms the product.

Homburger-Erikson (131) suggests that through the use of toys, the child is allowed to experience space which has psychological implications to him. Through spatial configurations, the child weaves fantasies around real

objects. The author uses the configuration of toys and the spatial arrangements produced by the child as indications of the child's feelings in reference to the situations. For example, in the rooms, the grouping, the height of the walls, the openness of the house, the absence or presence of windows and the location of the windows and doors are significant. These configurations are called the hieroglyphs of play, and all have definite meaning.

The use of drawings is described by Despert (74). She suggests that by saving the drawings of a child over a period of time, it is possible to analyze them for stages of development in the child. Cashdon (50) mainly uses drawings diagnostically. He describes five stages in the therapeutic process which can be diagnosed through the drawings of the child. They consist of presentation of the problem, defining of the relationship, evidences of emotional learning, separation, and finally, adaptation.

Nickols (226) describes using regulated throwing of darts, suction-cupped projectiles, and pistols with appropriate stimulus as a projective technique. He feels that by providing the appropriate background stimulus, the child will use the materials to express his feelings in relation to peers, siblings, and parents.

Gerard (95) uses observation of both child and parent in a nonstructured play setting for diagnostic purposes.

She suggests that the etiology of the child's disturbance is closely connected with that of the mother's, and she must be observed during her interaction with the child.

Anna Freud used the preanalytic treatment period of time for diagnostic purposes. She used play techniques as a part of her "wooing" the child into therapeutic readiness (90).

Summary

Chapter III has been an overview of the position and research of the variables effecting process and outcome in play therapy. The material found was divided into focus sections reporting position and research.

The focus section on the dimensions affecting process, which is described as the interaction within each play therapy session, contained the largest amount of material. Process "type" material consisted mainly of position with some "beginning" research. The research found on stages of development of the process consisted of identifying stages of development, identifying types of verbalizations, and identifying movement through stages. The methods of research employed tended to consist of the recording and analyzing of child/therapist statements and the child's use of toys. No research was found on the importance of the initial session in play therapy. The position articles all stressed that this session is highly important for the

establishment of rapport and for acquainting the child with the attitude of the therapist and the opportunities in the playroom. It was found that there is a high degree of agreement about the use of limits and that this agreement tended to cross philosophical orientations. The only research found on the use of limits were surveys identifying the types of limits used. No research was found on the effect of specific limitations on the therapeutic process.

A large amount of material was found on the selection and use of materials appropriate for the playroom setting. Orientation tended to align with the nondirective therapists who stressed the inclusion of nonstructured media as being critical to the process or with others whose position was that the type of toy was not the important variable. Research presented by Lebo (160, 163) described the development of a verbal index formula based on the number of statements made by the child while using a particular toy. In addition, he conducted a study including toys recommended by nondirective therapists. He found that nondirective toys do not facilitate more child verbalizations than do directive toys. He also concluded that special considerations should be made in planning facilities for older children. Other findings in relation to the selection of materials for the playroom were reported by Schall (260), who concluded that anthromorphic models in the playroom

affect process, and Pulaski (238), who stated that less structured toys elicit a greater variety of fantasy themes than do structured toys. Hartley and others (122) found that well-adjusted children and troubled children use toys differently, and Beiser (33) concluded that the potential use of a toy depends on the child and his unique use of it. No research reported the affect the use of a specific toy has on process in relation to a particular child.

As a result of the search of the literature, it was found that persons using play therapy (12, 15, 16, 17, 22, 57, 58, 59, 60, 61, 62, 80, 90, 133, 149, 150, 151, 211, 214, 215, 244, 277, 280) have described positive results in working with retarded children, emotionally disturbed children, children with social hunger, children in situational crisis situations, children with speech difficulties, children with reading difficulties, children with psychosomatic difficulties, and normal children. No valid research was included in this section, and all the material found was position in nature. In the few articles on research presented, the variables were uncontrolled, and it was not explicitly found that it was the technique which caused improvement in the child.

Some material was found describing the different activities exhibited between boys and girls in a play setting. Erikson (85) reported that the two sexes tend to make

different configurations in toy designs. Clark and others (53) concluded that boys and girls tend to spend their time in different activities. Robinson (247) found that boys and girls tend to build different types of structures and embellish these structures differently. Rosenberg Sutton-Smith (254) found that the female perception of activities which fit her role model is broader than that perceived by boys. Moore and Ucko (209) discovered that boys tended to have more difficulties in the use of unstructured play than did girls. McDowell and Howe (191) indicated no differences between boys and girls in either the frequency of choice or in the degree of creative attainment with blocks.

In addition, studies investigating the use of toys by the different age groups were presented in this section. Preferences of subjects for shapes and sizes of blocks were not related to age concluded Moyer and Gilmer (219). Robinson (247) found that as children grow older, they use more blocks, build for longer periods of time, and build larger and taller constructions. Older children were more involved with play partners than the younger children (two-year-olds), suggest Updegradd and Herbst (293). Lebo and Lebo (166) found that differences exist in the number of verbalizations made by different age groups. Lebo (158) concluded that nondirective toys are

not as suitable for twelve-year-olds as they are for the younger child. He also found (165) that older children verbalize through the use of toys less than younger children do and that they test fewer limits. They verbalize likes and dislikes more readily than do younger children.

Most of the major theorists in the area of child therapy have included their views on the importance of working with the parents as they work with the children. The orientations range from suggestions that children should not be worked with unless the parents are involved in therapy to suggestions that it is beneficial, but not necessary, to see parents as well as the child. Positions are presented by Anna Freud (90, 220), Solomon (279, 280, 281), Conn (60, 61, 62), Hambridge (110), Allen (5, 213), Axline (13, 19), Dorfman (77), Fuchs (93), Baruch (26), and Moustakas (214).

Ginott (99) discussed a model for working with parents in a guidance setting. In addition, the use of parents as delivery agents to their own children is suggested and described by Guerney (113), Guerney and others (114, 115), and Andronico and others (78).

Research was presented by Stover and Guerney (286), Guerney and others (113), and Andronico and others (7, 8) on the use of filial therapy as a conceivable model for

delivering services to children and for training parents. They stress the success of research in this area. Andronico and Blake (7) showed the successful use of filial therapy with parents who have children who stutter. Marshall and Hahn (197) found that parent/child interactions affect the fantasy level of the child. They found that when the parent indulges in fantasy play with the child, this type of play tends to increase in the presence of his peers. Levin and others (174) found that when the mother is an audience to the child's play, the child tends to be more aggressive with his peers. Levi (172) found that the variable of the personality and skill of the therapist is stronger than the variable of whether the parents are involved or not in the therapy.

Even though the variable of therapist training and attitude is probably the most critical in the entire process of play therapy, scant material was found on this subject. In addition to the scarce nature of the material, it was also found that the material was not focusing directly on the major issues--training, attitude, and personality of the therapist. Instead it consisted of such positions as noninvolvement (11), awareness of hidden racism (2), and physical distance (84).

Siegel (273) reported research in which she investigated therapist offered conditions as it effects client

responses. She found a high relationship between the offered conditions and movement in the client. Subotnik (288) concluded that the child tends to transfer his perceptions of his parents onto the therapist, and these perceptions tend to change as therapy progresses. Siegel and Kohn (272) found that children tend to be more aggressive in the presence of a permissive adult. Moustakas and Schalock (218) reported a difference in verbal interactions between therapist and disturbed child and therapist and not disturbed child in the playroom. Mehrabian (200) found that the subject indicates his liking for the addressee by his body movements. Stollak (285) found that undergraduates could become effective delivery agents in the area of play therapy. In addition, he discovered that the students trained to deliver the play therapy became more reflective and clarifying in their communication. In another study conducted with Linden (181), two different training models were used. Stollak (285) found that trainees who were exposed to a didactic as well as a dynamic model tended to be more potent in their work with children than the group who received only dynamic training skills.

This section also included descriptions of involvement of persons who work with children but who are not child therapists. Kranz (144) described the way in which teachers

were trained as play therapists and Guerney and Flumen (114) describe the training procedures they used in helping teachers acquire skills as play therapists. Schiffer (262, 264) presented information on a training model for teachers in a school setting who were functioning part-time as play therapists, and Andronico and Guerney (9) describe their work in training a teacher's aide in a headstart program in filial therapy.

Research which involved outcome type studies was presented in the section on types of difficulties. In addition, in the section specifically dealing with outcome research, various investigations were reported which described the evaluation of the results of the play therapy experience. Seeman, Barry, and Ellinwood (268) found that children in play therapy were perceived as significantly less maladjusted after therapy. Levi and Ginott (173) found that treated children had fewer symptoms at the end of the treatment period than did the control group who received no treatment. West (300) found that the children in his study did not improve significantly as a result of the play therapy group experience. Dorfman (76) found that improvement does occur as a result of play therapy, and, in addition, the variable of time is not the critical factor. Cox (65) found that adjustment scores and peer ratings showed change in the child as a result of play

therapy. Gitelson and others (106) reported improvement of children as a result of play therapy. However, he did not cite research, but used the case study method of reporting.

Quattlebaum (240) indicated that results did not show significant changes as measured statistically. However, behaviors did change in specific children. Pelham (230) found few differences in the behavior and adjustment of children as a result of play therapy. Perkins (231) found reinforcement therapy to provide more results than did play therapy in the children involved in his study. Herd (130) reported little statistical significance in change in the children seen in a play therapy group.

In the focus area on follow-up studies, work was included which described research in reference to the long range effects of play therapy. Rexford (243) reported a follow-up study which showed that after two to seven years after dismissal, nine of the unimproved children were found to be delinquent, while only seven of the improved were delinquents. Lehrman and others (168) reported a follow-up study involving fifty-three children. At the follow-up research a year later, an increase in successful adjustment was noted. In addition, Clay (54), Cunningham (66), and Axline (15, 18) report research substantiating their claim that play therapy has lasting effects on children.

Scarce research was found on the question of whether short-term or long-term therapy is more effective. Eisenberg and Gruenberg (82) and Phillips and Johnston (233) concur that short-term therapy can be as intensive and as effective as long-term therapy. Phillips (232) suggested that short-term therapy is more effective than is long-term therapy. Hare (118) contends that short-term methods are as effective as are longer treatment durations.

Included in this chapter was a focus area dealing with techniques for evaluating process and outcome. In addition, summaries were presented describing mechanical devices used in the recording of play therapy process. Much of the material presented in this chapter was position or theory in nature which was quite explicit and valuable. In addition, research was presented. The research tended to be outcome in nature rather than process. In the situations where process was dealt with, few variables were covered.

The compilation of this material is seen as a valuable endeavor in that needed research is clearly pointed out by the scarcity of the material presented. Also, a knowledge of the existing literature furnishes a base for further research in the area of play therapy.

CHAPTER BIBLIOGRAPHY

1. Ackerman, H. W., "Constructive and Destructive Tendencies in Children," American Journal of Orthopsychiatry, VII (1937), 301-319.

2. Adams, Paul, "Racism in Biracial Psychiatry," Journal of American Academy of Child Psychiatry, IX (1970), 33-43.

3. Aderhold, Elizabeth Clyde, "Doll Play Behavior As a Function of Age," unpublished doctoral dissertation, University of Georgia, Athens, Georgia, 1967.

4. Alexander, E. D., "School-Centered Play Therapy," Personnel and Guidance Journal, XLIII (1964), 256-261.

5. Allen, F. H., Psychotherapy with Children, New York, W. W. Norton, 1942.

6. Andriola, J., "Release of Aggressions through Play Therapy for a Ten-Year-Old Patient at a Child Guidance Clinic," Psychoanalytic Review, XXXI (1944), 71-80.

7. Andronico, M. and I. Blake, "The Application of Filial Therapy to Young Children with Stuttering Problems," Journal of Speech and Hearing Disorders, XXXVI (August, 1971), 377-381.

8. _____, J. Fidler, B. Guerney and L. F. Guerney, "The Combination of Didactic and Dynamic Elements in Filial Therapy," International Journal of Group Psychotherapy, XVII (1967), 10-17.

9. _____ and B. Guerney, "Psychotherapeutic Aide in a Headstart Program: Riegel Ridge Headstart Project, Milford, New Jersey," Children, XVI (January, 1969), 14-17.

10. Amster, Fanny, "Differential Uses of Play in Treatment of Young Children," American Journal of Orthopsychiatry, XIII (1943), 63-68.

11. Arthur, Helen, "A Comparison of Techniques Employed in Psychotherapy and Psychoanalysis of Children," American Journal of Orthopsychiatry, XXII (1952), 484-498.

12. Axline, Virginia, Dibs: In Search of Self, Boston, Houghton Mifflin Co., 1964.

13. _____, "Group Therapy As a Means of Self-Discovery for Parents and Children," Group Psychotherapy, VIII (1955), 152-160.

14. _____, "Mental Deficiency, Symptom or Disease?" Journal of Consulting Psychology, XIII (1949), 313-327.

15. _____, "Nondirective Therapy for Poor Readers," Journal of Consulting Psychology, XI (1947), 61-69.

16. _____, "Play Therapy: A Way of Understanding and Helping Reading Problems," Childhood Education, XXVI (1949), 156-161.

17. _____, "Play Therapy and Race Conflict in Young Children," Journal of Abnormal Social Psychology, XLIII (1948), 300-310.

18. _____, "Play Therapy Experiences As Described by Child Participants," Journal of Consulting Psychology, XIV (1950), 53-63.

19. _____, Play Therapy: The Inner Dynamics of Childhood, introduced by Carl R. Rogers, Boston, Houghton Mifflin, 1947.

20. _____, "Some Observations of Play Therapy," Journal of Consulting Psychology, XII (1948), 209-216.

21. _____, "The Child's World Via Play Experience," Progressive Education, XXVII (1950), 68-75.

22. _____ and Carl R. Rogers, "A Teacher-Therapist Deals with a Handicapped Child," Journal of Abnormal and Social Psychology, XL (1945), 119-142.

23. Baker, Bruce E., "The Effectiveness of Parental Counseling with Other Modalities in the Treatment of Children with Learning Disabilities," Journal of Education, CLIV (October, 1971), 74-82.

24. Barbour, R. F. and C. J. Beedell, "The Follow-up of a Child Guidance Clinic Population," Journal of Mental Science, CI (1955), 794-809.

25. Baruch, Dorothy W., "Aggression During Doll Play in a Preschool," American Journal of Orthopsychiatry, XI (1941), 252-260.

26. _____, One Little Boy, New York, Dell Publishing Company, 1952.

27. _____, "Play Techniques in Preschool As an Aid in Guidance, Psychological Bulletin, XXXVI (1939), 570.

28. _____, "Therapeutic Procedures As Part of the Educational Process," Journal of Consulting Psychology, XLI (1940), 165-172.

29. Bender, Lauretta, "Art and Therapy in the Mental Disturbances of Children," Journal of Nervous and Mental Disorders, LXXXVII (1938), 418-449.

30. _____ and A. G. Woltman, "Play and Psychotherapy," Nervous Child, I (October, 1941), 17-42.

31. _____, "The Use of Plastic Material As a Psychiatric Approach to Emotional Problems in Children," American Journal of Orthopsychiatry, VII (1937), 283-299.

32. _____, "The Use of Puppet Shows As a Psychotherapeutic Method for Behavior Problems in Children," American Journal of Orthopsychiatry, VI (1936), 283-299.

33. Beiser, H. R., "Play Equipment for Diagnosis and Therapy," American Journal of Orthopsychiatry, XXV (1955), 761-770.

34. Bills, R. E., "Nondirective Play Therapy with Retarded Readers," Journal of Consulting Psychology, XIV (1950), 140-149.

35. _____, "Play Therapy with Well-Adjusted Retarded Readers," Journal of Consulting Psychology, XIV (1950), 246-249.

36. Bixler, Ray H., "Limits Are Therapy," Journal of Consulting Psychology, XIII (1949), I-II.

37. _____, "Treatment of a Reading Problem Through Nondirective Play Therapy," Journal of Consulting Psychology, IX (1945), 105-118.

38. Blackham, Garth J., "Strategies for Change in the Child Client," Elementary School Guidance and Counseling Journal, III (March, 1969), 174-183.

39. Bower, Eli M., Fostering Maximum Growth in Children, Washington, D. C., National Education Association, 1965.

40. Boynton, P. L. and J. D. Wong, "Relation of the Play Interests of Children to Their Economic Status," Journal of Genetic Psychology, LX (1944), 129-138.

