AN INVESTIGATION OF LITERATURE ON PLAY THERAPY IN AN EFFORT TO DETERMINE ITS VALUE IN SPECIAL EDUCATION CLASSES

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INTRODUCTION

Play therapy is a relatively new area of the discipline of clinical psychology. Its value as a technique for understanding a child has been widely explored and tested over a period of thirty-five years. Its emphasis centers about what a child can do as anxieties are stirred in him and how he can acquire, through the use of his natural tools of expression, attitudes about himself and his relations with others that will free him from these disorganized feelings.

THE PROBLEM

Statement of the problem. It is the purpose of this report to present an investigation of the literature in an attempt to determine the value of play as a technique for understanding the emotionally disturbed child and as a tool for the other special education teachers in preschool and primary grades.

One of the major objectives of elementary education is to further the total development of a healthy personality. If play therapy is a realistic means of helping the educationally disadvantaged child grow in terms of self control and feelings of security, then its possible use by or in connection with the special education program should be investigated.

Limitations of the study. To begin this study, an investigation of the literature in the Kansas State University Library was conducted. The investigation produced a quantity of material relating to the

technique of play therapy; however materials pertaining to its function as a tool in specific categories of special education were limited. Some of these were available through the University of Kansas Library.

Only those materials pertaining to the problem at hand were used.

DEFINITIONS OF TERMS USED

Play. The term play, as it is used in this paper, applies to activities of children that are spontaneous and self-generating, that are ends in themselves, and that are unrelated to "lessons" or to the normal physiological needs of the child; activities which take place within a defined area and are observed by a therapist or other trained personnel.

Transference. Since the term transference is meant to be a psychoanalytic concept, transference shall be interpreted as follows. When a patient recounts free associations, he soon speaks of events or fantasies of vital interest to himself and when these are told, the listener is gradually invested with the emotion which accompanies them. The feelings toward the listener, more and more are those felt toward the people the patient is talking about. Transferency lends itself for conscious, scientific utilization of a dynamic force, and particularly the analysis of its unconscious sources.

Therapeutic. The therapeutic process occurs as a unique growth experience, created by one person seeking and needing help from another who accepts the responsibility of offering it. This basic structure characterizes each potentially therapeutic setting irrespective of methods or techniques employed or whether it is a child or adult who seeks assistance.

RESULTS OF THE INVESTIGATION OF LITERATURE

Much has been written in regard to the treatment of emotionally disturbed children by the therapeutic process of play therapy. If play therapy is to become a useful technique in the field of special education, then it is important to develop an understanding of its beginnings, the various approaches, and the equipment necessary. Only a brief summary of work done by leaders in the field will be presented here.

THE THERAPEUTIC PROCESS

Development of the Technique of Play Therapy

The first person to advocate studying the play of children in order to understand and educate them was Rousseau. He recognized that childhood was a period of growth and found great value in the games of childhood. However, references to play and games of childhood were more in line with educative or training purposes than in accord with the modern therapeutic use of play, in which child psychiatrists of today concern themselves.[1] It is this kind of play that Leo Kanner is speaking of when he states, "The self expressive nature of play has suggested its use for the combined purposes of revealing a child's

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[1]D. Lebo, "The Development of Play as a Form of Therapy," American Journal of Psychiatry, XII (1955), p. 143.

approach to reality via the quasi-reality of his own creation."[1]

While psychoanalysis was employed with adult subjects, little was done with children prior to 1919 because of the difficulties of utilizing free association as it is achieved in adults. Even if they were able to establish a feeling of warmth and friendliness in the child, they found him frequently unable to put his anxieties into words. Play therapy furnished direct access to the child's unconscious; therefore spontaneous play activity was substituted for free association. A generous supply of toys was offered the child and these could be used in any way he wished during the analytic period of time. The child's conversation and actions with toys were regarded as being equivalent to an adult's wandering free associations.[2]

Melanie Klein formulated psychological principles of infant analysis in 1927. She regarded the child's super-ego as highly developed at age six and emphasized the necessity of making immediate interpretation to the child. In contrast to another pioneer in the field, Anna Freud, Klein did not feel that it was important for an emotional relationship to exist between the analyst and the child. It would be difficult to describe her psychoanalytic theory of child's play acting, but it will suffice to say that it embraces the belief that most play activities of the emotionally disturbed child have a symbolic significance for the coitus between the parents. She believes that her technique tends to strengthen the child's ego. Accordingly she places a strong emphasis

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[1]Leo Kanner, Child Psychiatry (Springfield, Illinois: Charles C. Thomas Company, 1957), p. 231.

[2]C. E. Moustakas, Children in Play Therapy. (New York: McGraw-Hill Book Company, Inc., 1953), p. 1.

upon early insistent interpretation of the child's play in psychosexual terms.[1]

Leo Kanner, in criticizing Klein's technique stated:

> The fallacy of this type of use of play lies in the assumption that the same performance has the same meaning to every child, that the patient's participation is not needed in interpreting his activities, and that merely telling him what his play symbolized to the interpreter constituted somehow a significant therapeutic procedure.[2]

Child factors other than the actual acting out of a situation were implicated by a more recent writer, Terence Moore, who stressed the importance of taking full note of facial expressions, gesture, and tone of voice in interpreting play activities. He concluded, "When a child draws parallels between the dolls and his own family, some measure of identification can be assumed."[3]

Play therapy may be structured in form--that is, the therapist may assume responsibility for guidance and interpretation or it may be non-directive (unstructured). The therapist then leaves the responsibility and direction to the child.[4]

Structured Approach

This approach was referred to as structured, directive, or situational depending upon the writer. These terms vary slightly in meaning but all

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[1]Melanie Klein, "The Psychoanalytic Play Technique," American Journal of Orthopsychiatry, XXV (April, 1955), pp. 223-236.

[2]Kanner, op. cit., pp. 231-232.

[3]Moore, Terence, "Realism and Fantasy in Children's Play," Journal of Child Psychology and Psychiatry, (June, 1964), p. 3.

[4]Virginia Axline, Play Therapy (Boston: Houghton Mifflin Company, 1947), p. 9.

fit into the category of Structured Play Therapy. The therapist, familiar with the disturbing elements in the child's life, set the stage for play, gave the child toys, and asked him to act out what would happen.

Klein believed that structuring is a very important process during the early phases of play therapy. It involves introducing the child to the playroom and creating a warm permissive relationship. It is partly through structuring that the therapist conveys attitudes of faith, respect and acceptance to the child.[1]

Newell expressed his ideas about situational play therapy as follows:

> I know of no other method of examining or interviewing a child which offers quicker insight into mental mechanisms or which gives clues more rapidly regarding the child's unconscious. It is truly amazing how readily a child hiding behind the anonymity of a doll will tell of death wishes toward a parent. or sibling, of Oedipus wishes, as well as about masturbatory activities, castration anxieties and the many forms of infantile primitive sex theories. This method is thus a short cut to insight which eliminates the necessity for building up a transference---Another important use is to treat specific symptoms, preferably those of short duration. No other method can so quickly desensitize a child to a specific fear. To make this use of controlled play it is important to obtain a careful history, to uncover, if possible--the specific events that precipitated the fear reaction.[2]

Situational play therapy need not be a fixed technique, but an opportunity for the child to express himself and at the same time reveal to himself the role which he has played in his illness. This is accomplished by providing an opportunity for the child to speak for each of a number of dolls, and simultaneously to view all that is going on while

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[1]Klein, op. cit., pp. 223-237.

