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.