41. Bruch, Hilde, "The Role of the Parent in Psychotherapy with Children," Psychiatry, XI (1948), 169-175.

42. Bucur, Raymond R., "Nondirective Group Play Therapy with Aggressive Boys," unpublished master's thesis, North Texas State University, Denton, Texas, 1970.

43. Buhlen, C., "Play Therapy," Child Study, XVIII (1941), 115-116.

44. Burlingam, S., "Therapeutic Effects of a Play Group for Preschool Children," American Journal of Orthopsychiatry, VIII (1938), 627-638.

45. Burns, Brenda S., "The Use of Play Techniques in the Treatment of Children," Child Welfare, XLIX (1970), 37-41.

46. Buros, Oscar K., Tests in Print, Highland Park, New Jersey, Gryphon Press, 1961.

47. Butts, Arden E., "Communications with the Elementary Age Child," Elementary School Guidance and Counseling Journal, V (May, 1971), 310-312.

48. Buxbaum, E., "Technique of Child Therapy: A Critical Evaluation," The Psychoanalytical Study of the Child, IX (1954), 297-333.

49. Cameron, W. M., "Treatment of Children in Psychiatric Clinics with Play Techniques," Menninger Clinic Bulletin, IV (1940), 172-180.

50. Cashdon, Sheldon, "The Use of Drawings in Child Psychotherapy, A Process Analysis of a Case Study," Psychotherapy: Theory, Research, and Practice, IV (1967), 81-86.

51. Cassell, Sylvia, "Effect of Brief Puppet Therapy Upon the Emotional Responses of Children Undergoing Cardiac Catheterization," Journal of Consulting Psychology, XXIX (1965), 1-8.

52. Chalmers, T., "Value of Play in Nursing Severely Subnormal Children," Nursing Mirror, XXV (1966), 12-16.

53. Clark, A. H., S. M. Syon and M. P. H. Richards, "Free Play in Nursery School Children," Journal of Child Psychology and Psychiatry, X (February, 1969), 205-216.

54. Clay, C. O., "A Follow-up Study of Eight Mothers and Eight Children Served by a Child Guidance Clinic of Jacksonville, Florida," unpublished master's thesis, Florida State University, Tallahassee, Florida, 1956.

55. Cline, David, "Video Documentation of Behavioral Change in Children," American Journal of Orthopsychiatry, XLII (1972), 40-47.

56. Colm, Hanna, "A Field Theory Approach to Transference and Its Particular Application to Children," Psychiatry, XVIII (1955), 339-353.

57. Conn, Jacob H., "Play Interview Therapy of Castration Fear," American Journal of Orthopsychiatry, XXV (1955), 747-754.

58. _____, "The Child Reveals Himself Through Play: The Method of the Play Interview," Mental Hygiene, XXIII (1939), 49-70.

59. _____, "The Play Interview As an Investigative and Therapeutic Procedure," Nervous Child, VII (1948), 257-286.

60. _____, "The Timid, Dependent Child," Journal of Pediatrics, XIX (1941), 91-102.

61. _____, "The Treatment of Fearful Children," American Journal of Orthopsychiatry, XI (1941), 744-752.

62. _____, "Treatment of Anxiety States in Children by Play Interviews," Sinai Hospital Journal, I (1952), 57-65.

63. Cowen, Emory and W. M. Cruickshank, "Group Therapy with Physically Handicapped Children I: Report of Study," Journal of Educational Psychology, XXXIX (April, 1948), 193-215.

64. _____, "Group Therapy with Physically Handicapped Children: Eleven Evaluations," Journal of Educational Psychology, XXXIX (April, 1948), 281-296.

65. Cox, F. E., "Sociometric Status and Individual Adjustment Before and After Play Therapy," Journal of Abnormal Psychology, XL (1953), 354-356.

66. Cunningham, J. M., H. H. Westerman and J. Fischhoff, "A Follow-up Study of the Patients Seen in a Psychiatric Clinic for Children," American Journal of Orthopsychiatry, XXVI (1956), 602-612.

67. Daly, Mary M. and John Carr, "Tactile Contact: A Measure of Therapeutic Progress," Nursing Research, XVI (1967), 16-21.

68. Davidson, E. Rita, "Play for the Hospitalized Child," American Journal of Nursing, XXXIX (1949), 138-141.

69. Dawley, A., "Inter-related Movement of Parent and Child in Therapy with Children," American Journal of Orthopsychiatry, IX (1939), 748-754.

70. Demaago, Joan, Play Therapy: Client-Centered Counseling for Elementary School Children, Kalamazoo, Michigan, Western Michigan University Press, December, 1971.

71. Despert, J. L., "A Method for the Study of Personality Reactions in Preschool Children by Means of Analysis of Their Play," Journal of Psychology, IX (1940), 17-29.

72. _____, "Play Analysis in Research and Therapy" in Modern Trends in Child Psychiatry, edited by Nolan Lewis and B. L. Parella, New York, International University Press, 1945.

73. _____, "Play Therapy: Remarks on Some of Its Aspects," Nervous Child, VII (July, 1948), 287-295.

74. _____, "Technical Approaches Used in the Study and Treatment of Emotional Problems in Children, Part III: Drawing," Psychiatric Quarterly, XI (1937), 267-294.

75. _____, "Technical Approaches Used in the Study and Treatment of Emotional Problems in Children, Part V: The Play Room," Psychiatric Quarterly, XI (1937), 677-693.

76. Dorfman, Elaine, "Personality Outcomes of Client-Centered Child Therapy," Psychological Monographs, LXXII (Spring, 1958), 1-22.

77. _____, "Play Therapy," in Client-Centered Therapy, edited by Carl R. Rogers, Boston, Houghton Mifflin Company, 1965.

78. Drabkova, H., "Experiences Resulting from Clinical Use of Psychodrama with Children," Group Psychotherapy, XIX (1966), 32-36.

79. Dudek, S. Z., "Suggestion and Play Therapy in the Cure of Warts in Children, A Pilot Study," Journal of Nervous and Mental Disease, CXLV (1967), 37-42.

80. Dupent, H. J., T. Landsman and M. Valentine, "The Treatment of Delayed Speech by Client-Centered Therapy," Journal of Consulting Psychology, XVII (1953), 122-125.

81. Durfee, M. B., "Use of Ordinary Office Equipment in Play Therapy," American Journal of Orthopsychiatry, XII (1942), 495-508.

82. Eisenberg, L. and E. M. Gruenberg, "The Current Status of Secondary Prevention in Child Psychiatry," American Journal of Orthopsychiatry, XXXI (1961), 355-367.

83. Eme, Robert Francis, "Level of Experiencing As a Predictor of Short-Term Play Therapy Outcome," unpublished doctoral dissertation, Loyola University of Chicago, Chicago, Illinois, 1972.

84. Engebretson, D. E., "Human Territorial Behavior: The Role of Interaction Distance in Therapeutic Interventions," American Journal of Orthopsychiatry, XLIII (1973), 57-63.

85. Erikson, E. H., "Sex Differences in Play Configurations of Preadolescents," American Journal of Orthopsychiatry, XXI (1951), 667-692.

86. Finke, Helene, "Changes in the Expression of Emotionalized Attitudes in Six Cases of Play Therapy," unpublished master's thesis, University of Chicago, Chicago, Illinois, 1947.

87. Fleming, Louise and W. U. Snyder, "Social and Personal Changes Following Nondirective Group Play Therapy," American Journal of Orthopsychiatry, XVII (1947), 101-116.

88. Flint, Betty M., "The Child and the Institution: A Study of Deprivation and Recovery," University of Toronto Press, Buffalo, 1969.

89. Fraiberg, Selma, "Technical Aspects of the Analysis of a Child with a Severe Behavior Disorder," Journal of American Psychoanalytic Association, X (1962), 338-367.

90. Freud, Anna, The Psychoanalytical Treatment of Children, translated by Nancy Proctor-Gregg, London, Imago, 1946; third edition, New York, Anglo Books, 1951.

91. Frick, Willard B., "Use of Food in Child Psychotherapy," Journal of Consulting Psychology, XXIX (1965), 389-391.

92. Fries, Margaret E., "Play Technique in the Analysis of Young Children," Psychoanalytic Review, XXIV (1937), 233-245.

93. Fuchs, Natalie Rogers, "Play Therapy at Home," The Merrill-Palmer Quarterly, III (1957), 89-95.

94. Ganter, Grace and others, Retrieval from Limbo, The Intermediary Group Treatment of Inaccessible Children, New York, Child Welfare League of America, Inc., 1967.

95. Gerard, M. W., "Trends of Orthopsychiatric Therapy: V Treatment of the Young Child," American Journal of Orthopsychiatry, XVIII (1948), 414-421.

96. Ginott, Haim G., "A Rationale for Selecting Toys in Play Therapy," Journal of Consulting Psychology, XXIV (1960), 243-246.

97. _____, "Differential Treatment Groups in Guidance, Counseling, Psychotherapy, and Psychoanalysis," International Journal of Social Psychiatry, III (1957), 231-235.

98. _____, Group Psychotherapy with Children: The Theory and Practice of Play Therapy, New York, McGraw-Hill, 1961.

99. _____, "Group Screening of Parents in a Child Guidance Setting," International Journal of Group Psychotherapy, VI (1956), 405-409.

100. _____, "Parent Education Groups in a Child Guidance Clinic," Mental Hygiene, XLI (1957), 82-86.

101. _____, "Play Therapy: The Initial Session," American Journal of Psychotherapy, XV (1961), 73-89.

102. _____, "The Theory and Practice of Therapeutic Intervention in Child Treatment," Journal of Consulting Psychology, XXIII (1959), 160-166.

103. _____, Libby Blek and Ruby Barnes, "A Study in Non-Attendance of Initial Interviews in a Community Clinic," International Journal of Group Psychotherapy, IX (1959), 314-321.

104. _____ and Dell Lebo, "Most and Least Used Play Therapy Limits," Journal of Genetic Psychology, CIII (1963), 153-159.

105. _____, "Play Therapy Limits and Theoretical Orientation," Journal of Consulting Psychology, XV (1961), 337-340.

106. Gitelson, Maxwell and collaborators, "Clinical Experiences with Play Therapy," American Journal of Orthopsychiatry, VIII (1938), 466-468.

107. Golden, Bobbie, "Monitored Play Therapy: Conceptual and Methodological Issues," Georgia State University, September, 1969 (ERIC ED033426).

108. Goldings, C. R., "Books in the Playroom: A Dimension of Child Psychiatric Technique," Journal of the American Academy of Child Psychiatry, XI (1972), 52-65.

109. Gordor, E. I., Art and Play Therapy, New York, Doubleday Papers in Psychology, 1954.

110. Gondor, L. H., "Use of Fantasy Communications in Child Psychotherapy," American Journal of Psychotherapy, XI (1957), 323-328.

111. Graham, T. F., "Doll-Play Fantasies of Negro and White Primary School Children," Journal of Clinical Psychology, XI (1955), 29-33.

112. Grant, Frances F., "The Kasperl Theatre As Play Therapy," American Journal of Psychotherapy, IV (1950), 279-285.

113. Guerney, B. G., Jr., "Filial Therapy: Description and Rationale," Journal of Consulting Psychology, XXVIII (1964), 304-310.

114. _____ and A. Flumen, "Teachers As Psychotherapeutic Agents for Withdrawn Children," Journal of School Psychology, VIII (1970), 107-113.

115. _____, Louise Guerney and M. Andronico, "Filial Therapy," Yale Scientific Magazine, XL (1966), 6-14.

116. Hambridge, Gove, "Structured Play Therapy," American Journal of Orthopsychiatry, XXV (1955), 601-617.

117. Hammer, Max and Arthur Kaplan, The Practice of Psychotherapy with Children, Homewood, Illinois, The Dorsey Press, 1967.

118. Hare, Marjorie, "Shortened Treatment in a Child Guidance Clinic: The Results in 119 Cases," British Journal of Psychiatry, CXII (1966), 613-616.

119. Harms, E., "Play Diagnosis: Preliminary Considerations for a Sound Approach," Nervous Child, VII (1948), 233-246.

120. Harries, Margaret, "Sublimation in a Group of Four Year Old Boys," Psychoanalytic Study of the Child, VII (1952), 230-240.

121. Hartley, Ruth E., Growing Through Play: Experiences of Teddy and Bud, New York, Columbia University Press, 1952.

122. _____, K. Lawrence and Robert Goldenson, New Play Experiences for Children: Planned Play Groups, Miniature Life Toys and Puppets, New York, Columbia University Press, 1952.

123. Hawkey, M. L., "Play Analysis: Case Study of a Nine-Year-Old Girl," British Journal of Medical Psychology, XXIV (1951), 206-214.

124. _____, "The Use of Puppets in Child Psychotherapy," British Journal of Medical Psychology, XXIV (1951), 206-214.

125. Haworth, Mary R. and Frank Menolascino, "Video-Tape Observations of Disturbed Young Children," Journal of Clinical Psychology, XXIII (1967), 135-140.

126. Hayward, Helen, "Social Worker's Use of Play Interviews in Child Guidance," Smith College Studies of Social Work, XIX (1949), 111-112.

127. Heinicke, C. and A. Goldman, "Research on Psychotherapy with Children: A Review and Suggestions for Further Study," American Journal of Orthopsychiatry, XXX (1960), 483-493.

128. Hellersburg, Elizabeth F., "Child's Growth in Play Therapy," American Journal of Psychotherapy, XXV (1955), 484-508.

129. Hendricks, Shirley Jo, "A Descriptive Analysis of the Process of Client-Centered Play Therapy," unpublished doctoral dissertation, North Texas State University, Denton, Texas, 1971.

130. Herd, Ruby, "Behavioral Outcomes of Client-Centered Play Therapy," unpublished doctoral dissertation, North Texas State University, Denton, Texas, 1969.

131. Holmer, P., "The Use of the Play Situation As an Aid to Diagnosis, A Case Report," American Journal of Orthopsychiatry, VII (1937), 523-531.

132. Homburger, E. H. and Erik Erikson, "Configurations in Play, Clinical Notes," Psychoanalytic Quarterly, VI (1937), 139-140.

133. Homefield, Harold Dennis, "Creative Role-Playing As Therapy for Stuttering Children, With Special Reference to the Use of Masks," unpublished doctoral dissertation, New York University, New York, New York, 1959.

134. Howard, R. W., "Fantasy and the Play Interview," Character and Personality, XIII (1944), 152-165.

135. Hume, Katherine, "Counseling and Consulting: Complementary Functions," Elementary School Guidance Counseling, V (October, 1970), 3-11.

136. Jackson, Lydia, "Non-Speaking Children," British Journal of Medical Psychology, XXIII (1950), 87-100.

137. Jenkins, R. L. and E. Beckh, "Finger Puppets and Mask Making As Media for Work with Children," American Journal of Orthopsychiatry, XII (1942), 294-301.

138. Jerome, Alice, "From the Teacher's Notebook," Journal of American Academy of Child Psychiatry, IX (1970), 12-32.

139. Jessner, Lucie, Gastor Blon and S. Kaplan, "The Use of Play in Psychotherapy with Children," Journal of Nervous and Mental Disorders, CIV (1951), 175-177.

140. Johnson, Elizabeth, "Klopfer's Prognostic Scale Used with Raven's Progressive Matrices in Play Therapy Prognosis," Journal of Projective Techniques, XVII (1953), 320-326.

141. _____, "The Clinical Use of Raven's Progressive Matrices to Appraise Potential for Progress in Play Therapy: A Study of Institutionalized Mentally and Educationally Retarded Children," American Journal of Orthopsychiatry, XXIII (1953), 391-405.

142. Jones, John W., "Play Therapy and the Blind Child," New Outlook for the Blind, XLVI (1952), 189-197.

143. Kamp, L. N. and E. S. Kessler, "The World Test: Developmental Aspects of a Play Technique," Journal of Child Psychology and Psychiatry, XI (November, 1970), 113-115.

144. Katz, Barney, "Do Children Need Play Therapy?" Psychology in The Schools, II (May, 1965), 113-115.

145. Kidd, A. H. and N. Y. Walton, "Dart Throwing As a Method of Reducing Extrapunitive Aggression," Psychological Reports, XIX (1966), 88-90.

146. Kimmel, Mary Anne Rousseau, "The Use of Play Techniques in a Medical Setting," Social Casework, XXXIII (1952), 30-34.

147. King, P. and R. Ekstein, "The Search for Ego Controls: Progression of Play Activity in Psychotherapy with a Schizophrenic Child," Psychoanalytic Review, LIV (1967), 25-37.

