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A PROPOSED MODEL FOR THE IMPLEMENTATION OF PLAY  
THERAPY IN ELEMENTARY SCHOOLS

BY  
NANCY KING

A thesis submitted  
in partial fulfillment of the requirements for the  
degree Master of Science, Major in Guidance  
and Counseling, South Dakota  
State University

1970

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A PROPOSED MODEL FOR THE IMPLEMENTATION OF PLAY  
THERAPY IN ELEMENTARY SCHOOLS

This thesis is approved as a creditable and independent investigation by a candidate for the degree, Master of Science, and is acceptable as meeting the thesis requirements for this degree, but without implying that the conclusions reached by the candidate are necessarily the conclusions of the major department.

Thesis Adviser

Date

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Head, Guidance and  
Counseling Department

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Date

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NAK

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## CHAPTER I

### INTRODUCTION

Play therapy is based upon the belief that the natural medium of self-expression for a child is play. Through his play he can express himself fully, "play out" his feelings and problems and try out different roles and theories of getting along in his world. In this paper, various approaches to play therapy will be explored.

### STATEMENT OF THE PROBLEM

The objectives of this study were to determine the applicability of play therapy in the elementary school, how it is being implemented in South Dakota schools, and to suggest a workable program that could be implemented in an elementary school counseling situation. Specifically, the purposes were:

1. To analyze the theoretical and research literature related to play therapy.
2. To analyze stated opinions of counselor educators in South Dakota concerning the needs of counselor preparation and the value of play therapy in elementary school counseling programs.
3. To analyze attitudes and experiences of elementary counselors in South Dakota concerning elementary school play therapy.

On the basis of these methods of investigation, an organizational model for implementing play therapy was devised.



## IMPORTANCE OF THE STUDY

Play therapy is a field in which relatively little research has been done. Few studies have been made on the success of therapeutic outcomes, changes in children's attitudes, counselor techniques and the selection and use of play media. With very few exceptions, the work done has been in clinical settings by trained therapists, psychologists, and psychiatrists. Little has been written for the counselor in an elementary school who must deal with children who are disturbed, socially maladjusted, handicapped, "normal" with developmental problems, retarded in reading and who have various other problems that could be helped through play therapy. There is a need for bringing together the information that is available and the theories of those who have successfully used play therapy, so that a workable program can be set up in the elementary school.

The need for research and study of play therapy is well-documented by many authorities. Van Hoose (1968, p. 96) states that "Play activity with the normal child is an area still in need of much research."

According to Dorfman (1965), there is a need for more studies of (1) follow-ups on large numbers of play therapy cases at regular intervals, (2) the assessment of personal adjustment before and after therapy, (3) the actual process of therapy, and (4) comparisons of group and individual therapy.

Axline (1969, p. 28) believes this form of nondirective counseling with children ". . . is well worth further study and more extensive application."

## DEFINITION OF TERMS

Several counseling terms appear in this paper. To assure clarity for the reader, the following basic terms are defined.

Play Therapy--A specialized play situation in which a child is enabled to work out tensions, frustrations, and emotional problems through the use of play media and the help of a counselor with whom he has a well-established relationship.

Nondirective Play Therapy--An approach to play therapy in which the child is allowed to determine which direction the therapy will take, to be himself without pressure to change, to learn to know himself, and to grow emotionally. Nondirective play therapy is, according to Axline (1969, p. 15):

based upon the assumption that the individual has within himself, not only the ability to solve his own problems satisfactorily, but also this growth impulse that makes mature behavior more satisfying than immature behavior.

Client-centered Theory--A theory formulated by Carl Rogers in which it is:

the counselor's function to assume, in so far as he is able, the internal frame of reference of the client, to perceive the world as the client sees it, to perceive the client himself as he is seen by himself, to lay aside all perceptions from the external frame of reference while doing so, and to communicate something of this empathic understanding to the client (Rogers, 1965, p. 29).

This approach assumes that an individual behaves according to how he perceives. How he perceives is for him reality. As his perceptions change, his behavior changes.

## DELIMITATIONS

The scope of this paper was limited to an extensive analysis of

the nondirective approach to play therapy. Other approaches to play therapy were analyzed in the review of literature. However, it was the decision of the writer to thoroughly explore the nondirective approach as the basis for a model of a play therapy program for elementary schools.

The number of people who completed the questionnaires was necessarily limited because there are only four counselor training institutions in South Dakota. Also, as far as could be determined, only eight counselors are actively involved in counseling in South Dakota elementary schools. Five of these counselors use play therapy.

The focus of the paper was placed on the one-to-one relationship in play therapy, rather than on group play therapy. However, the same principles apply to both counseling settings.

The literature review on play therapy in counseling is limited. Even in recent books and articles on elementary counseling, little is written concerning this special approach to counseling in the elementary schools.

## CHAPTER II

## REVIEW OF LITERATURE

In the literature review, the major theoretical approaches to play therapy are explained. These include: psychoanalytic, active, relationship and client-centered therapies. Play therapy with physically disabled children, group play therapy and play therapy in an individual counseling setting are also discussed. The last part of the chapter is devoted to research that has been completed in play therapy.

The beginning of play as a form of therapy can be traced back to J. J. Rousseau, the first person to advocate studying children's play as a method of understanding children's behavior (Lebo, 1955a). He felt that childhood is an important period of growth and development which should not be interfered with or hurried along. He rejected the notion from psychoanalytic theory that children should be thought of and treated as tiny men and women. He advocated joining their games and becoming a companion. However, his reasons were more for educative purposes than therapeutic.

## PSYCHOANALYTIC THERAPY

In 1909, Sigmund Freud had the first recorded case of play in therapy with a five-year-old boy, Little Hans. Although this is often cited as a classical case in child analysis, Freud actually saw the child only once. He allowed the boy's father to conduct the analysis. The father's qualifications were his authority as a father and a physician. From the father's observations and interpretations, Freud made

suggestions and gave advice mostly through the mail, concerning the treatment to be used (Moustakas, 1959). Although Freud did not become directly involved in the play, he did interpret the play to the boy. The aim was to bring about free association by bringing to consciousness repressed experiences and the reliving of the accompanying affects in the "antiseptic" relationship with the therapist (Dorfman, 1965). Most early therapy applied the principles of adult psychoanalysis to children. This presented problems because children were neither as willing or as able to verbalize their anxieties or to go back over their past and stages of development as in adult analysis, where great emphasis was placed on the early years.