[2]H. W. Newell, "Play Therapy in Child Psychiatry," American Journal of Orthopsychiatry, XI (1941), pp. 245-251.

he is participating in an intimate discussion of his own attitudes. It is not he who is envious or hates, but the doll character. Therefore he can give an account of the motives and imaginations which may explain the doll's behavior and consequently his own. Toy furniture and dolls representing various characters (himself, parents, teachers, siblings, etc.) are used during the play interview and various scenes are arranged by the therapist as a miniature stage.[1]

It was pointed out by Gove Hambidge of the University of Maine that the difference in technique depends on the nature of the therapist's activity during the sessions with the child. For instance, the therapist acts to focus attentions, to stimulate future activity, to give approval, to gain information or to interpret or set limits.

The structural play situation is used as a stimulus to facilitate the independent, creative, free play of the child in treatment. Lack of adequate facilities may vitiate the advantages of using play therapy. Since the child's own selection is an important and significant element in treatment, play therapy should not be conducted with limited materials.[2]

The therapist introduces structured play when the therapeutic relationship has developed to a point where there will be neither anxiety nor acting out to an extent that would disrupt treatment. Anyone who is to use structured play must possess self-assurance in his ability to handle this form of treatment. This comes only with repeated experience and practice.

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[1]L. H. Conn, "The Child Reveals Himself Through Play," Mental Hygiene, XXIII (January, 1937), pp. 49-69.

[2]Hambidge; Gove, "Therapeutic Play Techniques," American Journal of Orthopsychiatry, XXV (1955), pp. 601-616.

Once structured play has been introduced to the child, Hambidge says:

> The ideal of the play therapist is to facilitate play, not to enter into play. He is a shifter of scenes. The consequence which arises from breaking the rule of the passive role of the therapist is that he may be seduced into going too far. He should keep out of the play except in order to facilitate it, in spite of the fact that the child, for the purposes of his own defenses, will try to draw him into it.[1]

In answer to questions concerning how many plays must be used in the treatment of a particular child, he stated:

> Let me repeat that the selection of structured play is not rigid. For example, if no problem arises about the birth of a baby, that play form is not used. In fact no play form is introduced unless there is prior evidence that its use will have direct bearing upon the resolution of the problems for which the child's treatment was undertaken.[2]

Non-Directive Approach

This unstructured form is based upon the assumption that the individual has within himself, not only the ability to solve his own problem satisfactorily, but also the growth impulse that makes mature behavior more satisfying than immature behavior. There are a variety of approaches that have been found effective. These approaches differ in their philosophies and in their theories of personality dynamics. They are similar in that they contain human values which the therapist attempts to communicate.[3]

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[1] Ibid., pp. 603-616.

[2] Ibid., p. 612.

[3] Elaine Dorfman, Client Centered Therapy (Boston: Houghton Mifflin Company, 1951), p. 95.

Although techniques, tools and methods play a large part in therapy, the values of the therapist pervade the relationship and to a large degree, determine its therapeutic effectiveness. The child is given complete freedom in his choice of toys and in setting his own stage for play. In this approach the therapist is an observer, watching what the child does. He may enter into the play on the request of the child, taking whatever part the child designs.[1]

Virginia Axline, in her book--Play Therapy--is concerned with the non-directive or unstructured type of play therapy. She states:

> "Play therapy is the opportunity that is offered a child to experience growth under most favorable conditions. By playing out his accumulated feelings of insecurity, aggression, fear and confusion he brings these feelings to the surface, faces them, learns to control them or abandons them."[2]

It is her belief that in the security of the playroom the child feels that he can look at himself squarely; he can test out his ideas; he can express himself fully; for this is his world, and he no longer has to compete with such other forces as adult authority or rival contemporaries or situations where he is the butt of someone else's frustrations. Here he is treated with dignity and respect.

It is a unique experience for a child suddenly to find adult suggestions, mandates, rebukes, restraints, criticisms, disapprovals and intrusions gone. These are all replaced by complete acceptance and permissiveness to be himself. The child is often bewildered during his first play session. After he has tried out rather timidly, he becomes more bold and is no longer blocked by exterior forces and can respond to the

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[1]Ibid., p. 95.

[2]Axline, op. cit., p. 16.

drive for growth within himself. As the therapist reflects his attitudes she also conveys a feeling of acceptance, thus giving him courage to go deeper and deeper into his innermost world and bring out into the open his real self.[1]

The initial steps of non-directive play therapy were described by Rogerson:

> A room was set aside for a certain period each week as an individual playroom. The room was equipped with a canvas mat on the floor, it had a supply of sand, running water and plenty of simple toys. The child was seen in this room alone. He was shown the toys and was told that this was a room to which he could come once a week. He could make as much noise as he liked, and in fact do anything except break the windows or lights. It was also explained to him that other children came to this room at other times, and sometimes when they were nervous or angry, or afraid, they told the doctor about it and then perhaps they felt better.[2]

Play provides the child with an opportunity to act out his fantasies and conflicts. "This cathartic effect," Newell wrote, "might as accurately be called the desensitizing effect." In play the child attempts to deal with his fears and fantasies regarding birth, death, sex, and hostility. Death to a child can seem to be a reversible process. People whom he kills in play can easily be brought back to life. Often an hour seems to complete a cycle of activity. Children select a problem to work on, carry it to a climax and then announce they are through.[3]

It is the same inner drive toward self-realization, maturity, fulfillment, and independence that also creates those conditions which we call maladjustment, which seems to be either an aggressive determination

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[1] Ibid., pp. 16-17.

[2] C. H. Rogerson, Play Therapy in Childhood, (London: Oxford University Press 1939), p. 18.

[3] Newell, op. cit., pp. 245-251.

on the part of the child to be himself by one means or another or a strong resistance to the blocking of his complete self-expression. For instance, when a child is scorned by his parents and teachers and friends because his attitude and behavior have made him unacceptable to them, then he may be determined to maintain his way before them, though they slay him. He will fight them, sulk, defy them, and in his complete frustration and conflict, he will weep with despair. He is fighting for maturity, independence, and a right to be himself. Through non-directive play therapy, the child is given an opportunity to channel this inner growth into a constructive and positive way of life. He is often capable of solving his own problems, making his own choices, and taking the responsibility for himself in many more ways.[1]

In defense of non-directive play therapy, Virginia Axline points out:

> The toys implement the process because they are definitely the child's medium of expression. They are the materials that are generally conceded to be the child's property. His free play is an expression of what he wants to do. He can order this world of his. That is why the non-directive therapist does not direct the play in any way.[2]

When the child plays freely without direction, he is expressing his personality and experiencing a period of independent thought and action. He is releasing the feelings and attitudes that have been pushing to get out into the open.