148. Klein, Melanie, "Personification in the Play of Children," International Journal of Psychoanalysis, X (1929), 193-204.

149. _____, The Psychoanalysis of Children, London, Hogarth Press, 1932.

150. _____, "The Psychoanalytic Play Technique," American Journal of Orthopsychiatry, XXV (1955), 223-237.

151. _____, "The Psychological Principles of Infant Analysis," International Journal of Psychoanalysis, VIII (1927), 25-37.

152. Kranz, Peter L., "Teachers As Play Therapists: An Experiment in Learning," Childhood Education, XLIX (November, 1972), 73-74.

153. Kulla, Michael, "A Therapeutic Doll Play Program with an Emotionally Disturbed Child," unpublished doctoral dissertation, University of Oklahoma, Norman, Oklahoma, 1966.

154. L'Abate, Luciano, "An Automated Playroom," unpublished paper read at a Workshop on Newer Approaches in Psychological Assessment Techniques, Child Development Clinic, St. Louis University School of Medicine, St. Louis, Missouri, February 29-March 1, 1968.

155. _____, "Design for a Playroom," Georgia State University, 1969 (ERIC Ed019133).

156. Landisberg, S. and W. U. Snyder, "Nondirective Play Therapy," Journal of Clinical Psychology, II (1946), 203-214.

157. Landreth, Garry, Louise Allen and Willard S. Jacquot, "A Team Approach to Learning Disabilities," Journal of Learning Disabilities, II (1969), 24-29.

158. Lebo, Dell, "Age and Suitability for Nondirective Play Therapy," Journal of Genetic Psychology, LXXXIX (1956), 231-238.

159. _____, "A Formula for Selecting Toys for Nondirective Play Therapy," Journal of Genetic Psychology, XCII (1958), 23-24.

160. _____, "The Expressive Value of Toys Recommended for Nondirective Play Therapy," Journal of Clinical Psychology, XI (April, 1955), 144-148.

161. _____, "The Present Status of Research on Nondirective Play Therapy," Journal of Consulting Psychology, XVII (1953), 177-183.

162. _____, "Quantification of the Nondirective Play Therapy Process," Journal of Genetic Psychology, LXXXVI (1955), 375-378.

163. _____, "The Question of Toys in Play Therapy: An International Problem," Journal of Education and Psychology, XIV (Spring, 1956), 63-73.

164. _____, "Theoretical Framework for Nondirective Play: Concepts from Psychoanalysis and Learning Theory," Journal of Consulting Psychology, XXII (1958), 275-279.

165. _____, "The Relationship of Response Categories in Play Therapy to Aggression and Age," Journal of Child Psychiatry, II (1952), 330-336.

166. _____ and Elaine Lebo, "Aggression and Age in Relation to Verbal Expression in Nondirective Play Therapy," Psychology Monographs, LXXI (1957), 449-461.

167. Lee, D. and C. Hutt, "A Playroom Designed for Filming Children: A Note," Journal of Child Psychology and Psychiatry, V (April-May, 1964), 263-265.

168. Lehrman, L. J., H. Sirluck, B. Black, S. Glick, and others, Success and Failure of Treatment of Children in The Child Guidance Clinics of the Jewish Board of Guardians, New York, Monograph of Jewish Board of Guardians Research, I, 1949.

169. Leland, H. and D. Smith, Play Therapy with Mentally Subnormal Children, New York, Grune and Stratton, 1965.

170. _____, "Unstructured Material in Play Therapy for Emotionally Disturbed Brain Damaged, Mentally Retarded Children, American Journal of Mental Deficiency, LXVI (1962), 621-628.

171. Leton, D. A., "The Factor Structure of Diagnostic Scores from School Play Sessions," Psychology in the Schools, III (February, 1966), 148-153.

172. Levi, Aurelia, "Parent Treatment and Outcome of Child's Therapy," unpublished doctoral dissertation, Columbia University, New York, New York, 1961.

173. _____ and Haim G. Ginott, "The Results of Psychotherapy with Children, Another Evaluation," in Haim G. Ginott, Group Psychotherapy with Children: The Theory and Practice of Play Therapy, New York, McGraw-Hill, 1961.

174. Levin, Harry and Valerie Turgeon, "The Influence of the Mother's Presence on Children's Doll Play Aggression," Journal of Abnormal Social Psychology, LV (1957), 304-308.

175. _____ and E. Wardwell, "The Research Uses of Doll Play," Psychological Bulletin, LIX (1962), 27-56.

176. Levitt, E. E., "Psychotherapy with Children, A Further Evaluation," Behavior Research Therapy, I (1963), 45-51.

177. _____, "The Results of Psychotherapy with Children, An Evaluation," Journal of Consulting Psychology, XXI (1957), 189-196.

178. Levy, David M., "Release Therapy in Young Children," Child Study, XVI (1939), 141-143.

179. _____, "Trends in Therapy, III Release Therapy," American Journal of Orthopsychiatry, IX (1939), 713-736.

180. _____, "Use of Play Technique As an Experimental Procedure," American Journal of Orthopsychiatry, III (1933), 266-277.

181. Linden, James I. and Gary Stollak, "The Training of Undergraduates in Play Techniques," Journal of Clinical Psychology, XXV (1969), 213-218.

182. Linder, Marie A., "Verbal Conditioning of Aggression in Doll Play: Comparison of the Effect of Two Therapeutic Tools on Aggression of Nursery School Boys in a Therapy-Like Situation," unpublished doctoral dissertation, University of Minnesota, Minneapolis, Minnesota, 1967.

183. Liss, E., "Play Techniques in Child Analysis," American Journal of Orthopsychiatry, VI (1936), 17-22.

184. Loomis, E. A., "The Use of Checkers in Handling Certain Resistances in Child Therapy and Child Analysis," Journal of the American Psychoanalytic Association, V (1957), 130-135.

185. _____, L. M. Hilgeman and L. R. Meyer, "Childhood Psychosis: II, Play Patterns As Nonverbal Indices of Ego Functions: A Preliminary Report," American Journal of Orthopsychiatry, XXVII (1957), 691-700.

186. Lovaas, O. I., D. M. Baer and Sidney Bijou, "Experimental Procedures for Analyzing the Interaction of Symbolic Social Stimuli and Children's Behavior," Child Development, XXXVI (March, 1965), 237-247.

187. _____, Gilbert Freitag, Vivian Gold and Irene Kassorla, "Recording Apparatus and Procedure for Observation of Behaviors of Children in Free Play Settings," Journal of Experimental Child Psychology, II (1965), 108-120.

188. Lowenfeld, Margaret, Play in Childhood, London, Gallancz, 1935.

189. _____, "World Pictures of Children," British Journal of Medical Psychology, XVIII (1939), 65-101.

190. Lynn, D. B. and R. Lynn, "The Structured Doll Play Test As a Projective Technique for Use with Children," Journal of Projective Techniques, XXIII (1959), 335-344.

191. McDowell, M. S. and S. R. Howe, "Creative Use of Play Materials by Preschool Children," Childhood Education, XVII (1941), 321-326.

192. McPherson, C. A., "The Value of Play in Meeting the Emotional Needs of Young Children in Hospital Settings," Bibliographia Pediatrics, LXXXIV (1965), 181-182.

193. Machler, Theodore, "Pinnocchio in the Treatment of School Phobia," Bulletin of the Menninger Clinic, XXIX (1965), 212-219.

194. Maisner, Edna A., "Contributions of Play Therapy Techniques to Total Rehabilitative Design in an Institution for High-Grade Mentally Deficient and Borderline Children," American Journal of Mental Deficiency, LV (1950), 235-250.

195. Mann, L., "Persuasive Doll Play: A Technique of Directive Psychotherapy for Use with Children," Journal of Clinical Psychology, XIII (January, 1957), 14-19.

196. Marcus, I. M., in J. H. Masserman, editor, Current Psychiatric Therapies, Vol. VI, 42-45, New York, Grune and Stratton, 1966.

197. Marshall, Helen R. and S. C. Hann, "Aspects of Experience Revealed Through Doll Play of Preschool Children," Journal of Psychology, LXI (September, 1965), 47-57.

198. Meeks, J. E., "Children Who Cheat at Games," Journal of American Academy of Child Psychiatry, IX (1970), 13-18.

199. Mehlman, Benjamin, "Group Play Therapy with Mentally Retarded Children," Journal of Abnormal Social Psychology, XLVIII (1953), 53-60.

200. Mehrabian, Albert, "Relationship of Attitude to Seated Posture, Orientation, and Distance," Journal of Personality and Social Psychology, X (1968), 26-30.

201. Mehus, Hilda, "Learning and Therapy," American Journal of Orthopsychiatry, XXIII (1953), 416-421.

202. Mende, Robert H. and James Kauffman, "Effects of Video-Tape Replays on Behavior of Culturally Different Children," Perceptual and Motor Skills, XXX (1971), 670-673.

203. Mendes, Leal and R. Maria, "Group-Analytic Play Therapy with Preadolescent Girls," International Journal of Group Psychotherapy, XVI (1966), 58-64.

204. Miller, Helen E., "Play Therapy for the Institutional Child," Nervous Child, VII (1948), 311-317.

205. _____, "Play Therapy for the Problem Child," Public Health Nurse Bulletin, XXXIX (1947), 294-296.

206. _____ and Dorothy Baruch, "Psychological Dynamics in Allergic Patients As Shown in Group and Individual Psychotherapy," Journal of Consulting Psychology, XII (January, 1948), 111-113.

207. Miyamoto, Misako, "The Meaning of Silence in Play Therapy," Psychologia, VIII (December, 1965), 191-196.

208. Moore, Terence, "Realism and Fantasy in Children's Play," Journal of Child Psychology and Psychiatry, V (June, 1964), 15-36.

209. _____ and L. E. Ucko, "Four to Six: Constructiveness and Conflict in Meeting Doll Play Problems," Journal of Child Psychology and Psychiatry, II (May, 1961), 21-47.

210. Moustakas, Clark E., "A Human Relations Seminar at the Merrill-Palmer School," Personnel and Guidance Journal, XXXVII (1959), 342-349.

211. _____, Children in Play Therapy, New York, McGraw Hill, 1953.

212. _____, "Emotional Adjustment and the Play Therapy Process," Journal of Genetic Psychology, LXXXVI (1955), 79-99.

213. _____, Existential Child Therapy: The Child's Discovery of Himself, New York, Basic Books, 1966.

214. _____, Psychotherapy with Children, New York, Harper and Row, 1959.

215. _____, "Situational Play Therapy with Normal Children," Journal of Consulting Psychology, XV (1951), 225-230.

216. _____, "The Frequency and Intensity of Negative Attitude Expressed in Play Therapy: A Comparison of Well-Adjusted and Disturbed Children," Journal of Genetic Psychology, LXXXVI (1955), 309-324.

217. _____ and Greta Makowsky, "Client-Centered Therapy with Parents," Journal of Consulting Psychology, XVI (1952), 338-342.

218. _____ and H. D. Shalock, "An Analysis of Therapist-Child Interaction in Play Therapy," Child Development, XXVI (1955), 143-147.

219. Moyer, Kenneth and Gilmer Von Haller, "Experimental Study of Children's Preferences and Use of Blocks in Play," Journal of Genetic Psychology, LXXXIX (1956), 3-10.

220. Murphy, Albert T. and Ruth M. Fitzsimmons, Stuttering and Personality Dynamics: Play Therapy, Projective Therapy, and Counseling, New York, Ronald Press, 1960.

221. Myrick, Robert D. and William Haldin, "A Study of Play Process in Counseling," Elementary School Guidance and Counseling Journal, V (May, 1971), 225-228.

222. Nelson, R. C., "Elementary School Counseling with Unstructured Play Media," Personnel and Guidance Journal, XLV (1966), 24-27.

223. _____, "Physical Facilities for Elementary School Counseling," Personnel and Guidance Journal, XLVI (1967), 552-556.

224. Newell, H. Whitman, "Play Therapy in Child Psychiatry," American Journal of Orthopsychiatry, XI (1941), 245-251.

225. Nickols, J., "A Multi-Purpose Table for Testing and Play Therapy," Perceptual and Motor Skills, XIII (1961), 89-90.

226. _____, "Target Game Technique for Examination and Play Therapy Activities with Children," Perceptual and Motor Skills, XIII (1961), 83-87.

227. Orgun, Ibrahim, "Playroom Setting for Diagnostic Family Interviews," American Journal of Psychiatry, CXXX (May, 1973), 540-542.

228. Pechy, B. M., "The Direct Analysis of the Mother-Child Relationship in the Treatment of Maladjusted Children," British Journal of Medical Psychology, XXVIII (1955), 101-112.

229. Peck, M. L. and R. H. Stewart, "Current Practices in Selection Criteria for Group Play Therapy," Journal of Clinical Psychology, XX (1964), 146-148.

230. Pelham, Lee Edward, "Self-Directive Play Therapy with Socially Immature Kindergarten Students," unpublished doctoral dissertation, University of Northern Colorado, Greeley, Colorado, 1971.

231. Perkins, Marshall Joseph, "Effects of Play Therapy and Behavior Modification Approaches with Conduct Problem Boys," unpublished doctoral dissertation, University of Illinois at Urbana-Champaign, Urbana, Illinois, 1967.

232. Phillips, E. L., "Parent-Child Psychotherapy: A Follow-up Study Comparing Two Techniques," Journal of Psychology, XLIX (1960), 195-202.

233. _____ and Margaret Johnston, "Theoretical and Clinical Aspects of Short-Term, Parent-Child Psychotherapy," Psychiatry, XVII (1954), 267-275.

234. Phillips, R., "Doll Play As a Function of the Realism of the Materials and the Length of the Experimental Session," Child Development, XVI (1945), 123-143.

235. Pintler, M. H., "Doll Play As a Function of Experimenter-Child Interaction and Initial Organization of Materials," Child Development, XVI (1945), 145-166.

236. Pothier, Patricia C., "Resolving Conflict Through Play Fantasy," Journal of Psychiatric Nursing and Mental Health Services, V (1967), 141-147.

237. Prestwich, Sheldon, "The Influence of Two Counseling Methods on the Physical and Verbal Aggression of Preschool Indian Children," Washington, D. C., Office of Economic Opportunity, August, 1969.

238. Pulaski, M. A., "Play As a Function of Toy Structure and Fantasy Predisposition," Child Development, XLI (1970), 531-537.

239. Pumfery, P. D. and C. D. Elliott, "Play Therapy, Social Adjustment and Reading Attainment," Educational Research, XII (June, 1970), 183-193.

240. Quattlebaum, Rebecca Fay, "A Study of the Effectiveness of Nondirective Counseling and Play Therapy with Maladjusted Fifth Grade Pupils," unpublished doctoral dissertation, University of Alabama, University, Alabama, 1970.

241. Rambert, M. L., "Une Nouvelle Technique en Psychoanalyse Infantile: le jeu de guignols," Rev. franc. Psychoanalysis, X (1938).

242. Raskin, N. J., "Play Therapy with Blind Children," New Outlook for the Blind, XL (1954), 290-292.

243. Rexford, Eveoleen N., "A Follow-up of Psychiatric Study of Fifty-Seven Antisocial Young Children," Mental Hygiene, XL (1956), 196-214.

244. Reynert, Martin I., "Play Therapy at Mooseheart," Journal of the Exceptional Child, XIII (1946), 2-9.

245. Richards, S. S. and E. Walff, "The Organization and Function of Play Activities in the Set-Up of a Pediatric Department: A Report of a Three Year Experiment," Mental Hygiene, XXIV (1940), 229-237.

246. Robinson, E. L., "Doll Play As a Function of the Doll Family Constellation," Child Development, XVII (1946), 99-119.

247. _____, "The Form and the Imaginative Content of Children's Block Buildings," unpublished doctoral dissertation, University of Minnesota, Minneapolis, Minnesota, 1958.

248. Rogers, Carl R., "Three Surveys of Treatment Measures Used with Children," American Journal of Orthopsychiatry, VII (1937), 48-57.

249. Rogers, Mary Brown, "The Processes of Monitored Play Therapy," Georgia State University, August, 1969 (ERIC Ed033425).

250. _____, "Therapist's Verbalizations and Outcome in Monitored Play Therapy," unpublished doctoral dissertation, Georgia State University, Atlanta, Georgia, 1972.

251. _____ and Luciano L'Abate, "Bibliography on Play Therapy and Children's Play," Georgia State University, September, 1969 (ERIC ED035897).