Dr. Hug-Hellmuth realized that certain modifications in the psychoanalytic procedure had to be made for work with children. She began to use drawing and occasionally play, but did not develop it into a specific technique. She believed play was essential in working with children under seven and helpful in facilitating verbal communication with older children (Klein, 1955).

In 1919, Melanie Klein began work in developing the play technique she called play analysis (Klein, 1955). In the psychoanalytic tradition, she assumed the character of a child to be like that of an adult. Instead of free association, however, she used free play. The child expressed fantasies, anxieties and defenses by play as she consistently interpreted the preconscious and unconscious meaning to him. She felt that even the young children understood her interpretations because she believed the connections between conscious and unconscious to be much closer in children than in adults, and the infantile

repressions much less powerful. Translating interpretations as clearly as possible and in the child's language, made it possible to get in touch with the emotions and anxieties operating at that moment. She was able to lessen anxiety in the child because she recognized the symbolism in his play and was able to interpret it. The symbols allowed the child to transfer interest fantasies, anxieties and guilt to objects, rather than people. Interpretations not only relieved anxiety, but also gave the child an idea of the value of the analysis for him--a sort of motive for him to continue therapy on his own, rather than at his parents' insistence (Dorfman, 1965).

Although Klein first worked in the child's home with his own toys, she soon established a playroom with many toys locked in a drawer. She was guided by one of Freud's discoveries, i.e., the patient first transfers his early thought and feelings to the parents, then to others, and finally, to the psychoanalyst. By analyzing this transference, the past, as well as the unconscious part of the mind, can be explored. She came to believe that transference situations could only be established if the playroom was something separate from his ordinary life. The child knew the locked drawer of toys were his and that his play with them would be known only to the psychoanalyst and himself. This characterized the intimate relationship between analyst and patient in the psychoanalytic transference situation. In 1927, she formulated some psychological principles of infant analysis (Lebo, 1955a).

Anna Freud encountered the same problem of trying to get children to free-associate. She began entering into a child's play as a way

to win him over. This, she felt, was the way to produce a positive emotional attachment to the analyst and to give her access to the child's secrets. She did not believe that transference neurosis would develop because the original love objects, the parents, were in the situation rather than fantasy objects which could be transferred to the therapist. She used few direct interpretations and gathered much information about current happenings from the parents (Woltmann, 1956).

Dorothy Baruch (1952), a clinical psychologist, worked in group and individual therapy. She was psychoanalytically-oriented. She had great feeling for children because she felt they often have to bury inside themselves intense feelings and fantasies for fear of ridicule and disapproval from adults. She believed the way to a better understanding of children is through listening to their fantasies without being shocked. Some of the feelings she believed all children have are: the castration complex in little girls; intense curiosity and interest in their bodies and body-feelings; the Oedipus complex in boys; fantasies about what results from masturbation; and angry, resentful feelings which, at times, lead to fantasies of wanting to kill.

#### ACTIVE PLAY THERAPY

From the early psychoanalytic theories of play therapy, another approach developed which was termed active play therapy. In this approach, the therapist enters into the child's play to encourage him to enact certain traumatic scenes with a few selected toys as tools. Various forms have been developed by Conn (1939), Solomon and Levy (Lebo, 1955a). Whereas Solomon and Anna Freud's therapies stress the

importance of establishing rapport between the child and therapist, Conn, Levy and Klein felt it unnecessary.

Conn, a physician, worked with children with illnesses for which there were no apparent physical causes. He felt that children have important past experiences and present life situations which can contribute to our understanding of them. Conn also believed that a child needs to express his fears, emotions, dissatisfactions, and hopes in a natural way such as play. Then the child can begin to understand and accept his share of the responsibility for what he is and does. Although Conn gave children the opportunity to play freely, he emphasized planned play situations. He arranged various play sets with toy furniture and dolls in an attempt to duplicate life situations, so that certain behavior patterns such as temper tantrums and night terrors emerged through them. The child was an "impartial" spectator who could view objectively what was taking place and, at the same time, actively participate in a discussion of his own attitudes. Conn did not interpret the play. He treated the child as an equal and let him know that his ideas and opinions about himself were important.

#### RELATIONSHIP THERAPY

Otto Rank formulated the principal ideas of relationship therapy (Lebo, 1955a). Taft and Allen modified it for application to psychotherapeutic work with children. It was unique in that a certain kind of therapeutic relationship was believed to be curative in its own right. Instead of being concerned with reliving earlier experiences during analysis, and thus permitting the patient to grow up again in



a better way, relationship theory was not concerned with history but with emotional problems as they existed in the present. The child could choose to play or not to play. The therapist played when invited by the child, but then very little. Since Rankian theory did not attempt to repeat certain developmental steps, this necessitated giving up interpretation in terms of the Oedipus complex and other psychoanalytical discoveries. From this evolved the nondirective approach.

Jessie Taft and Frederick Allen emphasized the importance of helping the child to define himself in relation to the therapist. The therapy hour was thought of as a concentrated growth experience in which the child could come to the realization of being a separate person with strivings of his own and could also exist in a relationship where the other person was allowed to have qualities of his own (Allen, 1942).

A review of the literature up to this point has shown mainly the work of psychoanalytic therapists and a sketch of the development of play therapy up to the work of Carl R. Rogers. It seems appropriate now to review the literature by Rogers and other client-centered therapists because it is with this school of thought that this paper is concerned. Although a few therapists will be presented whose methods are not completely client-centered, it is from the principles of client-centered therapy that a play therapy model for counseling in the elementary school will evolve.

#### CLIENT-CENTERED APPROACHES

Carl Rogers is responsible for this approach to understanding behavior. He was very much influenced by the work of Rank. In 1940

Rogers first published some principles and techniques of an approach which was called nondirective counseling. It is now called client-centered because the counselor adopts the client's frame of reference and is concerned with the way the client perceives the world at that moment. This is the phenomenological method. Following is a summary of the propositions on which this approach is based (Blocher, 1966):

The individual is the center of a continually changing world of experience not completely known to any other person. The way he perceives this private world is reality for him and he reacts to it as if it is. He reacts not only intellectually and emotionally, but as an organized whole. Within every individual is a basic striving to enhance and maintain himself. When allowed to do so, this inner striving force will direct the individual toward growth and development that is desirable for him and for society. However, he must perceive his choices clearly. If he does, he will choose to grow. All behavior makes sense and has a purpose, at least in the perceptual field of the person.