> That is why it does not seem to be necessary for the child to be aware that he has a problem before he can benefit from the therapy session. Many a child has utilized the therapy experience and has emerged from the experience

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[1]Axline, op. cit., pp. 75-76.

[2]Axline, op. cit., 22-23.

> with visible signs of more mature attitudes and behavior and still has not been aware that this was any more than a free play period.[1]

In comparing non-directive play therapy with structured play therapy, Kanner states:

> Non-directive play therapy takes a considerably longer time than the situational method, but it has its decided rewards in deeply neurotic conditions of long standing, in problems created by disturbed family relationships and in instances of profound hostility with severe guilty feelings and anxiety.[2]

The Play Room and Suggested Materials

Many types of rooms were described in the literature. In the beginning, Klein used play in the room of the child as a technique. She felt the child would relate better in an environment with which he was most familiar. After experimentation she came to the conclusion that the child would relate much better outside the home in a setting that was geared for play. Two things influenced this decision. First, the mother's attitude, which often was negative, and secondly, the knowledge that transference can be established and maintained only if the patient can feel that the consulting room or playroom is something separate from his ordinary home life. "For only under such conditions is he able to overcome his own resistances against experiencing and expressing thoughts, feelings and desires which are incompatible with conventions, and in the case of children, thought to be in contrast to much of what they have been taught."[3]

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[1] Ibid.

[2] Kanner, op. cit., p. 223.

[3] Klein, op. cit., p. 223.

It seemed to be agreed that the room itself should be kept as simple as possible. The floor should be washable. With the exception of basic furniture such as a few chairs, a table, a sofa, cushions and a chest of drawers, and a sink, the only things which should be there are toys. They should be of the type that would instill the child to use his imagination as much as possible to reveal his emotional needs, and still be simple, small and non-mechanical. The tools employed include almost all types of toys, psychodrama, drawing, fingerpaintings, clay and music.[1]

It was emphasized that the type of toy used in therapy is not really important. "It is far more important that it be something that will motivate the child to structure as well as endow the materials with conceptual and functional content." The toys should be inexpensive, for during acts of aggression it is not uncommon for the child to break the toy.[2]

One of the basic factors reported in the literature was that toys used with each child should be within the realm of his play. A child should not be exposed to toys that are too old for him because he would not be able to express his true emotions through them.

The doll family was considered to be the best means of getting the child to express his true feelings about his home situation. In recent research done by Terence Moore the value of doll play was reinforced.[3]

Dolls and household toys allow many children a chance for imaginative

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[1]Lauretta Bender, Child Psychiatry Techniques, (Springfield, Illinois: Charles C. Thomas, 1952), p. 32.

[2]Ibid., p. 3.

[3]Frederick Allen, Psychotherapy with Children (New York: W. W. Norton and Company, 1942), p. 143.

play that introduces the elements of relationship. This permits the dramatization of a part of the self which is sometimes hard to integrate into a healthy whole. "A doll or a nursery bottle is frequently used by children to represent the baby side of themselves. Such materials are used by children to externalize themselves in roles closely related to unacceptable aspects of themselves. For example, a child with enuresis may first create the problem in the "dydee" doll and then proceed to punish and correct the doll for this behavior."[1]

Paints and finger paints were found to be most valuable materials, particularly finger paints. This medium allows a child unusually wide scope for his movements. Children can put into a painting the feeling that cannot be given a verbal expression.

Running water is a must in the playroom, for many of the child's activities are carried out around the basin which is equipped with bowls, tumblers and spoons. "The repetitious and somewhat monotonous nature of water play, together with the soft and yielding quality of the material may account for its relaxing effect on tense and overactive children."[2]

"The emotional implications of clay depend upon the needs brought to it."[3] It seems to offer the best outlet for aggressive impulses of all the materials available to children. It is an outlet for forbidden interests having to do with sex parts and body functions. It adapts

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[1] Ibid., p. 142.

[2] L. K. Frank, Understanding Children's Play, (New York: Columbia University Press 1952), p. 174.

[3] Ibid., p. 13.

itself well to fantasy expressions and is used for this purpose both by troubled children and by those whose development seems to be running smoothly. "It offers, in a word, an unexcelled medium both for destruction without guilt and for construction with satisfaction."[1]

The aggressive feelings commonly encountered in therapeutic work with negative and anxious children require materials that externalize and objectify these feelings in a play medium. Soldiers, toy guns, and similar toys offer material for aggressive expression and enable children to be more daring with their feelings than otherwise possible. "Children, with inadequate feelings of their power and fearful of what others can or might do to them, find the toys associated with fight and aggression the reinforcements they need."[2]

Beiser advanced some ideas about storage of toys. He stated:

> In outlying clinics, play interviews may be held in offices ordinarily used for other purposes, and toys kept in a bookcase, or closet than can be opened when the child is seen. In the headquarter clinic in Chicago special rooms are set aside for play interviews. Each room contains a table, chair, sandbox, dollhouse, tool bench, and clean-up equipment. To such a room each examiner brings a box containing a doll family and structured materials. Each child is provided by the therapist with his own toy box which is kept for him alone as long as treatment continues. Items are added or removed with the changing needs of the child.[3]

Authors seem to agree on the importance of using the same room each time a child has his interviews, as the actual setting comes to take on considerable importance for a child. The therapist, the room with its

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[1] Ibid., p. 204.

[2] Ibid., p. 199.

[3] H. R. Beiser, "Play Equipment," American Journal of Orthopsychiatry, XXV (1955), p. 762.

materials and furniture, and the child who comes to it are the three facets of this experience that are interrelated. The therapist and the room provide a steady background which the child can move and change.[1]

THE BEGINNING PHASE OF THERAPY

Diagnosis

When parents bring a child because they are bothered about his behavior, they begin by naming the symptoms which bother them. They often assume that the symptoms are the difficulty which requires treatment. In spite of this fallacy, the symptoms serve a number of important and closely interrelated functions.

The symptom is not the problem; it merely indicates that there is a problem to be studied and it is left to the therapist to search for the seat of the trouble and deal with it after it has been discovered.

A child never comes to the therapist alone. He is always brought by someone, usually his mother. The story of the child's difficulty is not a statement of that which bothers the child. It represents the adult's report and evaluation of that which bothers him about the child. The complaint provides a title, a heading, and contains the message that someone is bothered by the child's problem.[2]

In regard to parent involvement, Solomon noted:

> Many children who show emotional problems do not respond completely to the direct approach unless the attitude within the home becomes disturbing. Some workers have abandoned efforts at direct therapy and have concentrated on the parental neurosis. Ideally

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[1]Axline, op. cit., p. 69.