252. Roheim, G., "Play Analysis with Normanby Island Children," American Journal of Orthopsychiatry, XI (1941), 524-530.

253. Roland, Mary C., "Psychotherapeutic Aspects of Play," American Journal of Occupational Therapy, VI (1952), 8-10.

254. Rosenberg, B. G. and B. Sutton-Smith, "A Revised Conception of Masculine-Feminine Differences in Play Activities," Journal of Genetic Psychology, XCVI (1960), 165-170.

255. Rosensweig, S. and D. Shakow, "Play Technique in Schizophrenia and Other Psychoses: I, Rationale," American Journal of Orthopsychiatry, VII (1937), 32-35.

256. _____, "Play Technique in Schizophrenia and Other Psychoses: II, An Experimental Study of Schizophrenic Constructions with Play Materials," American Journal of Orthopsychiatry, VII (1937), 36-47.

257. Rothschild, Jacob, "Play Therapy with Blind Children," New Outlook for the Blind, LIV (1960), 329-333.

258. Rucker, I. N., "Outcome of Play Interviews Conducted by Social Workers," Smith College Studies in Social Work, XVII (1946), 128-129.

259. Sargent, H., "Spontaneous Doll Play of a Nine-Year-Old Boy," Journal of Consulting Psychology, VII (1943), 216-222.

260. Schall, M. A., "A Study of the Effects of Three Anthromorphic Models on the Social Adjustment of Children," unpublished doctoral dissertation, Arizona State University, Tempe, Arizona, 1967.

261. Schiffer, A. L., "The Effectiveness of Group Play Therapy As Assessed by Specific Changes in a Child's Peer Relations," American Journal of Orthopsychiatry, XXXVII (1967), 219-220.

262. Schiffer, M., "A Therapeutic Play Group in a Public School," Mental Hygiene, XLI (1957), 185-193.

263. _____, "Permissiveness Versus Sanction in Activity Group Therapy," International Journal of Group Psychotherapy, II (1952), 255-261.

264. _____, "The Use of the Seminar in Training Teachers and Counselors As Leaders of Therapeutic Play Groups for Maladjusted Children," American Journal of Orthopsychiatry, XXX (1960), 154-165.

265. Sears, Pauline S., "Doll Play Aggression in Normal Young Children: Influence of Sex, Age, Sibling Status, Father's Absence," Psychological Monographs, LXV (1951), 2-42.

266. Sears, R. R., "Influence of Methodological Factors on Doll Play Performance," Child Development, XVIII (1947), 190-197.

267. Seeman, Julius, "Child Therapy in Education, Some Current Trends," Education, LXXIV (1954), 493-500.

268. _____, Barry and Ellinwood, "Interpersonal Assessment of Play Therapy Outcome," Psychotherapy: Theory, Research, and Practice, Nashville, Tennessee, George Peabody College, 1964.

269. _____ and Benner Edwards, "A Therapeutic Approach to Reading Difficulties," Journal of Consulting Psychology, XVIII (1954), 451-453.

270. Shirley, Mary, Betty Baum and Sylvia Polsky, "Outgrowing Childhood's Problems: A Follow-up Study of Child Guidance Patients," Smith College Student Social Work, XI (1940), 31-60.

271. Siegel, A. W., "Adult Verbal Behavior in Play Therapy Sessions with Retarded Children," Journal of Speech and Hearing Disorders, X (1963), 34-38.

272. Siegel, Alberta Engvale and Lynette Gayle Kohn, "Permissiveness, Permission, and Aggressions: The Effects of Adult Presence or Absence on Aggression in Children's Play," Child Development, XXX (1959), 131-141.

273. Siegel, Claire Lynn Fleet, "Changes in Play Therapy Behaviors Over Time As a Function of Differing Levels of Therapist-Offered Conditions," Journal of Clinical Psychology, XXVIII (1972), 235-236.

274. _____, "The Effectiveness of Play Therapy with Other Modalities in the Treatment of Children with Learning Disabilities," unpublished doctoral dissertation, Boston University Graduate School, Boston, Massachusetts, 1970.

275. Simpson, G., "Diagnostic Play Interviews," Understanding the Child, VII (1938), 6-10.

276. Smolen, Elwyn M., "Nonverbal Aspects of Therapy with Children," American Journal of Psychotherapy, XIII (1959), 872-881.

277. Sokoloff, Martin A., "A Comparison of Gains in Communicative Skills, Resulting from Group Play Therapy and Individual Speech Therapy, Among a Group of Non-Severely Dysarthric, Speech Handicapped Cerebral Palsied Children," unpublished doctoral dissertation, New York City University, New York, New York, 1959.

278. Solomon, J. C., "Active Play Therapy," American Journal of Orthopsychiatry, VIII (1938), 479-498.

279. _____, "Active Play Therapy, Further Experiences," American Journal of Orthopsychiatry, X (1940), 763-781.

280. _____, "Play Technique," American Journal of Orthopsychiatry, XVIII (1948), 402-413.

281. _____, "Play Technique and the Integrative Process," American Journal of Orthopsychiatry, XXV (1955), 591-600.

282. _____, "Play Technique As a Differential Therapeutic Medium," Nervous Child, VII (1947), 296-300.

283. _____, "Therapeutic Use of Play," in H. H. Anderson and G. L. Anderson, editors, An Introduction to Projective Techniques, New York, Prentice Hall, 1951.

284. Stephenson, P. S., "Working with Nine to Twelve Year Old Children," Child Welfare, LII (June, 1973), 375-382.

285. Stollak, Gary E., "The Experimental Effects of Training College Students As Play Therapists," Psychotherapy: Theory, Research and Practice, V (1968), 77-80.

286. Stover, Lillian and Bernard G. Guerney, "The Efficacy of Training Procedures for Mothers in Filial Therapy," Psychotherapy: Theory, Research and Practice, IV (1967), 110-115.

287. Styrt, J. and others, "Spontaneous Play in Resolution of Problems: A Brief Example," Mental Hygiene, XLIX (1965), 405-407.

288. Subotnik, Leo, "Transference in Client-Centered Play Therapy," Psychology, III (1966), 2-17.

289. _____ and R. J. Callahan, "A Pilot Study in Short Term Play Therapy with Institutionalized Educable Mentally Retarded Boys," American Journal of Mental Deficiency, LXIII (1959), 730-735.

290. Symonds, P. M., "Play Technique As a Test of Readiness," Understanding the Child, IX (1940), 8-14.

291. Taft, Jesse, The Dynamics of Therapy, New York, The Macmillan Company, 1933.

292. Tallman, F. F. and L. N. Goldensohn, "Play Technique," American Journal of Orthopsychiatry, XI (1941), 551-562.

293. Updegraff, R. and E. K. Herbst, "An Experimental Study of the Social Behavior Stimulated in Young Children by Certain Play Materials," Journal of Genetic Psychology, XXXII (1933), 372-391.

294. Vance, T. F. and L. T. McCall, "Children's Preferences Among Play Materials As Determined by the Method of Paired Comparison Pictures," Child Development, V (1934), 267-277.

295. Vittner, Donald, "Structured Puppet Play Therapy," Elementary School Guidance Counseling Journal, IV (October, 1969), 68-70.

296. Wall, L. V., The Puppet Book, London, Faber and Faber, 1950.

297. Waterland, Jean C., "Actions Instead of Words: Play Therapy for the Young Child," Elementary School Guidance and Counseling Journal, IV (March, 1970), 180-197.

298. Weiss, Anni B. and A. W. Frankle, "Diagnostic and Remedial Play," Understanding the Child, VII (1938), 3-5.

299. _____, "Play Interviews with Nursery School Children," American Journal of Orthopsychiatry, XI (1941), 33-39.

300. West, William B., "An Investigation of the Significance of Client-Centered Play Therapy As a Counseling Technique," unpublished doctoral dissertation, North Texas State University, Denton, Texas, 1969.

301. Whitted, B. A. and R. B. Scott, "Significance of a Play Program in the Care of Children in a General Hospital," Journal of the National Medical Association, LIV (1962), 488-491.

302. Winn, Evangeline V., "The Influence of Play Therapy on Personality Change and the Consequent Effect on Reading Performance," unpublished doctoral dissertation, Michigan State University, East Lansing, Michigan, 1959.

303. Withall, John and A. Reddenhouse, "Child-Therapy, A Frame of Reference," Exceptional Children, XXI (1955), 122-126.

304. Witmer, Helen L. and Jane Keller, "Outgrowing Childhood's Problems: A Study of the Value of Child Guidance Treatment," Smith College Studies in Social Work, XIII (1942), 74-90.

305. Woltmann, A. G., "Concepts of Play Therapy Techniques," American Journal of Orthopsychiatry, XXV (1955), 771-783.

306. _____, "Plastic Materials As a Psychotherapeutic Medium," in R. B. Winn, editor, Encyclopedia of Child Guidance, New York, Philosophical Library, 1943.

307. _____, "Play Therapy and Related Techniques," in D. Brower and L. E. Abt, editors, Progress in Clinical Psychology, Vol. II, New York, Grune and Stratton, 1956.

308. _____, "The Use of Puppetry in Therapy," in N. Long, W. Morse and R. Newman, editors, Conflict in the Classroom: The Education of Emotionally Disturbed Children, Belmont, California, Wadsworth Publishers, 1965.

309. _____, "The Use of Puppets in Understanding Children," Mental Hygiene, XXIV (1940), 445-458.

CHAPTER IV

SUMMARY, DISCUSSION, AND RECOMMENDATIONS

Summary

In summary, literature in the area of play was surveyed, summarized, and organized. The historical approach was used for the collection of data for this study. Materials gathered were acquired through the sources provided by library services as well as current authorities in the field of play therapy. As the material was collected, the focus areas or sections began to naturally develop because of the commonality of the articles. The material found was divided into theory, approach, position, and research. The material found on theory and approach was organized into Chapter II. The material found on position and research was organized into Chapter III.

After an exhaustive search of the literature, it was found that the material was scattered throughout many volumes of journals and books. An observation of the material found showed that a dirth of writing appeared in the literature when child therapy first became popular consisting of technique, theory, and complete case study

protocols. This work tended to tie into a theory which had been developed for working with adults and served to translate adult theories to child theories. More recently, the material found has been more specific. It has dealt with specific variables affecting the play therapy process and outcome. In addition, recent literature reveals a trend toward documentation and research methods in the area of play therapy. However, even though the trend seems to show a position of increased accountability, an overall scarcity of relevant material was observed. Very little research in any focus area was identified. The research which was reported tended to show inconclusive evidence and is reflective of an embryonic stage of development. It seems that instead of following the usual pattern of a scientific model (which includes movement from hypothetical to research to theory), persons in play therapy have started at the theory stage. Some research has been done in order to begin filling in the "gaps." However, this research is scant, lacks sequence, and tends to provide inconclusive evidence.

Discussion

For the last few years, pressure has been put on various professional groups to become accountable in the service areas. This trend has also focused on persons providing counseling services to children. Criticism has

been directed to the persons working within the psychodynamic philosophies in that it is felt that these particular models of delivery function without a research basis. In addition, because of the lack of structure within the theories themselves, persons using methods which are psychodynamic have generally been unable to document change in the children they are working with. This lack of structure has contributed to the overall confusion in that as persons have provided research information, it has been difficult to fit it into any existing system of constructs in the heirarchy of theory development. In surveying the literature of play therapy it was found that not one dynamic play therapy model was built past the level of position and approach.

There are probably many reasons for the discrepancy between what is theorized should happen and what actually happens. Probably the most important reason for this discrepancy is that we in the field of behavioral sciences have not yet arrived at conclusions as to what behaviors or dynamics would exist in an individual so that he will be able to fully function. There are equally wide variations among professionals as to what constitutes nonfunctioning or deviate behavior. Therefore, it seems that one of the major difficulties in building theory which is based on

research is that we are not in agreement on the desired outcomes resulting from therapy. This leads to the conclusion that different methods of defining outcome have to be developed.

Possibly another reason why persons in the field of play therapy have been resistant to developing models of delivery which could be measured is that many persons in the field assume erroneously that the process of evaluating will take away from the "experience." Others suggest that "inner man" has immeasurable qualities. Still others are so busy in their actual work with children that they honestly do not have time to develop designs for evaluation and research which will substantiate their progress and process. Possibly one other variable which is very difficult to acknowledge is the possibility that one's sense of value somehow depends on whether or not progress is shown by the client. It is far easier to assume that progress is occurring than to take the risk of being found inadequate.

Based on the information available in the literature, there is little evidence that persons in the field are doing what they are theorizing to do. However, this only seems to be true on the surface. There are highly qualified persons working with children every day. From the view of these persons and probably the children themselves, things do happen within this process for the child. There is a

possibility then, that the discrepancy is not so much between what is supposed to happen and what happens as it is between what is supposed to happen and what is measured. These then become two different concepts. We assume that just because professionals are, at present, unable or unwilling to become involved in research, they are producing nothing which is of value. A more positive approach would be to develop easily used, sensitive measures.

For example, the work done by behaviorists has been, in part, a reaction to the lack of measurable data exhibited by the persons working within the psychodynamic philosophy. Behaviorists have developed techniques which are applicable to the finite dimensions of the process and outcome described by the psychodynamic theorists. It is possible then to begin looking at the work done which has grown out of the psychodynamic philosophies--and instead of assuming that nothing has been done, begin developing new ways of defining and measuring outcome and process.

One way to begin idealizing possibilities is to quickly review the methods of research which have been employed in the past and then to look at possible ways for improving them. For purposes of simplicity, the types of research will be discussed within the broad framework of outcome research, follow-up research, and process research.

Outcome research in play therapy has tended mainly to be based on pre- and post-test procedures which have

used a combination of measures such as personality tests, sociometric tests, and behavioral checklists of various sorts. One of the difficulties persons find when looking for proof of change through outcome is that they have not tended to define clearly what constituted change. In addition, measures have not adequately tapped change which occurs after treatment is over. It is conceptualized that the greatest growth may take place after the person is no longer under the supporting influence of the therapist. Yet another difficulty in this type of research is that the number of subjects used in these studies tends to be small. Because of this lack of bulk in data, rarely are instruments sensitive enough to show evidence of change even when actually a great deal may have happened. Most study reports end by stating that "no specific changes have been identified; however, the trend seems to be that the child has progressed as a result of the experience." Possibly, the major difficulty in outcome research tends to be that researchers are looking for "global" changes in the individual and not attending to "dimensional" changes. In order for this to occur, development of measures sensitive to these many dimensions in persons have to be developed and applied in the field. In addition, researchers should begin redefining change and outcome.

Persons involved in follow-up type research have had difficulties finding a significant percentage of the original

subjects to be able to generalize anything of significance about their findings. Another difficulty observed is that in the follow-up research, these persons are still unable to identify what changes they expected to endure, what behaviors they would correlate with proof that the therapy was really beneficial. Again, they tend to look for global rather than dimensional characteristics.

Process research is still at the stage of trying to "prove that movement (process) happens." For example, three of the major process studies reported did not deal with dimensions which affect process, but were attempts to support the assumption that children do move through different stages in the development of the therapeutic relationship. However, these three process studies did describe what these stages consisted of. There was only one study (and it is not yet published) which is reported to be dealing with the effect on any variable on the movement within the relationship.

In summary, research procedures in the area of play therapy are in the infant stage. Persons have assumed that this lack of research data is proof that nothing is being done in the field. It should be considered though that this lack of research data only points to the fact that new techniques and models for research need to be developed which will be sensitive enough to evaluate process, outcome, and follow-up in the field of play therapy.

Recommendations

Recommendations for the development of more sensitive outcome research in the field of play therapy would include

1. Defining behaviors and personality dimensionally (specifically) rather than globally.

2. Defining changes in behavior rather than changes in personality.

3. Developing measures sensitive to specific behaviors.

Recommendations for the development of sounder procedures in process research would be the following:

1. Develop methods of evaluation of process which combine many ways of assessing activity and interaction. For example, simultaneous collection of data from verbal interactions, biofeedback, physical space configurations on the part of the child and therapist, body movements of both therapist and child, and information in reference to which toys are being used by the child could be collected, fed into a multi-line computer which offers immediate feedback to the therapist. This would allow the therapist to monitor the process in an objective/subjective way, and change within the session itself. This information could be combined post session with attitude, verbal reports of feeling by both therapist and child, and behavioral observations.

a. Verbal interaction scales between the therapist and child are being developed which allow the therapist to immediately check out the level of experiencing of the child. This is an area which is possible to being researching without extensive equipment and elaborate procedures.

b. Verbal interaction scales which allow the therapist to assess the level of experiencing of both therapist and child need to be developed. Models for this could grow from some of the adult verbal interactive models, but by using records of the child/therapist verbal interactions, it would be possible to develop a computer bank which would be applicable to play therapy.

c. Biofeedback can be used quite effectively by therapists in identifying their own level of experiencing or congruence in a situation. Primarily, these would probably be of most benefit in training procedures of student therapists in body awareness for the intuitive feedback which their body is constantly giving. In this way, therapists could be taught to monitor their own bodies for the signals it is sending to itself, and pick up on the distortions and incongruences which occur internally.

d. The entire area of physical space between the therapist and child has not yet been researched. The use of video cameras, certain kinds of marked floors, raters, and timers could be assessed as vehicles for this research.

e. Body movements of both child and therapist offer a whole area of research possibility. Since most of the child's language is nonverbal, it is critical that persons develop ways of evaluating and identifying his body signals.