In this approach, far more important than any techniques the counselor uses, is the attitude he holds toward the worth and significance of the individual. He must respect the client, his capacity and his right to self-direction. He must see him as a worthwhile person and convey these feelings to him by attitudes and behavior. If the counselor already has this point of view about the worth of the individual, the client-centered techniques are easily learned. Rogers (1965, p. 21) summarizes:

. . . by use of client-centered techniques, a person can implement his respect for others only so far as that respect is an integral part of his personality make-up; consequently the person whose

operational philosophy has already moved in the direction of feeling a deep respect for the significance and worth of each person is more readily able to assimilate client-centered techniques which help him to express this feeling.

The counseling relationship, according to Patterson (1966), is not an intellectual relationship in which the counselor helps the client by his knowledge. The desirable goals or ideal characteristics of the counselor are acceptance, congruence and understanding. Acceptance involves accepting the client as he is, without evaluating or judging him. Congruence requires the counselor to be aware of his own feelings and be willing to express them so that there is no contradiction between what he is and what he says. Understanding refers to the counselor's empathic understanding of the client's private world as far as is possible. This understanding enables the client to explore freely and come to a better understanding of himself. Communicating these characteristics to the client verbally and nonverbally is necessary. If the counselor has these desirable attitudes and has been able to let the client know he has, the resulting relationship develops in which the client feels "safe, secure, free from threat, and supporting but not supportive. The counselor is perceived as dependable, trustworthy, consistent. This is a relationship in which change can occur." (Patterson, 1966, p. 421)

Rogers (1942) states that his approach to psychotherapy differs from older ones in these general characteristics: (1) It relies on the individual's drive toward growth, health and adjustment--not doing something to him, but freeing him for normal growth and development, independently; (2) It stresses the emotional, feeling aspects rather than intellectual; (3) Greater emphasis is placed on the individual's present situation than upon the past; (4) Rather than expecting the

client to grow and change after the interview as formerly was expected, the therapeutic contact is the growth experience. He learns to understand himself, make important decisions alone and to relate more successfully to another person.

Four qualities that Rogers (1942) believes are helpful in a counseling atmosphere are:

1. Counselor warmth, interest and responsiveness, making possible the establishment of rapport with the client, which gradually becomes a deeper emotional relationship.
2. Permissiveness which allows the client to express all feelings and attitudes without fear of judgment or condemnation.
3. Certain limits which lend structure to the interview, such as limiting the session to one hour. In play therapy, the limits are on certain types of action such as attacking the therapist, throwing blocks through windows, or carrying on destructive activities in the hall or other offices.
4. Freedom from pressure or coercion from the counselor. He will not attempt to advise, suggest, pressure, or in any way force his own biases or wishes on the client. This allows the client to make choices and changes and to grow and develop in his own way.

In comparing counseling to play therapy, Rogers (1942, p. 167) says:

. . . in the structuring of the relationship, in the recognition of negative and positive feelings, in the matter of giving full expression to forbidden and repressed attitudes, in the gradual acquisition of a certain measure of insight, play therapy is very similar to counseling of a verbal nature.

Rogers feels that all counseling situations must be structured, but in play therapy it is done more through actions than words. As the child "tries out" the counselor and the playroom limits, he finds through experiencing freedom, rather than by being told that there is no pressure direction, or coercion.

Rogers believes every counselor must decide his own policy concerning limits in the playroom. If he sets too few and the child becomes too demanding, the counselor could lose his desire to help and even feel resentful and rejecting of the child. Then the child might feel that the one person that really wanted to help him has turned against him. This could be very damaging to the child. Concerning time limits, Rogers (1942, p. 101) states:

The time limits of the therapeutic situation like any of the other limits, are of assistance in furnishing the counseling situation with all the aspects of the life situation. The time limit sets up an arbitrary human limit, to which the client must make adjustment.

Rogers also sets limits on aggressive action such as damage to people or property.

Rogers is convinced that the degree of affection the counselor shows any client, but particularly a child, must be limited to prevent him from becoming dependent on the counselor. It may involve the child wanting his hour extended, to take some toys home, or not wanting others to play with the toys. Often, rejected children request gifts. Rogers feels that to provide the gifts is useless for they can rarely be satisfied.

Under certain conditions, Rogers (1942, p. 77) feels the child and Parent should be counseled separately. The conditions that must be met

are:

1. The child's problems are based, to an important extent, in the parent-child relationship.
2. The child is not yet emotionally or spatially independent of his family.
3. Either the parent or the child (nearly always the former) feels a need of help, thus creating an opportunity of working with the situation.
4. The parent is relatively treatable, which means that
  - a. he has some satisfactions, outside of the parent-child relationship, in social or marital relationships or in personal achievements;
  - b. he is reasonably stable;
  - c. he possesses dull-normal intelligence or better;
  - d. he is young enough to retain some elasticity of adjustment.
5. The child is relatively treatable, which means that
  - a. he is reasonably free from organic instabilities;
  - b. he has dull-normal intelligence or better;
  - c. he is old enough to express his attitudes through play materials or in other ways in the counseling situation. Ordinarily this means a chronological age of four or more.

Virginia Axline was a student of Rogers' who applied his basic theory of counseling to play therapy. No basic principles had to be changed and the work she did is the nucleus of all work done since then in the child-centered approach to play therapy. The basis of non-directive therapy is the assumption that the individual has within himself the ability to solve his own problems and the growth impulse that makes mature behavior more satisfying than immature behavior. The child is allowed to be himself without pressure to change. According to Axline (1969, p. 15):

This type of therapy starts where the individual is and bases the present configuration, allowing for change from minute to minute during the therapeutic contact if it should occur that rapidly, the rate depending upon the reorganization of the individual's accumulated experiences, attitudes, thoughts, and feelings to bring about insight, which is a prerequisite of successful therapy.

Axline describes play therapy as an opportunity that is offered

to the child to experience growth under the most favorable conditions. Through the medium of play, he can play out such feelings as tension, fear, insecurity, aggression and confusion. Once they are in the open, the child can face them, learn to control them or abandon them.