[2]Kanner, op. cit., p. 181.

works with both child and parent constitutes the method of choice.[1]

Axline feels that while parents or parent substitutes often are an aggravating factor in the case of a maladjusted child, and while therapy might move ahead faster if the adult were also receiving therapy or counseling, it is not necessary for the adults to be helped in order to ensure successful play therapy results.

It seems as though insight and self-understanding gained by children brings about more adequate ways of coping with their situations, and since the tensions ease, this in turn brings about certain changes in adults. If the child becomes more responsible and more mature, then the adult feels less irritation and less need to nag the child.

The therapist's first task is one of listening, but he uses more than his ears. Gestures give an indication of ease or tension, fond acceptance or resentment of the child, attitudes, beliefs and assumptions. It must be remembered that the child, when he enters the office, does so after some sort of preparation at home. He may have been given the impression that this step connotes an act of parental desperation. A child's complaint often differs from the parent's complaint. On the whole, few children start out with a verbal complaint unless they are forced to. This initial attitude tells much more than the acknowledgement of symptoms. He expresses his complaints through tension, suspiciousness, obstinacy, apprehensiveness, restlessness, affection, boisterousness, angelic exaggerated poise, or apparent boredom. A child's

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[1]Joseph C. Solomon, M. C., "Therapeutic Play Techniques," American Journal of Orthopsychiatry, XXV, (1955), p. 591.

contrariness should never be misinterpreted critically as lack of cooperation; it is as much a part of his way of introducing the complaint as anything that he may say with words.[1]

According to Bender, the first task for any child psychiatrist is to know the child who comes to him, his cultural background, the specific family problems important in the child's lifetime, the educational theories and techniques to which the child is exposed, his own group and interpersonal relationships. Then he must know how to evaluate the biological data on the child. He must know the child's intellectual level with any special disabilities and their meaning in the total picture. It is also necessary to evaluate discrepancies in function and what they mean and be able to compare them through a battery of test situations in order to get a pattern or profile of functioning. The child's personality development and any discrepancies with other maturational functions, his fantasy life, handling of anxiety, identifications, striving and goals--all must be understood. Any deviation at any point must be traced through the total personality to seek out syndromes which may lead to a specific diagnosis, implying a course of treatment, an outcome, and a specific treatment program. She further states:

> Diagnosis must be further checked with therapeutic tests and the final evaluation made in terms of the child's needs for treatment and his ability to use the treatment procedures available.[2]

The diagnosis is an important intermediate step between examination and treatment, according to Kanner. He states that efforts are now

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[1]Kanner, op. cit., p. 185.

[2]Laurette Bender, Child Psychiatric Techniques, (Springfield, Illinois: Charles C. Thomas, Publisher, 1952), p. 30.

underway to turn from symptom diagnosis and behavior pattern diagnosis to formulations which would indicate both the type of reaction and the motivating factors. The essential distinguishing criteria are neurotic difficulties and those that are immediate and rather obvious reactions to adverse circumstances. Although this distinction is very general in its scope, it gives an excellent diagnosis of two large categories, but not one which contains distinguishing features between individuals in each category. It would be impossible to have terms as concise as medical terms. "Neurosis," "behavior disorder," or "delinquency" do not even have the problem in clear focus. In contrast, Kanner would consider these four statements:

1. Restlessness and aggressiveness in an unwanted pre-school child driven incessantly by perfectionistic parents.

2. Preadolescent withdrawal after a brutal struggle to please a stern, nonapproving father.

3. Obsessiveness developed under the impact of coercive habit training.

4. Ostentatious delinquency for a child anxious to get away from drabness and domestic mistreatment.

Such statements make it unnecessary to grope for a one-word diagnosis. They are individualized enough to present a specific child and general enough to present a dynamic pattern.[1]

Some of the devices used in making the diagnosis are: electroencephalography, intelligence testing, and personality testing. The use of projective methods in which the child reports the contents of a dream, tells of a recurrent day-dream fantasy, or is asked to make

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[1]Kanner, op. cit., pp. 205-223.

three wishes the fulfillment of which would make him happier. Other methods start with wholly unstructured material. The child is led to a room where there are toys and he is asked to play with them, is given paper and crayons with which he may draw, is offered clay which he is to mold, or dips his fingers into paint and proceeds from there.[1]

Child-Therapist Relations

The establishment of rapport is regarded as an indispensable preliminary by all therapists. In spite of the fact that therapists approach this problem in a variety of ways, there are terms which are common to all. Among them are permissiveness, understanding, apathy, acceptance, warmth, and friendliness. Kanner states:

> It is the therapist's job to help the child sense acceptance and permissiveness. This may be accomplished by answering his questions--The underlying principle of this is that restrictive attitude is more likely to result in aggressiveness than a permissive attitude. The child eventually will come over to the desk on his own accord and respond in a well-mannered fashion.[2]

The feeling of acceptance is threatened if the therapist in any way threatens or disapproves or if he rewards and approves. A child who is rewarded or approved may tend to limit himself to those actions and expressions which bring favor and not accept his own inner feelings that are in conflict or that are opposed to the approved feelings. Criticism produces similar results.[3]

The natural laws of the physical world and the prohibitions of

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[1] Ibid., pp. 223-224.

[2] Ibid., p. 187-189.

[3] Axline, op. cit., p. 621.

culture force the child to supplement his direct approach to life with fantasy, where no problem is too difficult to solve and no forbidden sexual or aggressive impulse impossible to experience either in direct or symbolic form. The symbolic form of fantasy can thus be seen to serve simultaneously the dual purpose of fulfillment and protection. The job of the therapist is to redirect this fantasy toward approved goals, thus utilizing it ultimately as a constructive approach to reality.[1]

There needs to be sensitive communication between the therapist and the child. The communication seems to be more often a verbal than a non-verbal one. If the therapist hopes to help the child develop an honest awareness of his emotions, she will attempt to respond with sensitivity to the child's emotional expressions by a reflection of his expressed feelings, by simple acceptance of what the child says or does, by the manner in which he listens to the child, by the extent to which he is able to get right into the child's frame of reference. "Too much insistence on finding out everything may result in breakdown of communication and rapport."[2]

During the early phases of play therapy, structuring is a very important process. It involves introducing the child to the playroom and creating a warm permissive relationship. It is partly through structuring that the therapist conveys attitudes of faith, acceptance, and respect to the child. Structuring also assists the child in gaining impressions of the quality of the therapeutic relationship.[3]

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[1]Bender, op. cit., pp. 187-189.

[2]Virginia Axline, "Therapeutic Play Techniques, Procedures and Results," American Journal of Orthopsychiatry, (1955), XXV, p. 621.

[3]Moustakas, op. cit., p. 14.