2. Research is needed on the potential use of every toy which is included in the playroom.

3. Research is needed on the potential potency and effect of every type limit set within the play therapy process.

4. Research is needed on all dimensions of the person of the therapist--voice quality, training, personal characteristics, personal awareness, level of personal development, and technique.

5. Research is needed in reference to the effect parental involvement or lack of it has on the process of the child. Parent/child verbal and behavioral interactive models could be used to assess process between children and their parents.

6. Research is needed in reference to training models for the development of play therapy skills in professionals, paraprofessionals, and parents who function as delivery agents to children using play therapy.

It is possible that the information gained from some of the stated research suggestions could begin to be collected into a basic body of research. From this research,

an organized theory could grow. For each therapy session, transcriptions of all sorts of information could be collected and combined, and, through the use of computer/ statistical processes, persons in the field could begin developing a data bank for the focus areas strategic to the play therapy process and outcome. Gradually, specific data cans could be developed for use in training and continuous assessment procedures. In this way, research becomes an integral part of the actual process in that all data is being gathered, compiled, and sorted automatically. Persons in the field would not have to design specific research projects, but through the use of current facilities and mechanical devices could begin viewing every play therapy session as a way of providing more data for what eventually could become a sound theory rather than a fantasy.

APPENDIX A

HELEN BORKE CATEGORIES FOR QUANTIFYING PLAY THERAPY PROCESS

A. Curiosity about the situation and things present in it. (Why did you choose me? Anyone else been here? Who owns this?)

B. Simple descriptions, information, and comments about the play and the playroom. (This is an army. These are prisoners. More marbles.)

C. Statements indicating aggression. (all references to fighting, shooting, storms, burying, drowning, death, hurting, destroying.)

D. Story units

   1. Unconnected with play. Obviously farfetched stories or too exaggerated and inconsistent to have occurred.

   2. Any imaginary dialogue or story plot wound around the play, such as: He guards the opening. He is asleep. He doesn't know they're after him.

E. Definite decisions. (I'm going to build a bridge. I said I'd do it and I did.)

F. Inconsistencies, confusion, indecision, and doubt. (My mother has two children, no one. My brother is half my age and he's much taller. My sister's birthday was the day before mine last year but mine is before her's this year. I'm not sure what I should do. I wonder if this will work.)

G. Exploring the limits of the playroom. (Can I take this home? Can I get water? Can I paint this? I'm going to take this. One second. I can stay longer.)

H. Attempting to shift responsibility to the therapist. (What should I do next? Is this deep enough? Is this good? Do you like this?)

I. Evidence of interest in the counselor. (Were you here yesterday? What do you do? How are you? Can I trust you?)

J. Attempting to establish a relationship with the counselor. (Guess. Bet you can't guess. What's this? Look at that. See. Do you know what I'm doing? Want to see how cars crash?)

K. Negative statements about the self. (I'm dumb. I'm afraid. I never win.)

L. Positive statements about the self. (I'm good in school. I can do that. I play marbles best. I'll win it back.)

M. Negative statements about the family, school, things made or present in the playroom, the situation, activities, etc. (Is there going to be new sand? I wish this was bigger. I don't like my sister. I wish I had more toys at home.)

N. Positive statements about the family, school, things made or present in the playroom, the situation, activities. (I like it here. This doll is so pretty. We just got a wonderful new puppy at home.)

O. Straight information and stories about the family, school, pets, teacher, self, etc. (We have a big house. I went to the park yesterday. I have a sister. I was waiting for you. I thought you were my mother.)

P. Asking for information. (Do birds have ears? Where is the paint? How does this work?)

Q. Questions or comments pertaining to time during the interview. (How much longer do we have? I bet there are fifteen minutes left. Do I have time to play?)

R. Exclamations. (Here we go again! Hey! Darn! Oh! Crazy! Crazy!)

S. Unclassifiable. (Yes. Mmmmmm. Okay. Hello. Goodbye. Excuse me. Any answer to a question or a pure repetition of counselor's words.

T. Insightful statements revealing self understanding. (When I was worried, it made me steal. I wasn't loud but I was mean.)

U. Ambivalent statements. (I'm scared in here but I like to come here. I'd like to paint now and blow bubbles too.)

V. Sound effects. (Vocalizations which are not speech. Such noises as clucking, siren, machine gun, explosion, airplane, etc.)

W. Mumbling or talking to self in a voice too low to be heard. (Statements which cannot be heard and which the child does not direct to the therapist.)

Source: Lebo, Dell, "Quantification of the Non-directive Play Therapy Process," Journal of Genetic Psychology, LXXXVI (1955), 376-377.

APPENDIX B

ITEMS ON A QUESTIONNAIRE BY GINOTT AND LEBO

1. Taking home a playroom toy
2. Taking home a painting he made
3. Taking home an object he made of clay, etc.
4. Refusing to enter the playroom
5. Leaving the playroom at will
6. Turning off the lights for a long while
7. Pouring a generous amount of water in sand box
8. Spilling sand any place in the room
9. Spilling as much sand as he wants
10. Painting expensive toys
11. Painting inexpensive toys
12. Painting or marking walls or doors
13. Painting or marking furniture
14. Prolonging his stay at the end of the session
15. Bringing a friend
16. Bringing drinks or food to the playroom
17. Lighting matches brought with him
18. Smoking
19. Starting small fires
20. Reading books he brought with him
21. Doing his school work
22. Breaking inexpensive toys

23. Breaking expensive toys
24. Damaging furniture and fixtures
25. Breaking windows
26. Opening door or window and talking to passers-by
27. Using terms such as Nigger, Mick, Kike, etc.
28. Verbalizing profanities in the playroom
29. Yelling profanities at passers-by
30. Writing four-letter words on blackboard
31. Drawing, painting, or making obscene objects
32. Painting his face
33. Painting his clothes
34. Exploding a whole roll of caps at once
35. Climbing on window sills high above the ground
36. Hitting you mildly
37. Squirting water on you
38. Painting your clothes
39. Throwing sand at your shoes
40. Throwing sand at your person
41. Throwing rubber objects around the room
42. Throwing hard objects around the room
43. Tying you up playfully
44. Shooting suction-tip darts at you
45. Attacking you with some force
46. Sitting on your lap
47. Hugging you for long periods of time

48. Kissing you

49. Fondling you

50. Completely undressing

51. Masturbating openly

52. Drinking polluted water

53. Eating mud, chalk, or fingerpaints

54. Urinating or defecating on the floor

Source: Ginott, Haim G. and Dell Lebo, "Most and Least Used Play Therapy Limits," Journal of Genetic Psychology, CIII (1963), 153-154.

APPENDIX C

A DESCRIPTION OF MATERIALS SUGGESTED BY LOWENFELD

I. Phantasy Materials

a. Water and Water Toys

All this material is placed near a sink, which is fitted with accessible taps and rubber tubing for attaching to the taps. The sink is shallow enough for little children to be able to pull out the plug themselves and deep enough to sail boats in. A moveable high wooden step makes it accessible to quite small children.

Most easily procurable of the water toys are rubber, celluloid, wood, and tin toys that can sink and float. Then come toy baths, bathrooms, and lavatories with working parts, kettles, teapots, cans from which water can be poured, soap-bubble pipes, water pistols, and boats.

b. Earth and Sand

Inchoate mouldable material is supplied by Sand in white, light brown, and dark brown varieties that make intriguing colour differences and serve to express different forms of phantasy. For example, the brown can represent earth; the white, snow; the mixed brown and white seashore, etc.

Earth is not used in the playroom, and its use is reserved for gardening experiments in the garden, but if desired, it can be very well used in a tray.

Sand and Sand and Water lend themselves to the demonstration of a large variety of phantasies, as, for example, tunnelmaking, burying or drowning, land and seascapes. When wet, the sand may be moulded, and when dry it is pleasant to feel, and many tactile experiments can be made with the gradual addition of moisture. Wet sand can be dried up again and converted to wet, or by adding further water it becomes "slosh," and finally water when the dry land has completely disappeared.

Sand is used in a waterproof tray 18 in. by 27 in., with a rim 1 3/4 in. deep, made of wood and zinc lined.

Dough and Clay. Closely allied to water and sand are a number of other substances, but there are danger connected with their use. Sand is familiar to children, and familiarity has dulled the edge of stimulation, but other substances are new, and, for reasons that lie in the deeper regions of the psyche, they are powerfully stimulating to the infantile emotion. The chief of these intermediate substances are Clay and Flour.

c. Modeling Materials

After dough and clay, come two substances whose consistency cannot be greatly varied, and are, therefore, without the dangers attendance on flour and dough. These are Plasticine Substances and Colored Wax.

Plasticine Substances form an invaluable part of any apparatus for psychological work with children and can be used in a large number of ways. The substance is essentially mouldable, and can be satisfactorily cut and chopped. Coloured Wax is not so

mouldable and cuts poorly. It is, however, bright and clear in colour and sets hard, and can be pulled into very fine lengths. The purpose served by the two substances is quite different, and the playroom is, therefore, stocked with both.

d. Solid Objects for Phantasy Expression

Wood Shapes and Blocks. All these are of non-splintering wood. They are of infinite variety in size, shape, and colour, and are used to depict a very wide range of scenes and imaginative phantasies.

Coloured Paper Shapes. Coloured paper, both gummed and plain, already cut into shapes or in sheets serves many purposes. To it should be added plain white paper and scissors.

e. "The World."

Every child forms conceptions of the outside world at a very early age. Part of the work of the playroom laboratory is to provide material by which these concepts can be demonstrated and manipulated so that inter-relations between them may become manifest. In what is known as the "world" cabinet of the playroom the child can find material for the expression of these ideas. The cabinet consists of series of trays upon which cheap miniature models of practically every ordinary object are arranged in classes easily grasped by child. This "world" cabinet is in general used in connection with a sand tray, and placed beside it at a point that makes all its objects readily accessible to the child.

f. Painting and Drawing Materials

These serve the purposes of phantasy. They include crayons, chalks, pencils, brushes, rags, and two kinds of paints-powder paints and moist colour blocks, and "grotesques" of various kinds.

II. Construction

a. Material.

Many of the commercially produced constructive toys, Meccano, Kliptiko, etc., and many simple forms of motor-car and house construction come in usefully here. In addition, there should be a carpenter's bench and carpentry tools. For girls a collection of handcraft material, such as weaving, fancy-work, basketwork, etc., is valuable. These give outlet for constructive energies, fill gaps when phantasy work has been too stimulating, and offer possibilities of reassurance to timid children convinced of their incapacity for any form of achievement.

III. House Materials

a. Shop, Dolls, Prams, and Household Utensils.

These give children instruments with which to dramatise the everyday life they share in and see happening around them. Toy brooms, brushes, etc., are often included in the ordinary toys given to children; the only way in which those used at the Institute differ is that they must be really serviceable and workable, and only toy-like in that they are smaller editions of the real thing. These toys are not merely used by the children for imitating the often incomprehensible actions of the adult

world they see around them, but they furnish instruments with which the children can dramatise their versions of everyday life, and their conceptions of how they would like life to be.

IV. Movement and Destruction

a. Opportunities for movement can easily be supplied in many ways by ball games, rhythm work, and running games, but provision for the expression of destruction impulses requires more consideration.

b. Destruction.

The desire to destroy, since it is so rigorously suppressed by adult society, must be given special opportunities for satisfaction in the playroom, if the impulse is to be really accessible for study; and, moreover, if it is to be "played through" in such a way as to clear the road for constructive effort. Three types of destructive action are provided for: skittles, where the objects are merely knocked down and rolled over, hammer toys, grinding and mincing, where the chestnuts, etc., are put into a grinder and reduced to powder; and throwing and cutting-up games with plasticine. Many of the constructive implements such as are used in leather-work, punching, etc., can be used as outlets for destructive energy.

V. Trains, etc.

a. Trains fill many gaps in play and are used for many purposes and for children of all ages.

b. There are also Pull-Along Toys for little children.

Source: Lowenfeld, Margaret, Play in Childhood, London, Gallancz, 1935, pp. 47-51.

APPENDIX D

A REPORT OF CONCLUSIONS BY MOUSTAKAS AND SHALOCK

1. Data obtained from 9,084 observations of the therapist's behavior and an equal number of anxiety-hostility ratings were summarized. The five categories appearing most frequently were: Attentive Observation, Recognition of Stimulation, Offering Verbal Information, Interpretation by Restating Verbalized Feelings, and Seeking Impersonal Information. Together they accounted for eighty-four per cent of the therapist's interaction with the children. The therapist's primary emphasis was on being there, interacting with the child by observing, listening, and making statements of recognition. His behavior lacked supportive or reward approached to the child, expressions of affection or punishment, criticism, and evaluation, and seldom showed use of forbidding and restricting. He responded in nearly the same way to both groups of children (rank order correlation, .886).

2. Data obtained from 9,544 observations of the children's interactive behavior and an equal number of anxiety-hostility ratings, summarized for the two groups, showed more similar than divergent behavior in the two groups of children (rank order correlation, 694). The

behavior categories appearing most frequently in both groups, accounting for about 95 per cent of responses, were: Nonattentive, Attentive Observation, Statement of Condition or Action, Seeking Information, Giving Information Verbally, Recognition of Stimulation, and Nonrecognition of Stimulation. The most significant difference in behavioral categories (.01 level) between the two groups was in Nonattention. Group B, with emotional problems, showed such behavior 47 per cent of the time; Group A, without emotional problems, 33 per cent of the time.

Differences between the groups were probably related to the kinds of emotional problems in Group B. These children spent considerable time in noninteractive behavior, that is in fantasy, play, or other activity that included the therapist; or they responded in a way that discouraged interaction. In comparison, the children of Group A interacted significantly more often by talking about friends, school, home, and other conditions of their life. They also explained their behavior more often and gave the therapist more clues to an understanding of their behavior.

The children of Group B showed significantly greater number of hostile feelings, tended to be more forbidding, more prone to attack the therapist, and to block or restrain

the therapist. However, such behavior was infrequent in both groups. Dependency behavior was expressed more often by the children of Group B, while the children of Group A tended to be more assertive.

Both groups spent about one-third of their time in behavior that did not directly involve interaction with the therapist; that is, in playing alone, working through ideas and feelings without support or help. None of the children sought reward or affection. They looked for praise only once and reassurance only three times.

The disturbed children (Group B) spent only one per cent of their time in destructive behavior. About eight per cent of their expressions involved some or much hostility, while ninety-two per cent conveyed little or none. Thus, these children significantly more often expressed positive, accepting, behavior in negative, rejecting behavior.

3. A total of 1,882 interaction sequences initiated by the therapist and the children's responses to them were analyzed. When the therapist gave information, the children in both groups responded by exploring the information further, by simply recognizing it, or by failing to recognize it. About fifty per cent of the time, suggestions were well received, and were responded to almost consistently by cooperation. Acceptance led all children responses to the therapist's use of interpretation. As the interpretation diverted further from the child's concrete activity,

or verbal expression, the number of acceptances increased and the number of rejections decreased. Interpretation based on past history or associations with the child from previous interpretations, based on total behavioral clues rather than isolated expressions, resulted in more acceptance and less rejection.

4. A total of 771 interaction sequences initiated by the child were analyzed. When the child sought information, the therapist gave it about 75 per cent of the time and left the child to cope with the problem the remaining 25 per cent. Information was given mainly when it involved the location of particular toys or materials. In general, the therapist responded by cooperation to the child's suggestions. Similarly, he generally responded to simple commands by acceptance and cooperation. Briefly, when the child's request did not tend to create a dependency relationship or to dominate or control the therapist, the response was generally acceptance and cooperation.

Source: Moustakas, Clark E. and H. D. Shalock, "An Analysis of Therapist-Child Interaction in Play Therapy," Child Development, XXVI (1955), 154-156.