When he has achieved emotional relaxation, he begins to realize the power within himself to be an individual in his own right, to think for himself, to make his own decisions, to become psychologically more mature, and, by doing so, to realize selfhood (Axline, 1969, p. 16).

The playroom is really a place where he can achieve all this, for here he is treated with dignity and respect. He can do as he likes without someone to nag, suggest, pry, or push. He is in command of the situation and of himself. Probably for the first time in his life he is entering into a relationship with an adult who is completely acceptant, permissive, friendly and understanding. The therapist is sensitive to his feelings and attitudes expressed through play and verbalization and he reflects these back to the child in a way that helps him understand himself a little better. Axline (1969, p. 18) bases her work on the hypothesis that "given a chance, the child can and does become more mature, more positive in his attitudes, and more constructive in the way he expresses this inner drive", i.e. the drive that is striving for realization.

In line with Rogers' thinking, Axline would have no diagnostic interview before therapy, very little interpretation during therapy and no probing questions. The past is not significant; the individual starts therapy where he is and it is up to him to select the things that are important to him when he is ready. Play therapy is not meant to be a way of making a child over to fit an adult's standards of what he

should be. A child resists this because he is striving to be himself. He will not be happy with behavior patterns imposed on him in favor of his formerly less desirable behavior. He must want to change and only he can do the changing. He will be an individual, even if he has to do it by way of tantrums, teasing, and fighting. The playroom can give him opportunities to be himself in many ways and to be recognized as a person with value. From successful experience in the playroom, the child acquires a consistent philosophy of life in which he learns to respect and accept himself, to allow himself to utilize all of his capacities, and to assume responsibility for his own actions. He, in turn, develops acceptance and respect for other people as they are, and a belief in their capacities. He allows others the freedom to make their own decisions.

Axline (1969, p. 73) has suggested some basic principles which should guide the therapist in working with children. They 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.

According to Axline, the therapist should constantly check his responses and his actions against these basic principles and evaluate his work with each child.

Limitations Axline established in the playroom are concerned with material things such as destruction of play materials and damaging the room. Other limitations have to do with protecting the child from harm to himself, protecting the therapist from attack by the child, setting a time limit on the therapy session, and other common sense limitations that arise. When limits are broken, the therapist must reflect feelings rather than reject the child from the playroom or show anger with him. If the child throws a block through the window, in spite of the fact that the therapist did recognize his feelings of wanting to throw it, the therapist's response might be, "It was important to you to throw it anyway. You wanted to show me that you would throw it." (Axline, 1969, p. 131) He would not introduce any limitations until they are needed, nor would he use limitations as "pressure devices." For example it is not an honest limitation to tell a child with a feeding problem that he must eat if he is to come to the playroom. Limitations wisely and consistently used, give the child a feeling of reality and security.

Axline worked at times with a suitcase of toys, sometimes in a corner of an unused nursery or a schoolroom, and ideally, in a room set aside and furnished for a playroom. This room would be sound-proofed, have walls and floors that are easily cleaned and protected with a

material that can withstand clay, paint, water, and mallet pounding. Windows would have gratings and there would be a sink with running hot and cold water. At one end of the room would be a stage with an eight inch elevation. All toys would be on open shelves and the child allowed to choose from the display. Axline (1969, p. 54) suggests: nursing bottles; doll house with furniture; toy soldiers and army equipment; toy animals; playhouse materials, including table, chairs, cot, doll bed, stove, tin dishes, pans, spoons, doll clothes, clothesline, clothespins, and clothes basket; a didee doll; a large rag doll; puppets; a puppet screen; crayons; clay; finger paints; sand; water; toy guns; peg-pounding sets; wooden mallet; paper dolls; little cars; airplanes; a table; an easel; an enamel-top table for finger painting and clay work; toy telephone; shelves; basin; small broom; mop; rags; drawing paper; finger-painting paper; old newspapers; inexpensive cutting paper; pictures of people, houses, animals, and other objects; and empty berry baskets to smash. One of the most important media is sand, in a sand box flat on the floor. It lends itself to much imaginative activity, particularly aggressive play.

Axline applied the same principles of nondirective play therapy to groups. She indicated that the group experience may be more helpful than individual therapy if the child's problems are focused on social adjustments. This gives the child a chance to receive reactions from others and to develop a consideration for other's feelings.

Because Dorfman (1965) follows the theories of Rogers and Axline very closely, her work will be mentioned only briefly. It is her belief that a child should not be refused play therapy because neither of

his parents agree to counseling for themselves. Even if the child has to return to the same environment, he may be better able to cope with it because once he has changed even a little, the environmental situation will also be different. When he perceives himself differently, then others will also perceive him differently. As the child sees himself reacted to in a different manner, this will encourage him to keep changing.

Showing the child that the therapist believes he is capable of self-direction is very important to Dorfman. Respect may also be shown in many ways, for example, by keeping appointments and apologizing if the therapist misses or is late for an appointment.

The therapy hour should be used as the child desires. He sets the pace. He isn't hurried and he brings forth significant materials when he is psychologically ready to do so. If he chooses to sit or stand for the whole hour, he may. Improvement often comes about even when there is very little verbalization in the playroom. The therapist may have little opportunity to reflect feelings at all. However, the therapist does create the atmosphere which permits the child to be himself, to have time to do as he wishes and have privacy.

Reflecting and clarifying feelings gives the child a chance to get them in the open and look at them. The child may delve deeper within himself if he knows the therapist understands him. Since all types of feelings are reflected he doesn't feel that the therapist values one type of feeling above other feelings. Therefore, the child says what he needs to say, not what he thinks the therapist wants to hear.

Dorfman (1965, p. 256-257) explains why there is little danger

of the child transferring socially taboo behavior outside the therapy room as a result of the permissive play therapy atmosphere. (1) The therapist has not praised any form of behavior so the child is more likely to take a responsibility for his actions rather than make it the therapist's responsibility. (2) The child usually knows very well that the sessions are different from life "outside." (3) Restrictions in life haven't taken away the need for his particular behavior. If the therapist also had restrictions, the child would not be able to bring out his real feelings in a safe climate. Since being accepted despite of one's deficiencies is such an important part of therapy, the client can't be sure the therapist accepts him until the deficiencies in his personality have been revealed to the therapist. (4) The therapist's acceptance seems to reduce hostility rather than to increase it so the child would have less need to act out dangerously in the life situation.