In the beginning, the child is told about the play material that is available for his use. Whether he decides to play or not, and with what materials, is much less important than the fact that there is choice as to what he will or will not do. He may dodge that responsibility and put it back on the therapist by asking: "What shall I do?" That may be a part of the child's timidity about taking any liberties in this strange place, or it may be the first evidence of a struggle to make the therapist carry a responsibility he will not assume for himself. Some children rush to the toy shelf and start playing at once, without any preliminary explanations, and thus try to shut themselves away from the potential dangers of this new situation. Others immediately find in play a medium for expressing the feeling that has been roused by this new experience. Some may do this in direct conversation, Allen pointed out. He further states:

> As the therapist becomes concerned with the various uses the child makes of play material to establish himself in therapeutic relationship, he will be less concerned with the particular play activity chosen. He can help the child use the medium of his own spontaneous choice to experience and to share the feelings that have been aroused, and to take his first steps toward an organized and meaningful expression of himself in this new situation.[1]

While the non-directive therapist's role seems to be one of passivity, that is far from the actuality. There is no severer discipline than to maintain the completely accepting attitude and refrain at all times from injecting any directive suggestions or insinuations into the play of the child. To remain alert to catch and reflect accurately the feelings the child is expressing in his play or in his conversation

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[1]Allen, op. cit., p. 127.

calls for a complete participation during the entire hour that the therapy is in session.

It is necessary for successful therapy for the child to have a feeling of confidence in the therapist. Care must be taken to avoid extreme relations one way or another. A show of too much affection, too much concern, can easily smother the therapy and create new problems for the child. The crutches of a supportive relationship are just another thing that the child must get rid of before he is "free."[1]

Some children are brought for therapy because they are being faced with a disturbing new family experience which they perceived as threatening to themselves. Normal children who experience such catastrophies as fires and floods, or who have accidents or illnesses, or who are subjected to such family crises as divorce and death often show confusion, hostility, uncontrollable aggression, hate, and anxiety. The arrival of a new baby in the family is one of the commonest sources of such a disturbance in the child's behavior. To all children such an event brings a period of stress, for however stable, well organized, and rooted in positive emotions the family relationships may be faced with a difficult adjustment to the new situation.

These children who come for situational play therapy ordinarily establish a relationship with the therapist quickly, express their feelings earlier than disturbed children, and are direct in their expressions of attitudes about themselves and others. Therefore children coming for situational play therapy are able to make almost immediate

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[1]Virginia Axline, Play Therapy, (Boston: Houghton Mifflin Company, 1947), p. 66.

use of the therapeutic situation to express and explore tense and insecure attitudes. Often the threatening emotions are worked out in three or four play sessions.[1]

Some of the situations and experiences the child may show by his play are feelings of frustration and being rejected, jealousy of both father and mother, or of brothers and sisters, the aggressiveness accompanying such jealousy, the pleasure of having a playmate or ally against the parents and the feeling of love and hatred toward a newborn baby or one who is expected, as well as the ensuing anxiety, guilt and urge to make reparation. The child's play often reveals actual experiences and details of everyday life, often interwoven with fantasies.[2]

Aggressiveness is expressed in various ways in the child's play. Often a toy is broken, or when a child is more aggressive attacks are made with knife or scissors on the table or pieces of wood. It is essential to enable the child to bring out his aggressiveness, but what counts most is to understand why, in this particular moment in the transference situation destructive impulses come up and to observe their consequences in the child's mind. Feelings of guilt may very soon follow.

Sometimes it can be gathered from the child's behavior toward the psychoanalyst that not only guilt, but also persecutory anxiety has led up to his destructive impulses and he is afraid of retaliation.[3]

A child's attitude toward a toy he has damaged is very revealing. He often puts aside such a toy, representing for instance a sibling or

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[1]Moustakas, op. cit., pp. 42-43.

[2]Klein, op. cit., p. 230.

[3]Ibid., p. 227.

a parent and ignores it for a time. When he again seeks this toy it is often to make reprimands. When this happens it is usually noticeable that a change in the child's relation to the particular sibling for whom the toy stood, has occurred. This implies that the therapist should not show disapproval of the child's having broken a toy.[1]

Woltman implied that play has value to the child, even though there are certain phases of it which the therapist is unable to interpret when he stated:

> The child himself gets a good deal of satisfaction out of being able to play what he wants and how he wants. Watching the child and his play activities, and trying to decipher the real meaning of his activities, is a sign of mature professional responsibility. Therapy, in any shape of form, is a two-way street. The child's ability to structure a play situation and to "live out" many of his inner feelings, vague perceptions and conflicts, has a decided cathartic value for him, even though the real meaning of a particular play situation may not be immediately clear to the therapist.[2]

It takes a long time for a child to organize his experiences, to fit people, objects and events into categories and concepts familiar to adults. But in play he can manipulate, organize, and rearrange his smaller world of toys and materials and, if given the time, materials and opportunity to experiment in his own way, he finds himself; rights himself when he has gone astray; and gradually learns how to get along with himself and with others in a large complex world.[3]

Through verbalizing and interpreting the productions of a child there is afforded a medium for mastering his difficulties.

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[1] Ibid., p. 228.

[2] A. G. Woltman, American Journal of Orthopsychiatry, XXV, (1955), p. 772.

[3] Frank, op. cit., p. 116.

Since the therapist will find it very helpful to take notes on the activities and conversations that take place in the playroom, the necessary material must be at hand. The therapist will find that a critical evaluation of the written account of each session will improve his or her skill in handling the various problems that occur in the playroom, in developing insight into children's behavior and in becoming more sensitive to the feelings and attitudes that the children express in their play. The therapist must be a person who can and will accept the eight basic principles which govern all her contacts with the child. The principles are as follows:

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 feelings 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.[1]

The law of readiness operates in the therapy session. When a child is ready to express his feelings in the presence of the therapist, he will do so. He cannot be hurried into it. If the therapist feels that the child has a certain problem and she wants to attack the problem as soon as possible, she must remember that what she feels is not important. If the child has a problem, he will bring it out when he is ready.[2]

THE ENDING PHASE OF THERAPY

A Gradual Process

If the therapist thinks the child is not making any progress during weeks of therapy sessions, she should examine and reexamine her notes to see if she can spot something that has caused resistance to the therapy. She must remember that change is a gradual process and some children move at a snail's pace. She must also remember that therapy does not always bring about the desired results. The conditions which created the maladjustment may still be operating. The intrusion of a probing technique is dangerous and unreliable. It might not do any obvious harm to the therapy, but there is a very real danger that it might cause retreat and destruction of rapport.

The child's emotional problems and symptoms are reflections of his attitudes, and as the attitudes change, the problems and symptoms disappear. It must be remembered that these levels of the process and the changes in feeling tones are not distinct entities or even always

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[1]Axline, op. cit., pp. 67-75.