BIBLIOGRAPHY

Books

Abraham, Karl, "The Psycho-Sexual Differences Between Dementai Praecox," in Selected Papers on Psychoanalysis, translated by Douglas Bryan and Alix Strachey, London, Hogarth Press, 1950; New York, Basic Books, 1953.

Allen, F. H., Psychotherapy with Children, New York, W. W. Norton and Company, Inc., 1942.

Axline, Virginia, Dibs: In Search of Self, Boston, Houghton Mifflin Co., 1964.

_____, "Nondirective Play Therapy," in Mary R. Haworth, editor, Child Psychotherapy: Practice and Theory, New York, Basic Books, 1964.

_____, Play Therapy: The Inner Dynamics of Childhood, Boston, Houghton Mifflin Co., 1947.

Baruch, Dorothy W., One Little Boy, New York, Dell Publishing Company, 1952.

Buros, Oscar K., Tests in Print, Highland Park, New Jersey, Gryphon Press, 1961.

Despert, J. L., "Play Analysis in Research and Therapy," in Modern Trends in Child Psychiatry, edited by Nolan Lewis and B. L. Parella, New York, International University Press, 1945.

Dorfman, Elaine, "Play Therapy," in Client-Centered Therapy, edited by Carl R. Rogers, Boston, Houghton Mifflin Company, 1965.

Freud, Anna, Introduction to the Technique of Child Analysis, translated by L. Pierce Clark, M. D., New York and Washington, Nervous and Mental Disease Publishing Company, 1928.

_____, The Ego and the Mechanism of Defense, translated by Cecil Baines, New York, International Universities Press, 1948; London, Hogarth Press, 1954.

_____, The Psychoanalytic Treatment of Children, translated by Nancy Proctor-Gregg, 3rd edition, London, Imago, 1946; New York, Anglo-Books, 1951.

Freud, Sigmund, Analysis of a Phobia in a Five Year Old Boy, Standard Edition, Vol. X, edited and translated by James Strachey, London, The Hogarth Press, Ltd., 1955.

_____, The Basic Writings of Sigmund Freud, translated and edited by A. A. Brill, New York, The Modern Library, 1938.

Ginott, Haim G., Group Psychotherapy with Children, New York, McGraw-Hill Book Co., 1961.

Gordor, E. I., Art and Play Therapy, New York, Doubleday Papers in Psychology, 1954.

Hall, Calvin S. and Gardner Lindzey, Theories of Personality, New York, John Wiley and Sons, Inc., 1957.

Hammer, Max and Arthur Kaplan, The Practice of Psychotherapy with Children, Homewood, Illinois, The Dorsey Press, 1967.

Hartley, Ruth E., Growing Through Play: Experiences of Teddy and Bud, New York, Columbia University Press, 1952.

_____, K. Lawrence and Robert Goldenson, New Play Experiences for Children: Planned Play Groups, Miniature Life Toys and Puppets, New York, Columbia University Press, 1952.

Haworth, Mary R., editor, Child Psychotherapy, New York, Basic Books, Inc., 1964.

Kessler, Jane W., Psychopathology of Childhood, New Jersey, Prentice-Hall, Inc., 1966.

Klein, Melanie, The Psychoanalysis of Children, New York, W. W. Norton; London, Hogarth Press, 1932.

Leland, H. and D. Smith, Play Therapy with Mentally Subnormal Children, New York, Grune and Stratton, 1965.

Levi, Aurelia and Haim G. Ginott, "The Results of Psychotherapy with Children, Another Evaluation," in Haim G. Ginott, Group Psychotherapy with Children: The Theory and Practice of Play Therapy, New York, McGraw-Hill, 1961.

Lowenfeld, Margaret, Play in Childhood, London, Gallancz, 1935.

Mannoni, Maud, The Child, His Illness, and the Others, New York, Pantheon Books, 1970.

Marcus, I. M., in J. H. Masserman, editor, Current Psychiatric Therapies, Vol. VI, 42-45, New York, Grune and Stratton, 1966.

Moustakas, Clark E., Children in Play Therapy, New York, McGraw-Hill, 1953.

_____, Existential Child Therapy: The Child's Discovery of Himself, New York, Basic Books, 1966.

_____, Psychotherapy with Children, New York, Harper and Row, 1959.

Murphy, Albert T. and Ruth M. Fitzsimmons, Stuttering and Personality Dynamics: Play Therapy, Projective Therapy, and Counseling, New York, Ronald Press, 1960.

Piaget, J., Play, Dreams, and Imitation in Childhood, New York, W. W. Norton, 1951.

Rank, Otto, Will Therapy, New York, Alfred A. Knopf, Inc., 1936.

Rogers, Carl R., "A Theory of Therapy, Personality and Interpersonal Relationships, As Developed in the Client-Centered Framework," in S. Koch, editor, Psychology: A Study of Science. Study I Conceptual and Systematic. Vol. 3. Formulations of the Person and the Social Context, New York, McGraw-Hill, 1959.

_____, Client-Centered Therapy, Houghton Mifflin, 1965.

_____, Counseling and Psychotherapy, Boston, Houghton Mifflin Company, 1942.

Seeman, Julius, Barry and Ellinwood, "Interpersonal Assessment of Play Therapy Outcome," Psychotherapy: Theory, Research, and Practice, Nashville, Tennessee, George Peabody College, 1964.

Solomon, J. C., "Therapeutic Use of Play," in H. H. Anderson and G. L. Anderson, editors, An Introduction to Projective Techniques, New York, Prentice Hall, 1951.

Taft, Jessie, The Dynamics of Therapy in a Controlled Relationship, New York, The Macmillan Company, 1933.

Wall, L. V., The Puppet Book, London, Faber and Faber, 1950.

Woltmann, A. G., "Play Therapy and Related Techniques," in D. Brower and L. E. Abt, editors, Progress in Clinical Psychology, Vol. II, New York, Grune and Stratton, 1956.

_____, "The Use of Puppetry in Therapy," in N. Long, W. Morse and R. Newman, editors, Conflict in the Classroom: The Education of Emotionally Disturbed Children, Belmont, California, Wadsworth Publishers, 1965.

Articles

Ackerman, H. W., "Constructive and Destructive Tendencies in Children," American Journal of Orthopsychiatry, VII (1937), 301-319.

Adams, Paul, "Racism in Biracial Psychiatry," Journal of American Academy of Child Psychiatry, IX (1970), 33-43.

Alexander, E. D., "School-Centered Play Therapy," Personnel and Guidance Journal, XLIII (1964), 256-261.

Andriola, J., "Release of Aggressions through Play Therapy for a Ten-Year-Old Patient at a Child Guidance Clinic," Psychoanalytic Review, XXXI (1944), 71-80.

Andronico, M. and I. Blake, "The Application of Filial Therapy to Young Children with Stuttering Problems," Journal of Speech and Hearing Disorders, XXXVI (August, 1971), 377-381.

_____, J. Fidler, B. Guerney and L. F. Guerney, "The Combination of Didactic and Dynamic Elements in Filial Therapy," International Journal of Group Psychotherapy, XVII (1967), 10-17.

_____ and B. Guerney, "Psychotherapeutic Aide in a Headstart Program: Riegel Ridge Headstart Project, Milford, New Jersey," Children, XVI (January, 1969), 14-17.

Amster, Fanny, "Differential Uses of Play in Treatment of Young Children," American Journal of Orthopsychiatry, XIII (1943), 63-68.

Arthur, Helen, "A Comparison of Techniques Employed in Psychotherapy and Psychoanalysis of Children," American Journal of Orthopsychiatry, XXII (1952), 484-498.

Axline, Virginia, "Group Therapy As a Means of Self-Discovery for Parents and Children," Group Psychotherapy, VIII (1955), 152-160.

_____, "Mental Deficiency, Symptom or Disease?" Journal of Consulting Psychology, XIII (1949), 313-327.

_____, "Play Therapy: A Way of Understanding and Helping Reading Problems," Childhood Education, XXVI (1949), 156-161.

_____, "Play Therapy and Race Conflict in Young Children," Journal of Abnormal Social Psychology, XLIII (1948), 300-310.

_____, "Play Therapy Experiences As Described by Child Participants," Journal of Consulting Psychology, XIV (1950), 53-63.

_____, "Play Therapy Procedures and Results," American Journal of Orthopsychiatry, XXV (1955), 618-626.

_____, "Some Observations of Play Therapy," Journal of Consulting Psychology, XII (1948), 209-216.

_____, "The Child's World Via Play Experience," Progressive Education, XXVII (1950), 68-75.

_____ and Carl R. Rogers, "A Teacher-Therapist Deals with a Handicapped Child," Journal of Abnormal and Social Psychology, XL (1945), 119-142.

Baker, Bruce E., "The Effectiveness of Parental Counseling with Other Modalities in the Treatment of Children with Learning Disabilities," Journal of Education, CLIV (October, 1971), 74-82.

Barbour, R. F. and C. J. Beedell, "The Follow-up of a Child Guidance Clinic Population," Journal of Mental Science, CI (1955), 794-809.

Baruch, Dorothy W., "Aggression During Doll Play in a Preschool," American Journal of Orthopsychiatry, XI (1941), 252-260.

_____, "Play Techniques in Preschool As an Aid in Guidance," Psychological Bulletin, XXXVI (1939), 570.

_____, "Therapeutic Procedures As Part of the Educational Process," Journal of Consulting Psychology, XLI (1940), 165-172.

Bender, Lauretta, "Art and Therapy in the Mental Disturbances of Children," Journal of Nervous and Mental Disorders, LXXXVII (1938), 418-449.

_____ and A. G. Woltmann, "Play and Psychotherapy," Nervous Child, I (October, 1941), 17-42.

_____, "The Use of Plastic Material As a Psychiatric Approach to Emotional Problems in Children," American Journal of Orthopsychiatry, VII (1937), 283-299.

_____, "The Use of Puppet Shows As a Psychotherapeutic Method for Behavior Problems in Children," American Journal of Orthopsychiatry, VI (1936), 283-299.

Beiser, H. R., "Play Equipment for Diagnosis and Therapy," American Journal of Orthopsychiatry, XXV (1955), 761-770.

Bills, R. E., "Nondirective Play Therapy with Retarded Readers," Journal of Consulting Psychology, XIV (1950), 140-149.

_____, "Play Therapy with Well-Adjusted Retarded Readers," Journal of Consulting Psychology, XIV (1950), 246-249.

Bixler, Ray H., "Limits Are Therapy," Journal of Consulting Psychology, XIII (1949), 1-11.

_____, "Treatment of a Reading Problem Through Nondirective Play Therapy," Journal of Consulting Psychology, IX (1945), 105-118.

Blackham, Garth J., "Strategies for Change in the Child Client," Elementary School Guidance and Counseling Journal, III (March, 1969), 174-183.

Boynton, P. L. and J. D. Wong, "Relation of the Play Interests of Children to Their Economic Status," Journal of Genetic Psychology, LX (1944), 129-138.

Bruch, Hilde, "The Role of the Parent in Psychotherapy with Children," Psychiatry, XI (1948), 169-175.

Buhlen, C., "Play Therapy," Child Study, XVIII (1941), 115-116.

Burlingam, S., "Therapeutic Effects of a Play Group for Preschool Children," American Journal of Orthopsychiatry, VIII (1938), 627-638.

Burns, Brenda S., "The Use of Play Techniques in the Treatment of Children," Child Welfare, XLIX (1970), 37-41.

Butts, Arden E., "Communications with the Elementary Age Child," Elementary School Guidance and Counseling Journal, V (May, 1971), 310-312.

Buxbaum, E., "Technique of Child Therapy: A Critical Evaluation," The Psychoanalytical Study of the Child, IX (1954), 297-333.

Cameron, W. M., "Treatment of Children in Psychiatric Clinics with Play Techniques," Menninger Clinic Bulletin, IV (1940), 172-180.

Cashdon, Sheldon, "The Use of Drawings in Child Psychotherapy, A Process Analysis of a Case Study," Psychotherapy: Theory, Research, and Practice, IV (1967), 81-86.

Cassell, Sylvia, "Effect of Brief Puppet Therapy Upon the Emotional Responses of Children Undergoing Cardiac Catheterization," Journal of Consulting Psychology, XXIX (1965), 1-8.

Chalmers, T., "Value of Play in Nursing Severely Subnormal Children," Nursing Mirror, XXV (1966), 12-16.

Clark, A. H., S. M. Syon and M. P. H. Richards, "Free Play in Nursery School Children," Journal of Child Psychology and Psychiatry, X (February, 1969), 205-216.

Cline, David, "Video Documentation of Behavioral Change in Children," American Journal of Orthopsychiatry, XLII (1972), 40-47.

Colm, Hanna, "A Field Theory Approach to Transference and Its Particular Application to Children," Psychiatry, XVIII (1955), 339-353.

Conn, Jacob H., "Play Interview Therapy of Castration Fear," American Journal of Orthopsychiatry, XXV (1955), 747-754.

_____, "The Child Reveals Himself Through Play: The Method of the Play Interview," Mental Hygiene, XXIII (1939), 49-70.

_____, "The Play Interview As an Investigative and Therapeutic Procedure," Nervous Child, VII (1948), 257-286.

_____, "The Timid, Dependent Child," Journal of Pediatrics, XIX (1941), 91-102.

_____, "The Treatment of Fearful Children," American Journal of Orthopsychiatry, XI (1941), 744-752.

_____, "Treatment of Anxiety States in Children by Play Interviews," Sinai Hospital Journal, I (1952), 57-65.

Cowen, Emory and W. M. Cruickshank, "Group Therapy with Physically Handicapped Children I: Report of Study," Journal of Educational Psychology, XXXIX (April, 1948), 193-215.

_____, "Group Therapy with Physically Handicapped Children: Eleven Evaluations," Journal of Educational Psychology, XXXIX (April, 1948), 281-296.

Cox, F. E., "Sociometric Status and Individual Adjustment Before and After Play Therapy," Journal of Abnormal Psychology, XL (1953), 354-356.

Cunningham, J. M., H. H. Westerman, and J. Fischhoff, "A Follow-up Study of the Patients Seen in a Psychiatric Clinic for Children," American Journal of Orthopsychiatry, XXVI (1956), 602-612.

Daly, Mary M. and John Carr, "Tactile Contact: A Measure of Therapeutic Progress," Nursing Research, XVI (1967), 16-21.

Davidson, E. Rita, "Play for the Hospitalized Child," American Journal of Nursing, XXXIX (1949), 138-141.

Dawley, A., "Inter-related Movement of Parent and Child in Therapy with Children," American Journal of Orthopsychiatry, IX (1939), 748-754.

Despert, J. L., "A Method for the Study of Personality Reactions in Preschool Children by Means of Analysis of Their Play," Journal of Psychology, IX (1940), 17-29.

_____, "Play Therapy: Remarks on Some of Its Aspects," Nervous Child, VII (July, 1948), 287-295.

_____, "Technical Approaches Used in the Study and Treatment of Emotional Problems in Children, Part III: Drawing," Psychiatric Quarterly, XI (1937), 267-294.

_____, "Technical Approaches Used in the Study and Treatment of Emotional Problems in Children, Part V: The Play Room," Psychiatric Quarterly, XI (1937), 677-693.

Dorfman, Elaine, "Personality Outcomes of Client-Centered Child Therapy," Psychological Monographs, LXXII (Spring, 1958), 1-22.

Drabkova, H., "Experiences Resulting from Clinical Use of Psychodrama with Children," Group Psychotherapy, XIX (1966), 32-36.

Dudek, S. Z., "Suggestion and Play Therapy in the Cure of Warts in Children, A Pilot Study," Journal of Nervous and Mental Diseases, CXLV (1967), 37-42.

Dupent, H. J., T. Landsman, and M. Valentine, "The Treatment of Delayed Speech by Client-Centered Therapy," Journal of Consulting Psychology, XVII (1953), 122-125.

Durfee, M. B., "Use of Ordinary Office Equipment in Play Therapy," American Journal of Orthopsychiatry, XII (1942), 495-508.

Eisenberg, L. and E. M. Gruenberg, "The Current Status of Secondary Prevention in Child Psychiatry," American Journal of Orthopsychiatry, XXXI (1961), 355-367.

Engebretson, D. E., "Human Territorial Behavior: The Role of Interaction Distance in Therapeutic Interventions," American Journal of Orthopsychiatry, XLIII (1973), 57-63.

Erikson, E. H., "Sex Differences in Play Configurations of Preadolescents," American Journal of Orthopsychiatry, XXI (1951), 667-692.