Dorfman would set the same limits as Axline. No limits are on verbal expression of feelings but on certain types of behavior. The child cannot physically attack the therapist because it would be more difficult for the therapist to accept a child who has attacked him. Also, attacking the therapist may make the child feel guilty and anxious about the only person he feels can help him. These conditions could destroy the possibility of successful therapy.

Moustakas has worked mainly at the Merrill-Palmer Institute in Detroit. In an early book, Moustakas (1953) advocates a child-centered philosophy which emphasizes a relationship that allows children to grow emotionally and to gain faith in themselves as feeling individuals. Moustakas (1953, p. 2) describes play therapy:

. . . a set of attitudes in and through which children may feel free enough to express themselves fully, in their own way, so that eventually they may achieve feelings of security, adequacy, and worthiness through emotional insight.

These attitudes are faith, acceptance, and respect. Faith is known through feelings and when the child is with a therapist that he knows has faith in him, he is able to face himself, grow within himself and create more of himself. When a child has faith in himself he can express himself freely and not worry about being condemned for doing so. Faith is a belief that the therapist has in the child's potentials for working out his problems in the way that the child thinks is best. Acceptance must be complete throughout the entire relationship because it encourages the child to express his feelings and explore his attitudes to the fullest. Respect is shown in many ways through both acceptance and faith. Respect conveys to the child his worth and importance as an individual.

In a later book, Moustakas (1959) presents his ideas in a slightly different framework, that of relationship theory. He sees relationship theory as closely related to client-centered theory with the exception that the focus is on the curative aspect of the relationship itself. Every situation in relationship therapy is a unique, living experience with its own requirements, method or techniques. The therapist helps the child gradually be himself and make creative, responsible use of his abilities and capacities. Some interpretation and explanation are used.

He believes normal children should be given a chance to participate in play therapy as a form of preventive mental hygiene. Play

therapy provides an opportunity for normal children to explore feelings of temporary tension or conflict and work through these feelings in a few sessions. Moustakas (1959, p. 42) sees play therapy as an opportunity to:

. . . release tensions and frustrations that accumulate in the course of daily living, to have materials and an adult entirely to himself, without any concern with sharing, being cooperative, being considerate, polite, or mannerly.

Through clinical experience Moustakas (1959, p. 79) has found that in the first five years of life, the normal emotional growth process goes through these stages:

First level: Undifferentiated and ill-defined positive and negative feelings prominent. Second level: Emergence of focused positive and negative feelings in response to parents, sibling, and other people. Third level: Ambivalent feelings distinctive. Fourth level: Negative feelings in primary focus, sometimes specific. Fifth level: Ambivalent negative and positive attitudes prominent. Sixth level: Positive feelings predominant and appear as organized attitudes. Negative attitudes also present. Both positive and negative attitudes differentiated, focused, direct, and generally in line with reality.

He has found a parallel between this emotional development and the emotional growth in a play therapy situation. The levels of the therapeutic process according to Moustakas (1955a, p. 84) are:

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

#### PLAY THERAPY WITH PHYSICALLY DISABLED CHILDREN

Cowen (1955) is concerned with play therapy for physically

disabled children, since he states that they more frequently exhibit maladjustive behavior than physically normal persons. He stresses three factors that are the essence of therapy; the relationship, opportunities for expression and a configuration of therapeutic techniques. He suggests modified programs similar to those for the non-disabled be set up for the disabled. With mental defectives, Cowen suggests that it would be best to use a wide variety of play media. Groups may be very good for them because they are often deprived of play experiences. He recommends this type of sheltered play situation as ideal for them. Cerebral palsied children cannot function well in crowded, noisy, situations. Thus, groups would not be advisable for them. Hyperactive children may need to have chances provided to get rid of excess energy.

Cowen feels that physically disabled children have many emotional problems which stem from their disabilities. Little has been done with exceptional children in play therapy, particularly those with visual, auditory, and orthopedic defects. The group of children that has been worked with the most is the mentally deficient. According to Cowen, one of the main reasons relatively little has been done with exceptional children is because progress is so slow and the few therapists available have so many children to work with, that they choose to give their time to the cases which can get results in a shorter time.

Cowen makes several suggestions for more accurate research in therapy. He believes that the research has been questionable because of neglect in providing controls. He suggests ways to evaluate therapy programs that could be used with any group of non-disabled and some

disabled children.

#### PLAY THERAPY IN COUNSELING

Nelson (1966) is concerned with the word therapy and prefers "counseling in the playroom." He sees play media as necessary because it is through play that a child develops his social relations, tries out various roles and works through his frustrations and concerns.

He does not believe depth analysis is needed. Play should be treated as though it was verbalized behavior and the response the counselor makes should be to the emotional content of the behavior rather than an interpretation. If the play gets into symbolic avenues that are beyond the counselor's training, a referral should be made.

Nelson (1966, p. 26) believes that:

. . . the objective of counseling should be to create conditions for expression and communication, and to avoid, generally, viewing play from an analytical frame of reference. We must create play conditions in which the child can be himself and express himself without the need to protect himself from a watchful and analytical eye.

He prefers to use unstructured materials for play because they invite a wide range of responses and uses. He suggests such materials as clay, paints, crayons, pipe cleaners and puppets. Toys that are highly structured with only one use such as games, model airplane kits should seldom be used.

Waterland writes about the use of therapy in the elementary school counseling programs. She describes the counselor as ". . . a selective mirror, reflecting for the child his emotionalized perceptions and attitudes so that the child can become aware of them and in time change them." (Waterland, 1970, p. 180) The decision to change or not



is the child's. The counselor helps him understand his thoughts and feelings. He respects the child's ability to solve his own problems and does not direct his action or verbalizations. He accepts the child as he is.

Techniques used in play therapy are reflection, simple restatement, and interpretation. Reflections are made of the child's feelings without adding or subtracting from the original meaning. Restatement may be repeating what the child has said or rephrasing in the counselor's words, what the child has said. Interpretation should be used sparingly because there is danger of expressing something to the child before he is ready to accept as well as the possibility that it may be wrong. The counselor's idea about what the child thinks and feels is not important. What is important is how the child thinks and feels.

According to Waterland, silences in the playroom must be handled properly. The child should be allowed to be silent if he wishes. It is not up to the counselor to suggest that the child start playing or talking. He must not try to push or hurry the child.