[2]Axline, op. cit., pp. 127-128.

definitely observable. They occur in the child's play and in his emotional behavior, not step by step, but in individually varying sequences. The levels overlap at many points, yet they are definite sequences of the process which can be seen and analyzed. Moustakas summerizes:

> The therapeutic process does not automatically occur in a play situation. It becomes possible in a therapeutic relationship where the therapist responds in constant sensitivity to the child's feelings, accepts the child's attitudes, and conveys a consistent and sincere belief in the child and respect for him.[1]

The Development of a More Responsible Self

Children use the therapeutic experience to relive past periods of their development which failed to give the satisfaction necessary to enable them to move on to more mature periods. One child may have to be the infant again in the play experience before he can go on to a more creative use of the more mature self which a therapist can help him find. The therapist can help him do that if he is firmly oriented to the growth-inducing values of the immediate experience. Then he can start where the child is, in feeling, and assist him to grow from that point. The ending of therapy then can be what it should be, the affirmation of a more responsible feeling about the self, gained in the differentiating steps of the relationship which the therapist has enabled the child to establish. Moustakas concludes:

> Therapy is an awakening process, but if the waking up is not in the world of immediate reality of people and events, it is not a waking up but a new medium to continue a dream existence.[2]

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[1]Moustakas, op. cit., p. 9.

[2]Moustakas, op. cit., p. 9.

Ending is part of the growth process that is initiated in the first hours of a therapeutic experience. In order that this phase of therapy shall acquire its full meaning for the child it must be brought in relation with a plan that clearly defines what the child is ready to do. When, the child has reached a point where both he and the therapist are aware of his readiness to bring their relationship to a close a plan for effecting this is discussed between them. The ending phase becomes the more open and organized recognition by child and therapist of the progress made thus far.

The parent takes an active part in making an ending plan, and in their living through the final series of interviews, many reactions appear which give evidence of the fact that this is a stirring period for both child and parent. Some of the symptoms which have disappeared during the course of the therapeutic process may temporarily reappear as the child begins to assume responsibility for ending. To postpone the ending and fail to sense the meaning of these responses is a major error which may jeopardize the values that have emerged in the therapy by forcing the child to end negatively.

If the child can say in his final hours of therapy, "I don't want to stop coming," yet can go ahead with his plans to end the treatment, he is giving his feelings the partial expression so essential in normal living. The important emphasis on ending is that it is a gradual process and not merely the date of the final appointment. Allen added this note:

> No therapeutic experience can provide a patient with a paid-up insurance policy against future difficulties although the anxiety centering about ending may activate the patient's need to have such assurance.[1]

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[1]Allen, op. cit., pp. 268-273.

Hambidge stated:

> The goals are determined by the therapist's clinical judgement of the treatment necessary to resolve the conflicts which produce the disordered behavior for which the patient was referred. This is checked empirically during the course of treatment, so that the patient is discharged at the point of optimum therapeutic benefit. If treatment continues beyond this point the patient may suffer from overtreatment, and the therapist does not learn what the child is capable of doing on his own after the original objectives have been reached. The proof of progress in this field comes from good follow-up study.[1]

IMPLICATIONS FOR SPECIAL EDUCATION

Play Therapy and the Slow Reader

Many retarded readers fail to improve in spite of remedial reading. Several leaders in the field of play therapy have postulated that poor reading may result from inconsistencies in the attitudinal system of a child, or from difficulty in resolving a concept of self as a poor reader and a concept of self as a good reader.

If the difficulty which some retarded readers show is due mainly to inconsistencies within their value systems and if nondirective play therapy can aid the individual in changing his attitude towards self or in re-evaluating his concepts, then corresponding changes should occur in subject matter ability after nondirective play therapy.

In an experiment by Robert Bills of the University of Kentucky designed to test the hypothesis that significant improvements occur in the reading ability of a retarded reader when he has been given a non-directive play therapy experience, it was indicated that significant changes in reading ability do occur as a result of play therapy experience.

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[1] Hambidge, op. cit., p. 615.

The source of the reading gains which the children made in this study is in need of further investigation. It is possible that one of two things occurred--(1) These children were able to learn at a more rapid rate when they had received the play therapy experience, or (2) the gains which the children showed in reading skill resulted from information which the child already possessed but was unable to utilize effectively. In this study Bills states: "The size of the gains and the length of the study lend weight to the second interpretation."[1]

The problem of poor readers is so universal that research in the field is overwhelming. Yet we have with us a group of persistent slow readers who show every evidence of having capacity to read, who do not engage in the active participation necessary to correlate sound and meaning from the printed symbol.

Axline describes an experience with a group of thirty-seven second graders who were non-readers or poor readers. It was a study made by a teacher in an attempt to determine what results could be obtained by a therapeutic approach with the objective being the better adjustment of the children. The procedure was based upon the philosophy that is the foundation of nondirective psychotherapy--that is, a deep respect for the integrity of the individual and a belief in the capacity of the individual to help himself when that capacity is given optimum release.

In this experiment it was the purpose of the teacher to provide the kind of experience for these children that she thought would be primarily therapeutic. Therefore, the class program was designed to give the children

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[1]Robert Bills, "Nondirective Play Therapy With Retarded Readers," Journal of Consulting Psychology, XIV, (1950), p. 148.

ample expression through the medium of art materials, play material, free dramatics, puppet plays, music, creative writing (dictating their own stories), telling stories, listening to stories, sharing experiences and living together in an atmosphere of complete acceptance. In this framework, their feelings and attitudes were not only accepted, but clarified for them, and their ability to think for themselves was utilized.

Children were never compelled to join a reading group and after they came to realize this, they were active participants and willing to learn. There were no pressures; everything was done on a voluntary basis. The children were respected and accepted completely. They were granted the permissiveness to be themselves, to express their real thoughts and feelings and to utilize their capacities.

A comparison of reading scores (Gates Primary Reading Test, one and two) from February to May was made and a significant improvement was noted in every case. In the case of four of these children there was also a noteworthy difference in the first and second Binet test.[1]

Moustakas says in regard to Implications for Play Therapy in Education:

> People need not be psychotherapists; they need not know how to treat emotionally disturbed children in order to contribute to the emotional health of their children. The major requirements are strong motivations to understand human emotions and accept these emotions as they are.[2]

Kanner, in his book "Child Psychiatry," expressed his feelings about the value of play therapy in problems of scholastic performance as follows:

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[1]Virginia Axline, "Nondirective Therapy for Poor Readers," Journal of Consulting Psychology, XI, (1947), p. 61.

[2]Moustakas, op. cit., p. 208.

> A child whose deep-rooted aversion to learning has resulted in a reading disability may gain considerable help from certain forms of play therapy; yet his newly-acquired emotional reading readiness calls for remedial instruction if the loss during the years of frustration is to be made up.[1]

A Tool for the Speech Therapist

In speech correction, the statement that the method of improving articulation must be adapted to the needs of the child has long been accepted. Sometimes this has meant only a change in activity and materials to suit age and intelligence, rather than a basic change in approach. Because they often erect barriers against change, all children with speech defects will not respond to the direct method which shows how to improve and gives directed practice.