Fleming, Louise and W. U. Snyder, "Social and Personal Changes Following Nondirective Group Play Therapy," American Journal of Orthopsychiatry, XVII (1947), 101-116.

Fraiberg, Selma, "Technical Aspects of the Analysis of a Child with a Severe Behavior Disorder," Journal of American Psychoanalytic Association, X (1962), 338-367.

Frick, Willard B., "Use of Food in Child Psychotherapy," Journal of Consulting Psychology, XXIX (1965), 389-391.

Fries, Margaret E., "Play Technique in the Analysis of Young Children," Psychoanalytic Review, XXIV (1937), 233-245.

Fuchs, Natalie Rogers, "Play Therapy at Home," The Merrill-Palmer Quarterly, III (1957), 89-95.

Gerard, M. W., "Trends in Orthopsychiatric Therapy: V Treatment of the Young Child," American Journal of Orthopsychiatry, XVIII (1948), 414-421.

Ginott, Haim G., "A Rationale for Selecting Toys in Play Therapy," Journal of Consulting Psychology, XXIV (1960), 243-246.

_____, "Differential Treatment Groups in Guidance, Counseling, Psychotherapy, and Psychoanalysis," International Journal of Social Psychiatry, III (1957), 231-235.

_____, "Group Screening of Parents in a Child Guidance Setting," International Journal of Group Psychotherapy, VI (1956), 405-409.

_____, "Parent Education Groups in a Child Guidance Clinic," Mental Hygiene, XLI (1957), 82-86.

_____, "Play Therapy: The Initial Session," American Journal of Psychotherapy, XV (1961), 73-89.

_____, "The Theory and Practice of Therapeutic Intervention in Child Treatment," Journal of Consulting Psychology, XXIII (1959), 160-166.

_____, Libby Blek and Ruby Barnes, "A Study in Non-Attendance of Initial Interviews in a Community Clinic," International Journal of Group Psychotherapy, IX (1959), 314-321.

_____ and Dell Lebo, "Most and Least Used Play Therapy Limits," Journal of Genetic Psychology, CIII (1963), 153-159.

_____, "Play Therapy Limits and Theoretical Orientation," Journal of Consulting Psychology, XV (1961), 337-340.

Gitelson, Maxwell and collaborators, "Clinical Experiences with Play Therapy," American Journal of Orthopsychiatry, VIII (1938), 466-468.

Goldings, C. R., "Books in the Playroom: A Dimension of Child Psychiatric Technique," Journal of the American Academy of Child Psychiatry, XI (1972), 52-65.

Gondor, L. H., "Use of Fantasy Communications in Child Psychotherapy," American Journal of Psychotherapy, XI (1957), 323-328.

Graham, T. F., "Doll-Play Fantasies of Negro and White Primary School Children," Journal of Clinical Psychology, XI (1955), 29-33.

Grant, Frances F., "The Kasperl Theatre As Play Therapy," American Journal of Psychotherapy, IV (1950), 279-285.

Guerney, B. G., Jr., "Filial Therapy: Description and Rationale," Journal of Consulting Psychology, XXVIII (1964), 304-310.

_____ and A. Flumen, "Teachers As Psychotherapeutic Agents for Withdrawn Children," Journal of School Psychology, VIII (1970), 107-113.

_____, Louise Guerney and M. Andronico, "Filial Therapy," Yale Scientific Magazine, XL (1966), 6-14.

Hambridge, Gove, "Structured Play Therapy," American Journal of Orthopsychiatry, XXV (1955), 601-617.

Hare, Marjorie, "Shortened Treatment in a Child Guidance Clinic: The Results in 119 Cases," British Journal of Psychiatry, CXII (1966), 613-616.

Harms, E., "Play Diagnosis: Preliminary Considerations for a Sound Approach," Nervous Child, VII (1948), 233-246.

Harries, Margaret, "Sublimation in a Group of Four Year Old Boys," Psychoanalytic Study of the Child, VII (1952), 230-240.

Hawkey, M. L., "Play Analysis: Case Study of a Nine-Year-Old Girl," British Journal of Medical Psychology, XXIV (1951), 206-214.

_____, "The Use of Puppets in Child Psychotherapy," British Journal of Medical Psychology, XXIV (1951), 206-214.

Haworth, Mary R. and Frank Menolascino, "Video-Tape Observations of Disturbed Young Children," Journal of Clinical Psychology, XXIII (1967), 135-140.

Hayward, Helen, "Social Worker's Use of Play Interviews in Child Guidance," Smith College Studies of Social Work, XIX (1949), 111-112.

Heinicke, C. and A. Goldman, "Research on Psychotherapy with Children: A Review and Suggestions for Further Study," American Journal of Orthopsychiatry, XXX (1960), 483-493.

Hellersburg, Elizabeth F., "Child's Growth in Play Therapy," American Journal of Psychotherapy, XXV (1955), 484-508.

Holmer, P., "The Use of the Play Situation As an Aid to Diagnosis, A Case Report," American Journal of Orthopsychiatry, VII (1937), 523-531.

Homburger, E. H. and Erik Erikson, "Configurations in Play, Clinical Notes," Psychoanalytic Quarterly, VI (1937), 139-140.

Howard, R. W., "Fantasy and the Play Interview," Character and Personality, XIII (1944), 152-165.

Hug-Hellmuth, H. Von, "On the Techniques of Child-Analysis," International Journal of Psychoanalysis, X (1929), 287-305.

Hume, Katherine, "Counseling and Consulting: Complementary Functions," Elementary School Guidance Counseling, V (October, 1970), 3-11.

Jackson, Lydia, "Non-Speaking Children," British Journal of Medical Psychology, XXIII (1950), 87-100.

Jenkins, R. L. and E. Beckh, "Finger Puppets and Mask Making As Media for Work with Children," American Journal of Orthopsychiatry, XII (1942), 294-301.

Jerome, Alice, "From the Teacher's Notebook," Journal of American Academy of Child Psychiatry, IX (1970), 12-32.

Jessner, Lucie, Gastor Blon and S. Kaplan, "The Use of Play in Psychotherapy with Children," Journal of Nervous and Mental Disorders, CIV (1951), 175-177.

Johnson, Elizabeth, "Klopfer's Prognostic Scale Used with Raven's Progressive Matrices in Play Therapy Prognosis," Journal of Projective Techniques, XVII (1953), 320-326.

_____, "The Clinical Use of Raven's Progressive Matrices to Appraise Potential for Progress in Play Therapy: A Study of Institutionalized Mentally and Educationally Retarded Children," American Journal of Orthopsychiatry, XXIII (1953), 391-405.

Jones, John W., "Play Therapy and the Blind Child," New Outlook for the Blind, XLVI (1952), 189-197.

Kamp, L. N. and E. S. Kessler, "The World Test: Developmental Aspects of a Play Technique," Journal of Child Psychology and Psychiatry, XI (November, 1970), 113-115.

Katz, Barney, "Do Children Need Play Therapy?" Psychology in the Schools, II (May, 1965), 113-115.

Kidd, A. H. and N. Y. Walton, "Dart Throwing As a Method of Reducing Extrapunitive Aggression," Psychological Reports, XIX (1966), 88-90.

Kimmel, Mary Anne Rousseau, "The Use of Play Techniques in a Medical Setting," Social Casework, XXXIII (1952), 30-34.

King, P. and R. Ekstein, "The Search for Ego Controls: Progression of Play Activity in Psychotherapy with a Schizophrenic Child," Psychoanalytic Review, LIV (1967), 25-37.

Klein, Melanie, "Personification in the Play of Children," International Journal of Psychoanalysis, X (1929), 193-204.

_____, "The Psychoanalytic Play Technique," Mental Hygiene, XXII (1939), 49-69.

_____, "The Psychological Principles of Infant Analysis," International Journal of Psychoanalysis, VIII (1927), 25-37.

Kranz, Peter L., "Teachers As Play Therapists: An Experiment in Learning," Childhood Education, XLIX (November, 1972), 73-74.

Landisberg, S. and W. U. Snyder, "Nondirective Play Therapy," Journal of Clinical Psychology, II (1946), 203-214.

Landreth, Garry, Louise Allen and Willard S. Jacquot, "A Team Approach to Learning Disabilities," Journal of Learning Disabilities, II (1969), 24-29.

Lebo, Dell, "Age and Suitability for Nondirective Play Therapy," Journal of Genetic Psychology, LXXXIX (1956), 231-238.

_____, "A Formula for Selecting Toys for Nondirective Play Therapy," Journal of Genetic Psychology, XCII (1958), 23-24.

_____, "The Development of Play As a Form of Therapy: From Rousseau to Rogers," American Journal of Psychiatry, CXII (1958), 418-422.

_____, "The Expressive Value of Toys Recommended for Nondirective Play Therapy," Journal of Clinical Psychology, XI (April, 1955), 144-148.

_____, "The Present Status of Research on Nondirective Play Therapy," Journal of Consulting Psychology, XVII (1953), 177-183.

_____, "Quantification of the Nondirective Play Therapy Process," Journal of Genetic Psychology, LXXXVI (1955), 375-378.

_____, "The Question of Toys in Play Therapy: An International Problem," Journal of Education and Psychology, XIV (Spring, 1956), 63-73.

_____, "Theoretical Framework for Nondirective Play: Concepts from Psychoanalysis and Learning Theory," Journal of Consulting Psychology, XXII (1958), 275-279.

_____, "The Relationship of Response Categories in Play Therapy to Aggression and Age," Journal of Child Psychiatry, II (1952), 330-336.

_____ and Elaine Lebo, "Aggression and Age in Relation to Verbal Expression in Nondirective Play Therapy," Psychology Monographs, LXXI (1957), 449-461.

Lee, D. and C. Hutt, "A Playroom Designed for Filming Children: A Note," Journal of Child Psychology and Psychiatry, V (April-May, 1964), 263-265.

Lehrman, L. J., H. Sirluck, B. Black, S. Glick, and others, "Success and Failure of Treatment of Children in the Child Guidance Clinics of the Jewish Board of Guardians, Monograph of Jewish Board of Guardians Research, I (1949).

Leland, H. and D. Smith, "Unstructured Material in Play Therapy for Emotionally Disturbed Brain Damaged, Mentally Retarded Children," American Journal of Mental Deficiency, LXVI (1962), 621-628.

Leton, D. A., "The Factor Structure of Diagnostic Scores from School Play Sessions," Psychology in the Schools, III (February, 1966), 148-153.

Levin, Harry and Valerie Turgeon, "The Influence of the Mother's Presence on Children's Doll Play Aggression," Journal of Abnormal Social Psychology, LV (1957), 304-308.

_____ and E. Wardwell, "The Research Uses of Doll Play," Psychological Bulletin, LIX (1962), 27-56.

Levitt, E. E., "Psychotherapy with Children, A Further Evaluation," Behavior Research Therapy, I (1963), 45-51.

_____, "The Results of Psychotherapy with Children, An Evaluation," Journal of Consulting Psychology, XXI (1957), 189-196.

Levy, David M., "Release Therapy in Young Children," Child Study, XVI (1939), 141-143.

_____, "Trends in Therapy, III Release Therapy," American Journal of Orthopsychiatry, IX (1939), 713-736.

_____, "Use of Play Technique As an Experimental Procedure," American Journal of Orthopsychiatry, III (1933), 266-277.

Levy, John, "Relationship Therapy," American Journal of Orthopsychiatry, VIII (1938), 64-69.

Linden, James I. and Gary Stollak, "The Training of Undergraduates in Play Techniques," Journal of Clinical Psychology, XXV (1969), 213-218.

Liss, E., "Play Techniques in Child Analysis," American Journal of Orthopsychiatry, VI (1936), 17-22.

Loomis, E. A., "The Use of Checkers in Handling Certain Resistances in Child Therapy and Child Analysis," Journal of the American Psychoanalytic Association, V (1957), 130-135.

_____, L. M. Hilgeman and L. R. Meyer, "Childhood Psychosis: II, Play Patterns As Nonverbal Indices of Ego Functions: A Preliminary Report," American Journal of Orthopsychiatry, XXVII (1957), 691-700.

Lovaas, O. I., D. M. Baer, and Sidney Bijou, "Experimental Procedures for Analyzing the Interaction of Symbolic Social Stimuli and Children's Behavior," Child Development, XXXVI (March, 1965), 237-247.

_____, Gilbert Freitag, Vivian Gold and Irene Kassorla, "Recording Apparatus and Procedure for Observation of Behaviors of Children in Free Play Settings," Journal of Experimental Child Psychology, II (1965), 108-120.

Lowenfeld, Margaret, "World Pictures of Children," British Journal of Medical Psychology, XVIII (1939), 65-101.

Lynn, D. B. and R. Lynn, "The Structured Doll Play Test As a Projective Technique for Use with Children," Journal of Projective Techniques, XXIII (1959), 335-344.

McDowell, M. S. and S. R. Howe, "Creative Use of Play Materials by Preschool Children," Childhood Education, XVII (1941), 321-326.

McPherson, C. A., "The Value of Play in Meeting the Emotional Needs of Young Children in Hospital Settings," Bibliographia Pediatrics, LXXXIV (1965), 181-182.

Machler, Theodore, "Pinnocchio in the Treatment of School Phobia," Bulletin of the Menninger Clinic, XXIX (1965), 212-219.

Maisner, Edna A., "Contributions of Play Therapy Techniques to Total Rehabilitative Design in an Institution for High-Grade Mentally Deficient and Borderline Children," American Journal of Mental Deficiency, LV (1950), 235-250.

Mann, L., "Persuasive Doll Play: A Technique of Directive Psychotherapy for Use with Children," Journal of Clinical Psychology, XIII (January, 1957), 14-19.

Marshall, Helen R. and S. C. Hann, "Aspects of Experience Revealed Through Doll Play of Preschool Children," Journal of Psychology, LXI (September, 1965), 47-57.

Meeks, J. E., "Children Who Cheat at Games," Journal of American Academy of Child Psychiatry, IX (1970), 13-18.

Mehlman, Benjamin, "Group Play Therapy with Mentally Retarded Children," Journal of Abnormal Social Psychology, XLVIII (1953), 53-60.

Mehrabian, Albert, "Relationship of Attitude to Seated Posture, Orientation, and Distance," Journal of Personality and Social Psychology, X (1968), 26-30.

Mehus, Hilda, "Learning and Therapy," American Journal of Orthopsychiatry, XXIII (1953), 416-421.

Mende, Robert H. and James Kauffman, "Effects of Video-Tape Replays on Behavior of Culturally Different Children," Perceptual and Motor Skills, XXX (1971), 670-673.

Mendes, Leal and R. Maria, "Group-Analytic Play Therapy with Preadolescent Girls," International Journal of Group Psychotherapy, XVI (1966), 58-64.

Miller, Helen E., "Play Therapy for the Institutional Child," Nervous Child, VII (1948), 311-317.

_____, "Play Therapy for the Problem Child," Public Health Nurse Bulletin, XXXIX (1947), 294-296.

_____ and Dorothy Baruch, "Psychological Dynamics in Allergic Patients As Shown in Group and Individual Psychotherapy," Journal of Consulting Psychology, XII (January, 1948), 111-113.

Miyamoto, Misako, "The Meaning of Silence in Play Therapy," Psychologia, VIII (December, 1965), 191-196.

Moore, Terence, "Realism and Fantasy in Children's Play," Journal of Child Psychology and Psychiatry, V (June, 1964), 15-36.

_____ and L. E. Ucko, "Four to Six: Constructiveness and Conflict in Meeting Doll Play Problems," Journal of Child Psychology and Psychiatry, II (May, 1961), 21-47.

Moustakas, Clark E., "A Human Relations Seminar at the Merrill-Palmer School," Personnel and Guidance Journal, XXXVII (1959), 342-349.

_____, "Emotional Adjustment and the Play Therapy Process," Journal of Genetic Psychology, LXXXVI (1955), 79-99.

_____, "Situational Play Therapy with Normal Children," Journal of Consulting Psychology, XV (1951), 225-230.

_____, "The Frequency and Intensity of Negative Attitude Expressed in Play Therapy: A Comparison of Well-Adjusted and Disturbed Children," Journal of Genetic Psychology, LXXXVI (1955), 309-324.

_____ and Greta Makowsky, "Client-Centered Therapy with Parents," Journal of Consulting Psychology, XVI (1952), 338-342.

_____ and H. D. Shalock, "An Analysis of Therapist-Child Interaction in Play Therapy," Child Development, XXVI (1955), 143-147.