Structure is necessary because it helps create a reality-oriented framework for the relationship between the counselor and child. Some kinds of structure necessary include time limits set by the counselor, the child's responsibility to make the decisions about what to do, the child's responsibility for his safety, a restriction upon attacking the counselor, and that play material must stay in the room. Limits set and followed consistently provide a feeling of security for the child. When limits are broken it is important for the counselor to recognize the child's feeling about them and remain acceptant of

him so that the child is not made to feel guilty.

#### GROUP PLAY THERAPY

Ginott (1961) stresses group play therapy. He believes it has certain advantages over individual play therapy in many instances. Children recommended as suitable for play therapy groups are: (1) withdrawn children such as the over-inhibited, fearful, schizoid, isolate, submissive, inarticulate, constricted and meek; (2) immature children; (3) children with phobic reactions; (4) effeminate boys; (5) children with pseudo assets, that is, the "too good" children; (6) children with habit disorders such as thumb-sucking and temper tantrums; and (7) children with conduct disorders.

According to Ginott, children with the following behavioral manifestations are not suitable for play therapy groups: (1) intense sibling rivalries, (2) sociopathic children, (3) those with accelerated sexual drives, (4) children exposed to perverse sexual experiences, (5) children who steal, (6) extremely aggressive children and (7) those who exhibit gross stress reactions.

Ginott (1961, p. 35) feels that the groups must be carefully planned and balanced for the impact of members upon each other. They should associate and identify with children who have personalities different from their own. They should be separated from school friends and siblings. Usually, a group would be made up of children nearly the same age.

The matter of selection of toys for the playroom is very important, so Ginott (1961, p. 53) selects or rejects materials on the

basis of five criteria. A treatment toy should:

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

Ginott feels it is easier to establish desired relationship with each child when several children are present. He believes that this is an advantage over individual therapy. It is less threatening for the child to enter the new situation with other children rather than alone.

Group play therapy provides free associative catharsis, as in individual play therapy, but also "vicarious" and "induced" catharsis. That is, experience through the other children's activities, and experiences encouraged by the other children's activities.

In group play therapy, a child has the opportunity to get peer reactions to his behavior, and may possibly re-evaluate or change it.

Group therapy opens more channels for sublimation. A child alone may do the same activity time after time but in group therapy the children teach each other a number of ways to use the media.

#### PLAY THERAPY RESEARCH

A study of four children was completed by Landisberg and Snyder (1946). Their purpose was the analysis of client and therapist responses in order to determine trends throughout the period of therapy. It was found that 75% of the therapist responses were nondirective, (simple acceptance, recognition of feeling, restatement of content). 5% of all responses were interpretations. The most marked trend

demonstrated by the children was an increase in physical activity in the last 3/5 of the therapy. Seventy per cent of the children's responses expressed feeling either verbally or behaviorally. The increased feeling was significantly related to actions rather than verbal responses.

Unlike some work done with adults, the children showed an increase of negative feelings during therapy. Positive feelings constituted about 30% of the children's responses. They directed their feelings toward other people more as therapy progressed.

An attempt was made in another study to discover whether trends existed in the differential frequencies among feeling categories during therapy. Finke (1947) composed 19 categories of feelings expressed by children in therapy. Six children were seen from eight to fourteen times at a children's home and at school. Nondirective play therapy was used. Some of the categories which showed no trends were: Positive Statements About the Self; Positive Statements About the Family, Home Situation, etc.; and Negative Statements About the Self. Only five categories did show significant trends. Story Units showed a high in the fifth session, then declined. Attempting to Establish a Relationship with the Counselor showed a high in the third session, then stayed low until the eighth, when it began to rise and continue to the end of therapy. Testing Limits stayed level until the ninth session, then it declined steadily. Total Number of Statements reached a steady level after the third session. This study supported the findings of the Landisberg and Snyder study, in that increased expression of feeling was found to be significantly related to the action rather than to the verbal responses.

Axline (1947) worked with 37 second grade children who were retarded in reading. It was not a playroom situation, but instead, a special class in which the teacher was permissive and understanding in a therapeutic atmosphere. It was hypothesized that adjustment and learning would occur together in such an atmosphere without a special emphasis put on learning to read. No statistical test was made by Axline and there was no control group. However, during the three-and-one-half months there were some remarkable gains in reading age, some as much as seventeen months.

Ginott and Lebo (1961) studied limit setting to see if different kinds of limits were employed in play therapy by therapists using different types of counseling theory. They found that psychoanalytic therapists, nondirective therapists and "others" used a similar number of limits in their work with children. Limits were studied in these areas: physical aggression against equipment, socially unacceptable behavior, safety and health, playroom routines, and physical affection. Ginott (1961) cites another study by Ginott and Lebo (1960) in which the same sample of therapists was used to help determine the most- and least-used play therapy limits. They found most limits have to do with protection of playroom property, child's safety and the therapist's attire. Least-used limits concern symbolic expression of socially unacceptable behavior and playroom routines. Other conclusions reached were that child therapists show great permissiveness in some areas that are prohibited in society at large and also that blatant physical aggression is not tolerated in the playroom.

Axline (1949) did another study in which she tried to find out

whether mental deficiency was a symptom or a disease. She was not able to find the complete answer, but did find that after play therapy five children diagnosed mentally deficient were more able to express their capacities and emotions and showed gains on I.Q.'s.

Axline (1950) did some follow-up studies years after what she considered "successful" therapy with 22 children. She interviewed those she was able to contact and concluded that the experiences of her clients were emotional ones that sharpened awareness of themselves as "feeling" individuals. Through these "feeling" experiences the clients began to understand themselves better and with this understanding became better able to control their emotions and feelings.

A study was undertaken to find the effects of nondirective play therapy in reading retardation. Bills (1950a) chose eight retarded readers on the basis of discrepancies between their mental age scores and reading age as measured by the Gates Primary Reading Tests of Paragraph Meaning. The study was divided into three, six-week periods. The first was a control period with testing before and after it. No therapy was offered. The second period was designated for the experimental treatment. Therapy was offered and testing was conducted after the completion of therapy. The third period was a follow-up. No therapy was offered and children were tested when it was finished. One group was compared with itself, and was its own control. Judges with teaching experience determined that the reading instructions were alike for the three periods of study. It was found that better gains were made during the experimental period and were maintained during the period after therapy.