In the nondirective approach, it is held that the individual must solve present personal problems in his adaptation to his environment before he can turn his attention to the means of communicating and that he has to discover for himself, through acting out and verbalizing, the new behavior patterns which will help him to understand and adjust his attitudes toward listeners, toward himself, and toward his speech.[2]

The clinician contributes most importantly to the process by giving it some kind of organization, a plan or framework in which therapeutic interaction is to occur. He patterns the activity so as to move toward his goal pattern of complete self realization, but is always prepared to alter the pattern according to changes that take place as therapy

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[1]Kanner, op. cit., p. 242.

[2]Elise Hahn, "Indications for Direct, Nondirect, and Indirect Methods in Speech Correction," Journal of Speech and Hearing Disorders, XXXVI, (1961), pp. 230-236.

progresses.[1]

In nondirective therapy, Hahn believes that the therapist should be versed in methods of play therapy. He first is a comfortable listener and observer who has provided a situation in which the child can act out and express freely. He does not correct or respond to the child's defective speech, but he attends to expressive physical behaviors and to emotional aspects of voice, rather than to the surface communication of words. As the child begins to recognize, understand, and accept his own painful and confused feelings, barriers to his growth will be lifted. The improvement of his communication will be a part of that new growth.

In indirect speech correction the clinician takes an overly active part. By suggestion and example, he leads the child to discover that talk can be personally satisfying and that it is possible for him to clarify feelings and to produce an effect on a valued listener. The session requires objects which can be structured into units: unstructured materials such as clay, blocks, paper, blackboard, and chalk: or inexpensive commercial toys which can make up such units as the farm, the zoo, the store, the harbor, the doll house, the gas station, roads and cars, Indians and covered wagons, jungle, or bank and postoffice.

The clinician sets up situations suitable to the child's level of play and he then participates fully in the action, talking about what he is doing and how he feels about it. The parallel play with verbalization can induce a desire to participate. The clinician begins to repeat the child's statements, producing them correctly. If imitation

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[1]A. T. Murphy and R. M. Fitzsimons, Stuttering and Personality Dynamics, (New York: The Ronald Press Company, 1960), p. 231.

is taking place in play, imitation of speech will gradually follow. The clinician begins to suggest, "People will understand you more quickly if you say it this way." The clinician must be quick to perceive when the child is ready for direct correction of his own communication or when his feelings disturb him to the extent that the clinician must word and accept these before further communication is possible. Eventually the child may learn to understand, accept, or modify his feelings so that he can live with them more easily. With this growth, a change in his manner of speaking sometimes occurs with seeming spontaneity. Sometimes the playing out of problems gets the child ready for less personally emotional play so the communication and correction can be tolerated. It should be emphasized, however, that only the trained person should undertake this nondirective therapy.[1]

"When a stuttering child enters the play-therapy situation for the first time, we can be reasonably sure that he brings at least one fear with him--the fear of his harsh conscience."[2] This occurs primarily because the child has been emotionally hurt by his parents and tends to associate all adults with his parents, perceiving other adults as he has learned to perceive his parents. The prime task of the clinician is to estimate how the child is perceiving self, parents, and world as well as how much he is distorting and misinterpreting. Then he introduces to the child a smaller world of toys, a world which can be manipulated more easily than the world outside therapy. The child then contributes to his therapy by revealing his needs. The more he is given the opportunity to

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[1]Hahn, op. cit., p. 232.

[2]Murphy and Fitzsimons, op. cit., p. 231.

reveal his deeper wishes, self-estimates and drives, the more he helps the clinician to understand his needs. Thus he helps to formulate the treatment structure and goals.

The goal structure will vary with the stutterer's age, symptom severity and other factors, but in sum, it amounts to the development of greater personal and speech comfort through increased self-awareness and the reduction of anxiety--the harmonious synthesis of inner drives with outer social reality plus the restoration in the stutterer of faith in his own general and speech future.[1]

According to Kanner, speech pathology and clinical psychology are such closely related disciplines that training in both areas becomes imperative when dealing with those patients whose symptoms are expressed in their speech. He stated:

> Play therapy, in its true sense cannot be used by the speech therapist who has not been adequately trained in clinical psychology. The understanding of the dynamics of behavior and the learning of therapeutic skills to free the child from his anxieties are basic to the removal of the symptoms which is but the symbol of the patient's conflict. Individual psychotherapy for the stuttering child can be instituted at school age or before by allowing the child to release his tensions of hostility through play or drawing. Speech therapy for stuttering children is the supportive treatment given to them singly or in addition to, and as a part of general psychotherapy.[2]

On the other hand, Travis, in writing about play therapy in the public school speech therapy class states that the purpose of having groups of children with functional speech disorders work with paints and clay is to give substitute satisfactions through the free acting out of

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[1] Ibid., pp. 232-237.

[2] Kanner, op. cit., pp. 530-531.

messing impulses, opportunity for sublimative activity (painting pictures and making clay models), gratifying experiences, group status, recognition of achievement, and unconditional love and acceptance from an adult (speech therapist). With these beneficial results as a foundation he believes speech-training may proceed with sureness and speed.[1]

Travis devoted an entire chapter in his book entitled Handbook of Speech Pathology to suggestions for psychotherapy in public school speech correction. In this chapter he presented a variety of play situations which have been used by speech correctionists in the public schools. He concluded:

> Our strong clinical impression is that those procedures discussed here have been sufficiently helpful to deserve further consideration. In using only these suggestions, some children (both functional articulatory and stuttering cases) overcame their speech troubles entirely. Other children improved markedly. Our current feeling is that some form of psychotherapy is the only approach, even in the public schools, to the problem of stuttering, and an important supplementary tool with functional articulatory disorders.[2]

Play Therapy with Educable Mentally Retarded Children

Many retarded children are relatively deficient in their use of language; therefore techniques which minimize the necessity for verbal communication have been incorporated in psychotherapy with the retarded. Because play therapy is such a technique, and is also a method which may easily be adapted to the institutional setting, a number of therapists have utilized this method of treatment with retarded children. Most authors have been enthusiastic about the effectiveness of play therapy

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[1]Lee Travis, Handbook of Speech Pathology, (New York: Appleton, Century and Crofts, Inc., 1957), p. 52.

[2]Ibid., p. 54.

under such conditions.

A special program developed at the Wayne County Training School was intended to be a wedge aimed at getting an "in" with the child for the purpose of reversing the vicious cycle created by academic failure, and starting a constructive cycle of need-satisfaction. Maisner believes play therapy has been an appropriate and successful method for most of the children participating in this program to date. This has been indicated through test results, written reports by teachers and cottage workers, and school progress. The apparent success of the program is attributed to the interaction of this program with the total educational experience provided for the child.[1]

It is sometimes assumed that psychotherapy with the mentally retarded is inadvisable because of their limited insight as well as their poor verbal development. In a report of a play therapy project carried out by Munday, the most important finding was considered to be that resistance to psychotherapy hardly exists with subnormal institutionalized children. Consequently, a sound transference situation can be easily established in a short time. She also reports the development of verbal ability in one group of patients who were initially considered imbeciles.[2]

An investigation to determine whether group play therapy techniques would be effective in rehabilitating post nursery children where other therapeutic techniques failed was undertaken by Leland. The patients

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[1]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 Deficiencies, 1950, L, pp. 235-250.