Moyer, Kenneth and Gilmer Von Haller, "Experimental Study of Children's Preferences and Use of Blocks in Play," Journal of Genetic Psychology, LXXXIX (1956), 3-10.

Myrick, Robert D. and William Haldin, "A Study of Play Process in Counseling," Elementary School Guidance and Counseling Journal, V (May, 1971), 225-228.

Nelson, R. C., "Elementary School Counseling with Unstructured Play Media," Personnel and Guidance Journal, XLV (1966), 24-27.

_____, "Physical Facilities for Elementary School Counseling," Personnel and Guidance Journal, XLVI (1967), 552-556.

Newell, H. Whitman, "Play Therapy in Child Psychiatry," American Journal of Orthopsychiatry, XI (1941), 245-251.

Nickols, J., "A Multi-Purpose Table for Testing and Play Therapy," Perceptual and Motor Skills, XIII (1961), 89-90.

_____, "Target Game Technique for Examination and Play Therapy Activities with Children," Perceptual and Motor Skills, XIII (1961), 83-87.

Orgun, Ibrahim, "Playroom Setting for Diagnostic Family Interviews," American Journal of Psychiatry, CXXX (May, 1973), 540-542.

Pechy, B. M., "The Direct Analysis of the Mother-Child Relationship in the Treatment of Maladjusted Children," British Journal of Medical Psychology, XXVIII (1955), 101-112.

Peck, M. L. and R. H. Stewart, "Current Practices in Selection Criteria for Group Play Therapy," Journal of Clinical Psychology, XX (1964), 146-148.

Phillips, E. L., "Parent-Child Psychotherapy: A Follow-up Study Comparing Two Techniques," Journal of Psychology, XLIX (1960), 195-202.

_____ and Margaret Johnston, "Theoretical and Clinical Aspects of Short-Term, Parent-Child Psychotherapy," Psychiatry, XVII (1954), 267-275.

Phillips, R., "Doll Play As a Function of the Realism of the Materials and the Length of the Experimental Session," Child Development, XVI (1945), 123-143.

Pintler, M. H., "Doll Play As a Function of Experimenter-Child Interaction and Initial Organization of Materials," Child Development, XVI (1945), 145-166.

Pothier, Patricia C., "Resolving Conflict Through Play Fantasy," Journal of Psychiatric Nursing and Mental Health Services, V (1967), 141-147.

Pulaski, M. A., "Play As a Function of Toy Structure and Fantasy Predisposition," Child Development, XLI (1970), 531-537.

Pumfery, P. D. and C. D. Elliott, "Play Therapy, Social Adjustment and Reading Attainment," Educational Research, XII (June, 1970), 183-193.

Rambert, M. L., "Une Nouvelle Technique en Psychoanalyse Infantile: le jeu de guignols," Rev. franc. Psychoanalysis, X (1938).

Raskin, N. J., "Play Therapy with Blind Children," New Outlook for the Blind, XL (1954), 290-292.

Rexford, Eveoleen N., "A Follow-up of Psychiatric Study of Fifty-Seven Antisocial Young Children," Mental Hygiene, XL (1956), 196-214.

Reynert, Martin I., "Play Therapy at Mooseheart," Journal of the Exceptional Child, XIII (1946), 2-9.

Richards, S. S. and E. Walff, "The Organization and Function of Play Activities in the Set-Up of a Pediatric Department: A Report of a Three Year Experiment," Mental Hygiene, XXIV (1940), 229-237.

Robinson, E. L., "Doll Play As a Function of the Doll Family Constellation," Child Development, XVII (1946), 99-119.

Rogers, Carl R., "Three Surveys of Treatment Measures Used with Children," American Journal of Orthopsychiatry, VII (1937), 48-57.

Roheim, G., "Play Analysis with Normanby Island Children," American Journal of Orthopsychiatry, XI (1941), 524-530.

Roland, Mary C., "Psychotherapeutic Aspects of Play," American Journal of Occupational Therapy, VI (1952), 8-10.

Rosenberg, B. G. and B. Sutton-Smith, "A Revised Conception of Masculine-Feminine Differences in Play Activities," Journal of Genetic Psychology, XCVI (1960), 165-170.

Rosensweig, S. and D. Shakow, "Play Technique in Schizophrenia and Other Psychoses: I, Rationale," American Journal of Orthopsychiatry, VII (1937), 32-35.

_____, "Play Technique in Schizophrenia and Other Psychoses: II, An Experimental Study of Schizophrenic Constructions with Play Materials," American Journal of Orthopsychiatry, VII (1937), 36-47.

Rothschild, Jacob, "Play Therapy with Blind Children," New Outlook for the Blind, LIV (1960), 329-333.

Rucker, I. N., "Outcome of Play Interviews Conducted by Social Workers," Smith College Studies in Social Work, XVII (1946), 128-129.

Sargent, H., "Spontaneous Doll Play of a Nine-Year-Old Boy," Journal of Consulting Psychology, VII (1943), 216-222.

Schiffer, A. L., "The Effectiveness of Group Play Therapy As Assessed by Specific Changes in a Child's Peer Relations," American Journal of Orthopsychiatry, XXXVII (1967), 219-220.

Schiffer, M., "A Therapeutic Play Group in a Public School," Mental Hygiene, XLI (1957), 185-193.

_____, "Permissiveness Versus Sanction in Activity Group Therapy," International Journal of Group Psychotherapy, II (1952), 255-261.

_____, "The Use of the Seminar in Training Teachers and Counselors As Leaders of Therapeutic Play Groups for Maladjusted Children," American Journal of Orthopsychiatry, XXX (1960), 154-165.

Sears, Pauline, "Doll Play Aggression in Normal Young Children: Influence of Sex, Age, Sibling Status, Father's Absence," Psychological Monographs, LXV (1951), 2-42.

Sears, R. R., "Influence of Methodological Factors on Doll Play Performance," Child Development, XVIII (1947), 190-197.

Seeman, Julius, "Child Therapy in Education, Some Current Trends," Education, LXXIV (1954), 493-500.

_____ and Benner Edwards, "A Therapeutic Approach to Reading Difficulties," Journal of Consulting Psychology, XVIII (1954), 451-453.

Shirley, Mary, Betty Baum and Sylvia Polsky, "Outgrowing Childhood's Problems: A Follow-up Study of Child Guidance Patients," Smith College Student Social Work, XI (1940), 31-60.

Siegel, A. W., "Adult Verbal Behavior in Play Therapy Sessions with Retarded Children," Journal of Speech and Hearing Disorders, X (1963), 34-38.

Siegel, Alberta Engvale and Lynette Gayle Kohn, "Permissiveness, Permission, and Aggressions: The Effects of Adult Presence or Absence on Aggression in Children's Play," Child Development, XXX (1959), 131-141.

Siegel, Claire Lynn Fleet, "Changes in Play Therapy Behaviors Over Time As a Function of Differing Levels of Therapist-Offered Conditions," Journal of Clinical Psychology, XXVIII (1972), 235-236.

Simpson, G., "Diagnostic Play Interviews," Understanding the Child, VII (1938), 6-10.

Smolen, Elwyn M., "Nonverbal Aspects of Therapy with Children," American Journal of Psychotherapy, XIII (1959), 872-881.

Solomon, J. C., "Active Play Therapy," American Journal of Orthopsychiatry, VIII (1938), 479-498.

_____, "Active Play Therapy, Further Experiences," American Journal of Orthopsychiatry, X (1940), 763-781.

_____, "Play Technique," American Journal of Orthopsychiatry, XVIII (1948), 402-413.

_____, "Play Technique and the Integrative Process," American Journal of Orthopsychiatry, XXV (1955), 591-600.

_____, "Play Technique As a Differential Therapeutic Medium," Nervous Child, VII (1947), 296-300.

Stephenson, P. S., "Working with Nine to Twelve Year Old Children," Child Welfare, LII (June, 1973), 375-382.

Stollak, Gary E., "The Experimental Effects of Training College Students As Play Therapists," Psychotherapy: Theory, Research and Practice, V (1968), 77-80.

Stover, Lillian and Bernard G. Guerney, "The Efficacy of Training Procedures for Mothers in Filial Therapy," Psychotherapy: Theory, Research and Practice, IV (1967), 110-115.

Styrt, J. and others, "Spontaneous Play in Resolution of Problems: A Brief Example," Mental Hygiene, XLIX (1965), 405-407.

Subotnik, Leo, "Transference in Client-Centered Play Therapy," Psychology, III (1966), 2-17.

_____ and R. J. Callahan, "A Pilot Study in Short Term Play Therapy with Institutionalized Educable Mentally Retarded Boys," American Journal of Mental Deficiency, LXIII (1959), 730-735.

Symonds, P. M., "Play Technique As a Test of Readiness," Understanding the Child, IX (1940), 8-14.

Tallman, F. F. and L. N. Goldensohn, "Play Technique," American Journal of Orthopsychiatry, XI (1941), 551-562.

Updegraff, R. and E. K. Herbst, "An Experimental Study of the Social Behavior Stimulated in Young Children by Certain Play Materials," Journal of Genetic Psychology, XXXII (1933), 372-391.

Vance, T. F. and L. T. McCall, "Children's Preferences Among Play Materials As Determined by the Method of Paired Comparison Pictures," Child Development, V (1934), 267-277.

Vittner, Donald, "Structured Puppet Play Therapy," Elementary School Guidance Counseling Journal, IV (October, 1969), 68-70.

Waterland, Jean C., "Actions Instead of Words: Play Therapy for the Young Child," Elementary School Guidance and Counseling Journal, IV (March, 1970), 180-197.

Weiss, Anni B. and A. W. Frankle, "Diagnostic and Remedial Play," Understanding the Child, VII (1938), 3-5.

_____, "Play Interviews with Nursery School Children," American Journal of Orthopsychiatry, XI (1941), 33-39.

Whitted, B. A. and R. B. Scott, "Significance of a Play Program in the Care of Children in a General Hospital," Journal of the National Medical Association, LIV (1962), 488-491.

Withall, John and A. Reddenhouse, "Child-Therapy, A Frame of Reference," Exceptional Children, XXI (1955), 122-126.

Witmer, Helen L. and Jane Keller, "Outgrowing Childhood's Problems: A Study of the Value of Child Guidance Treatment," Smith College Studies in Social Work, XIII (1942), 74-90.

Woltmann, A. G., "Concepts of Play Therapy Techniques," American Journal of Orthopsychiatry, XXV (1955), 771-783.

_____, "The Use of Puppets in Understanding Children," Mental Hygiene, XXIV (1940), 445-458.

Reports

Ganter, Grace and others, Retrieval from Limbo, The Intermediary Group Treatment of Inaccessible Children, New York, Child Welfare League of America, Inc., 1967.

Prestwich, Sheldon, "The Influence of Two Counseling Methods on the Physical and Verbal Aggression of Preschool Indian Children," Washington, D. C., Office of Economic Opportunity, August, 1969.

Publications of Learned Organizations

Bower, Eli M., Fostering Maximum Growth in Children, Washington, D. C., National Education Association, 1965.

Demaago, Joan, "Play Therapy: Client-Centered Counseling for Elementary School Children," Kalamazoo, Michigan, Western Michigan University, December, 1971.

Flint, Betty M., "The Child and the Institution: A Study of Deprivation and Recovery," Buffalo, University of Toronto, 1969.

Encyclopedia Articles

Woltmann, A. G., "Plastic Materials As a Psychotherapeutic Medium," Encyclopedia of Child Guidance, edited by R. B. Winn, New York, Philosophical Library, 1943.

Unpublished Materials

Aderhold, Elizabeth Clyde, "Doll Play Behavior As a Function of Age," unpublished doctoral dissertation, University of Georgia, Athens, Georgia, 1967.

Bucur, Raymond R., "Nondirective Group Play Therapy with Aggressive Boys," unpublished master's thesis, North Texas State University, Denton, Texas, 1970.

Clay, C. O., "A Follow-up Study of Eight Mothers and Eight Children Served by a Child Guidance Clinic of Jacksonville, Florida," unpublished master's thesis, Florida State University, Tallahassee, Florida, 1956.

Eme, Robert Francis, "Level of Experiencing As a Predictor of Short-Term Play Therapy Outcome," unpublished doctoral dissertation, Loyola University of Chicago, Chicago, Illinois, 1972.

Finke, Helene, "Changes in the Expression of Emotionalized Attitudes in Six Cases of Play Therapy," unpublished master's thesis, University of Chicago, Chicago, Illinois, 1947.

Hendricks, Shirley Jo, "A Descriptive Analysis of the Process of Client-Centered Play Therapy," unpublished doctoral dissertation, North Texas State University, Denton, Texas, 1971.

Herd, Ruby, "Behavioral Outcomes of Client-Centered Play Therapy," unpublished doctoral dissertation, North Texas State University, Denton, Texas, 1969.

Homefield, Harold Dennis, "Creative Role-Playing As Therapy for Stuttering Children, With Special Reference to the Use of Masks," unpublished doctoral dissertation, New York University, New York, New York, 1959.

Kulla, Michael, "A Therapeutic Doll Play Program with an Emotionally Disturbed Child," unpublished doctoral dissertation, University of Oklahoma, Norman, Oklahoma, 1966.

L'Abate, Luciano, "An Automated Playroom," unpublished paper read at a Workshop on Newer Approaches in Psychological Assessment Techniques, Child Development Clinic, St. Louis University School of Medicine, St. Louis, Missouri, February 29-March 1, 1968.

Levi, Aurelia, "Parent Treatment and Outcome of Child's Therapy," unpublished doctoral dissertation, Columbia University, New York, New York, 1961.

Linder, Marie A., "Verbal Conditioning of Aggression in Doll Play: Comparison of the Effect of Two Therapeutic Tools on Aggression of Nursery School Boys in a Therapy-Like Situation," unpublished doctoral dissertation, University of Minnesota, Minneapolis, Minnesota, 1967.

Pelham, Lee Edward, "Self-Directive Play Therapy with Socially Immature Kindergarten Students," unpublished doctoral dissertation, University of Northern Colorado, Greeley, Colorado, 1971.

Perkins, Marshall Joseph, "Effects of Play Therapy and Behavior Modification Approaches with Conduct Problem Boys," unpublished doctoral dissertation, University of Illinois at Urbana-Champaign, Urbana, Illinois, 1967.

Quattlebaum, Rebecca Fay, "A Study of the Effectivenesss of Nondirective Counseling and Play Therapy with Maladjusted Fifth Grade Pupils," unpublished doctoral dissertation, University of Alabama, University, Alabama, 1970.

Robinson, E. L., "The Form and the Imaginative Content of Children's Block Buildings," unpublished doctoral dissertation, University of Minnesota, Minneapolis, Minnesota, 1958.

Rogers, Mary Brown, "Therapist's Verbalizations and Outcome in Monitored Play Therapy," unpublished doctoral dissertation, Georgia State University, Atlanta, Georgia, 1972.

Schall, M. A., "A Study of the Effects of Three Anthromorphic Models on the Social Adjustment of Children," unpublished doctoral dissertation, Arizona State University, Tempe, Arizona, 1967.

Siegel, Claire Lynn Fleet, "The Effectiveness of Play Therapy with Other Modalities in the Treatment of Children with Learning Disabilities," unpublished doctoral dissertation, Boston University Graduate School, Boston, Massachusetts, 1970.

Sokoloff, Martin A., "A Comparison of Gains in Communicative Skills, Resulting from Group Play Therapy and Individual Speech Therapy, Among a Group of Non-Severely Dysarthric, Speech Handicapped Cerebral Palsied Children," unpublished doctoral dissertation, New York University, New York, New York, 1959.

West, William B., "An Investigation of the Significance of Client-Centered Play Therapy As a Counseling Technique," unpublished doctoral dissertation, North Texas State University, Denton, Texas, 1969.

Winn, Evangeline V., "The Influence of Play Therapy on Personality Change and the Consequent Effect on Reading Performance," unpublished doctoral dissertation, Michigan State University, East Lansing, Michigan, 1959.

ERIC Materials

Golden, Bobbie, "Monitored Play Therapy: Conceptual and Methodological Issues," Georgia State University, September, 1969 (ERIC ED033426).

L'Abate, Luciano, "Design for a Playroom," Georgia State University, 1969 (ERIC ED019133).

Rogers, Mary Brown, "The Processes of Monitored Play Therapy," Georgia State University, August, 1969 (ERIC ED033425).

_____ and Luciano L'Abate, "Bibliography on Play Therapy and Children's Play," Georgia State University, September, 1969 (ERIC ED035897).