Bills (1950b) also did a study to see whether reading gains were due to improved personal adjustments. It was similar to the project with retarded readers, with the exception that in this study, well-adjusted, retarded readers were studied. They were given projective and objective personality tests to determine their degree of adjustment. Bills found that gains were not greater during the therapy period. This finding might suggest that play therapy may improve reading when there is emotional maladjustment, but it may not necessarily be the best method for reading difficulties in general (Dorfman, 1965).

Dorfman (1965) quotes a study by Fleming and Snyder (1947) of the effects of nondirective group play therapy upon personality test performance. Three measures used before and after therapy were Rogers' Test of Personality Adjustment, a Guess Who Test, and Fleming's Sociometric Test. The seven children studied, were selected for play therapy because they had the most deviant scores of 46 tested children in a children's home. The remaining children in the home served as the control group. It was found upon retesting that the boys' experimental group did not improve significantly more than did the control group. The girls' experimental group showed significant gains over the control group. Fleming and Snyder concluded that marked changes in personal and social adjustment take place as a result of nondirective group play therapy. The authors recommended that children in a play therapy group should not vary greatly in kind or degree of maladjustment. Dorfman concluded that since Fleming and Snyder did not use control and experimental groups that were equal in maladjustment scores, and since both groups were not treated alike in all other ways, the results of

this study were difficult to interpret.

Research was done by Moustakas (1955b) in which he attempted to show similarities and differences in the negative attitudes of well-adjusted and disturbed young children. The subjects were nine well-adjusted children and nine disturbed children. All subjects were four years old. They were matched in age, I.Q., and socioeconomic background. Trained observers judged and categorized their responses during four play therapy interviews conducted with each child. Moustakas found that both groups expressed about the same types of negative attitudes. The disturbed group expressed more negative attitudes and with greater feeling. They also expressed more frequent and more severe negative attitudes of diffuse hostility, hostility toward home and family, cleanliness anxiety, orderliness anxiety, and regression in development. Although the disturbed group expressed hostility toward people in general and parents, they didn't do it significantly more than the other group.

The well-adjusted children expressed hostility toward siblings more frequently but not more intensely. Their negative attitudes were specific and focused while the disturbed group's attitudes tended to be diffuse and pervasive. The study suggests "that as therapy progresses, the negative attitudes of the disturbed child may become similar to those of the well-adjusted children, expressed more clearly and directly, less frequently, and with mild or moderate intensity of feelings." (Moustakas, 1955b, p. 325)

Ginott (1961) cites a study done by Levi (1961), in which he studied the variables affecting child-therapy outcomes. Some of the



variables were: type of parent, concomitance of parent treatment, length of treatment, age, sex, and symptoms of the child. Levi concluded that child therapy is not only possible without parent treatment, but the improvement is about the same with or without parent treatment.

A study was done by Lebo (1956) with children four to twelve years old to determine which ages are best worked with in nondirective play therapy. He chose four-year-olds as the lower limit because they can perform two simultaneous motor acts such as eating and talking or dressing and talking. Younger children find this difficult because of imperfect physical coordination. He found that fewer statements were made while playing with toys at the twelve year level than any other. The sight of "baby toys" made them feel that the playroom was not for them and the toys seemed to restrict their speech. He concluded children this old would not be suitable for nondirective play therapy.

In another study, Lebo (1958) presented a formula to enable the selection of toys for nondirective play therapy on an objective rather than an inferential basis. The formula was called the verbal index and considered both the number of statements made while a particular toy was used and the expressive variety of the statements. Use of the verbal index was suggested for determining the verbal expressive value of toys already in playrooms, deciding what new toys to buy, selecting specific kinds of toys rather than general types of toys, and selecting a minimum of the most verbally expressive toys.

Lebo found that many toys recommended by nondirective play therapists such as Arthur, Axline, Moustakas, and Watson, do not greatly facilitate verbal expression by the child. A table in Appendix A

presents an arrangement of toys on the basis of their obtained verbal index. Toys with numbers below ten were not considered good selections for a playroom. The toys with highest verbal indexes are considered the best choices.

Dorfman (1958) studied the outcomes of client-centered individual play therapy. She believed that personality changes occur during a therapy period but do not occur in the same child during a no-therapy period and do not occur in control cases. Two other hypotheses were that therapy is possible without treating the parents and that therapy can be conducted by an outsider in a school setting. The results of the study supported her hypotheses.

Lebo (1955b) reported a study by Finke (1947). Unlike Landisberg and Snyder who classified children's statements according to categories developed for use with adults in therapy, she used categories based on an analysis of children's statements. Lebo (1952) in a study of the Finke categories made several revisions in the categories, since he felt that there was almost no discrimination among the various categories when judged by experienced play therapists. After changing some categories and adding new ones, the Finke categories (Appendix B) for quantifying the play therapy process are as follows: (Lebo, 1955b, p. 376)

- A. Curiosity about the situation and things present in it.
- B. Simple descriptions, information, and comments about play and play room.
- C. Statements indicating aggression.
- D. Story units.

- E. Definite decisions.
- F. Inconsistencies, confusion, indecision, and doubt.
- G. Exploring the limits of the play room.
- H. Attempting to shift responsibility to the therapist.
- I. Evidence of interest in the counselor.
- J. Attempting to establish a relationship with the counselor.
- K. Negative statements about the self.
- L. Positive statements about the self.
- M. Negative statements about the family, school, things made or present in the play room, the situation, activities, etc.
- N. Positive statements about the family, school, things made or present in the play room, the situation, activities, etc.
- O. Straight information and stories about the family, school, pets, teacher, self, etc.
- P. Asking for information.
- Q. Questions or comments pertaining to time during the interview.
- R. Exclamations.
- S. Unclassifiable.
- T. Insightful statements revealing self understanding.
- U. Ambivalent statements.
- V. Sound effects.
- W. Mumbling or talking to self in a voice too low to be heard.

## CHAPTER III

## PROCEDURES AND RESEARCH METHODOLOGY

This chapter will present information concerning (1) the selection of the method of study, (2) the procedures used in the dissemination and collection of the data, and (3) the procedures used in the analysis of the data.

## SELECTION OF A METHOD

The methodology for this study was descriptive in nature. A two-fold procedure was used to obtain the information for the study:

(1) Data concerning the viewpoints of practicing elementary school counselors and counselor educators toward the use of play therapy in elementary schools were gathered through the use of a questionnaire technique.