[2]Munday, Lydia, "Therapy with Physically and Mentally Handicapped Children in a Mental Deficiency Hospital," Journal of Clinical Psychology, 1957, XIII, pp. 3-9.

were described as mildly mentally retarded (having an IQ range of approximately 50-75). It was concluded that the group play therapy did not create any major changes in the level of social maturation. However, Leland did consider that there was good evidence that the experiment did activate some of the intellectual potential which could not be tapped before the experiment.[1]

On the other hand, Mehlman and Subotnik did not obtain significant improvement in children with whom they worked. Mehlman's investigation involved thirty-two institutionalized and mentally retarded children and was aimed at determining the personal and intellectual changes following an experience in non-directive, group play therapy. He reported no statistically significant change for any of the groups on the Binet and Arthur tests, and only a slight increase in adjustment was found on the Hagerty-Olson-Wickman Behavior Rating scale.[2] Subotnik regarded play therapy as a supplemental treatment procedure with the limited objective of helping the child benefit from the regular program.

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[1]Leland, H., J. A. Walker and A. N. Taboada, "Group Play Therapy with a Group of Post Nursery Male Retardates," American Journal of Mental Deficiencies, 1959, LXIII, pp. 848-851.

[2]Mehlman, B., "Group Play Therapy with Mentally Retarded Children," Journal of Abnormal Social Psychology, 1953, XLVIII, pp. 53-60.

SUMMARY AND CONCLUSIONS

The literature was reviewed to determine the principles involved in the technique of play therapy as it was originally used for understanding the emotionally disturbed child. Literature on its more recent application to education of exceptional children, namely speech handicapped, slow readers and educable mentally retarded was also reviewed in an effort to determine the value of the technique in special education classes.

SUMMARY

The investigation of the literature concerning the technique of play therapy showed that in general all authors were in agreement concerning the value of play therapy in helping the child to grow in self-realization. Therefore, play therapy has become an indispensible method in child psychiatry. One main disagreement was found regarding the merits of using structured techniques or the unstructured.

It was emphasized that the type of toy used in therapy was not really important as long as it would motivate the child to provide the toy with functional content. The doll family was considered the best means of getting the child to express his true feelings concerning difficult adjustment at home, and it was suggested that the doll family be limited to the size of the child's family. Quite often the child destroys the person within the family who was responsible for his problem. When he eventually includes this doll in his play again, the therapist knows

the child is accepting the problem and is ready to attempt to cope with his personality conflicts.

Several authors felt that since reading retardation often results from poor self-concept, this could be improved by play therapy and thus a readiness to read could be established. It was also determined that play therapy is an effective tool for use with the speech handicapped, especially in cases of stuttering.

Differences of opinion existed regarding the merits of play therapy with educable mentally retarded children, but the majority of authors were enthusiastic about its effectiveness in evoking social change and activating intellectual potential. However, the relationship of personality and intelligence under therapeutic conditions was more often assumed than demonstrated.

It was obvious that a difference of opinion exists between the psychologist and the speech pathologist as to what person is qualified to conduct a therapeutical play situation. Some psychologists found real value in unstructured play therapy in the field of education as used by the classroom teacher with a minimum of special training. Others took opposite stands and insisted upon the necessity of special education in the field of psychiatry before attempting the technique.

Speech pathologist, Travis, felt strongly that the technique of play therapy could be used by the speech therapist, utilizing the training and background he has for the discipline of speech therapy. This raised a question as to whether these approaches are necessarily in conflict or whether they can be reconciled and integrated within a single remedial program.

CONCLUSIONS

As a result of the review of literature concerning the technique of play therapy as used with pre-school and primary age children, the writer believes that the application of this technique can be very helpful to the special reading teacher, the speech therapist and the special education teacher in their efforts to help the child to better understand himself and thus develop an improved self concept.

Through play, children are able to express the conflicts, tensions, and fears which are a part of growing up. They can find release in the symbolic play world through relatively unrestrained expressions of anger or fear, thereby reducing their feelings to more manageable proportions. They can also rehearse future patterns of behavior: going to the dentist, going to school, taking a field trip. They can progressively desensitize themselves to situations which would ordinarily frighten them by repeating them in the protected playroom until they no longer seem terrifying.

However, it is important that teachers keep in mind that they are not trained psychologists; thus the technique should never be used by them to analyze a child. Nor would the writer recommend its use in the regular classroom, except in simple structured forms requiring very few play materials. In regard to the merits of using structured or unstructured techniques, this will be determined by the amount of training of the teacher and his ability to understand what the child is trying to say through play.

Since the technique of play therapy is being applied in a number of government-sponsored pilot programs in special education which are currently being conducted in the United States, it is the opinion of the

writer that research should be conducted as a part of these programs and the findings published. The research that has been done in this field is important and has far-reaching implications. We should ask ourselves how these findings can be utilized constructively in our educational procedures and in bringing about more adequate solutions to social problems.

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AN INVESTIGATION OF LITERATURE ON PLAY THERAPY IN AN EFFORT TO DETERMINE ITS VALUE IN SPECIAL EDUCATION CLASSES

by

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AN ABSTRACT OF A MASTER'S REPORT

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The purpose of this report was to examine, present and evaluate the methods of helping exceptional children to achieve better self-realization through the application of the technique of play therapy.

A review of related pertinent literature available in books and periodicals was presented and analyzed to: (1) state information about the development and use of the technique of play therapy as it was originally intended, a therapeutic process for use with emotionally disturbed children; (2) report information about the use of play therapy with the educationally handicapped, namely, those children with speech defects, slow readers and the educable mentally retarded children and; (3) present data as to conclusions reached by researchers who have utilized this technique with children who are exceptional in one or more of these categories.

The study was limited to work with the pre-school and primary age child. Information for this report was restricted to library research.

Because children often erect barriers against change, all children will not respond to direct methods of teaching. The investigation of the literature indicated that the non-directive approach to problem solving, through which the child discovers for himself, either by acting out or by verbalizing his problems, produces new behavior patterns which will help him to understand himself and to adjust to frightening situations.

The two approaches presently used in conducting sessions in play therapy are the structured or directive approach, in which the therapist sets the stage and structures the play and the unstructured or non-directive approach in which the child is permitted complete freedom in selection and use of play materials. There is some disagreement among

the writers concerning the appropriate approach in certain situations, the length of time necessary to produce the desired results, and qualifications for conducting play therapy. The importance of establishing proper child therapist relationships was of major concern to writers in all of the areas investigated. All were in agreement that, if used properly, the technique yields the positive results of an improved self-image.

As a result of this study it was recommended that more research should be conducted and more findings published. It was also recommended that teachers keep in mind that they are not trained psychologists; thus the technique should never be used by them for the purpose of analyzing the child.