(2) Information was gathered through an intensive review of the theoretical literature to assess the aspects of play therapy theory which are applicable to an elementary school counseling program.

## PROCEDURES USED IN THE DISSEMINATION, COLLECTION,

## AND PREPARATION OF THE DATA FOR ANALYSIS

A letter asking for the names of counselor educators in South Dakota counselor training institutions and names of elementary counselors in South Dakota schools was sent to Mrs. Pauline Sherer, Administrator of Guidance and Counseling Services with the South Dakota Department of Public Instruction. From a directory of pupil personnel services that

## PROCEDURES USED IN THE ANALYSIS OF THE DATA

The data were analyzed on the basis of two techniques. First, the results from the questionnaires surveying the attitudes of counselor educators and practicing elementary school counselors were analyzed to reveal trends concerning the techniques and appropriateness of implementing play therapy in the elementary school. Second, an analysis of the theoretical and research literature of play therapy was conducted to provide a framework for organizing and administering a program of elementary school play therapy. Chapters IV and V contain the results of this analysis.

## CHAPTER IV

## FINDINGS

This chapter includes findings from questionnaires completed by counselor educators in counselor training institutions and counselors in elementary schools in South Dakota.

PLAY THERAPY AS VIEWED BY ELEMENTARY SCHOOL  
COUNSELORS IMPLEMENTING PLAY THERAPY

The following analysis is based on the responses of five elementary school counselors who are presently implementing play therapy in their schools. The questions, numbers one through eleven in the questionnaire, are concerned with their experiences in counseling in this manner.

Years In Operation

Of the five schools that use play therapy, one school is in its first year of operation, three schools are in their third year, and one school is in its sixth year.

Selection Of Children

The number of children per week, who come to the playroom, varies from school to school. Two estimates given were five and six. Those who come are referred by teachers, parents, or administrators; screened and selected by the counselor; or refer themselves. Three schools use all three methods; one school relies on referrals by teachers, parents, or administrators; and one school relies on screening and

selection by a counselor.

#### Restrictions On Selection

There are some restrictions regarding who may come to the playrooms. Those programs funded under Title I are for the "disadvantaged." This includes two schools. One school does not accept a child if he is also going to an outside agency. Two counselors feel that time places restrictions on the number of children who might otherwise come, and the time has to be spent where it will be most profitable.

#### Types Of Counseling

The counselors named the one-to-one interview as the basis on which they most often counsel. Group counseling and the one-to-one relationship in play therapy were named next in frequency as occurring about an equal number of times. Group play therapy is used the least and one counselor does not use it at all.

#### Counseling The Parent

Four of the counselors stated that they do attempt to counsel both parent and child. One counselor qualifies her answer with "sometimes."

#### Playroom Limitations

Concerning the setting of limits in the playroom, one counselor sets no limits because she has felt no need to do so. Three set limits of physical attack on the counselor, physical harm to the child himself, destroying property and destroying play equipment. One said simply, "abuse."

### Physical Properties Of Playrooms

Only two counselors have rooms especially for play therapy use. The other three use the nurse's rooms, empty classrooms, the libraries, or any rooms vacant at the time. One counselor visits three schools and only one of these has a special room for play therapy use. One counselor uses a regular office room. One counselor uses a lunchroom with cement floors and no natural lighting. Another counselor works in a large, all-purpose room. In one school, the playroom walls are paneled and the floors carpeted. Room furnishings mentioned were: small table, child's desk and chairs, counselor's desk and chairs, and storage shelves and bookcases.

### Counselor Aids

The tape recorder has been very helpful in play therapy for four of the counselors. Although the fifth counselor does not use one at the present time, she believes one would be helpful.

All feel that taking notes is helpful. One counselor takes notes after the child leaves the room.

### PLAY THERAPY AS VIEWED BY ALL ELEMENTARY SCHOOL

### COUNSELORS PARTICIPATING IN THE STUDY

The following analysis is based on the responses of seven elementary counselors to questions A through K of the questionnaire. One counselor did not complete this part of the questionnaire, which was concerned with opinions and attitudes of the counselors toward play therapy in counseling.



### Play Therapy Versus Interview Situations

The counselors generally agreed that play therapy is at least as effective as an interview situation with most elementary school children, but two counselors believe it is more effective with fearful children and early elementary children than an interview is. One of the reasons given is that young children have more difficulty verbalizing. One counselor believes the interview is more effective than play therapy with upper elementary children.

### Counselor-Child Relationship

The relationship that is established between the counselor and child is considered, by six counselors, to be more crucial than are the techniques of the counselor, e.g., what he says and does. One counselor feels the two are so necessary to successful therapy that they cannot be considered separately.

### Ages Worked With Effectively

There are various ideas concerning what age child can be worked with most effectively in play therapy. Some ages suggested were: four to eight, five to seven, five to eight, eight and younger, and five to ten years.

### Counseling Parents

Six counselors believe it is necessary, in most cases, for one or both parents to receive counseling if the counselor is to work effectively with the child. One counselor does not feel it is possible to generalize since each case is so different. Another feels that usually, sixth grade children do not want their parents involved.

Six counselors believe that counseling the parents should be a function of the elementary school counselor. They qualified their answers with, "up to a point where referrals to outside agencies may be necessary," "when necessary," "not extensively, but some," and "not counseling, but consulting." One counselor feels counseling the parents should not be a function of the elementary school counselor.

### Play Media

In furnishing the playroom, five counselors feel there should be a wide variety of play media, any of which the child may choose. One counselor believes the play media should be selected in advance according to the nature of the child's problem. One counselor likes the idea of having a suitcase of selected toys.

The most frequently mentioned play media that might be found in a well-equipped playroom includes: doll house, family figures, doll house furniture, telephone, toy soldiers, clay, crayons, guns, paints, easel, paper, brushes, airplanes, checkers, scissors, and punching clown.

### Setting Limits

All seven counselors believe there should be a permissive atmosphere, with just a few limits imposed, in the playroom.

### Need For Play Therapy

Six counselors estimate there are a sufficient number of children who could benefit from play therapy in their schools to justify having a program. One counselor did not respond.

### Acceptance Of Play Therapy

Opinions differ concerning whether a play therapy program would be accepted by the administration, parents, and other faculty members. Four counselors believe it would be accepted, three believe it would not.

### Disadvantages Of Play Therapy

The counselors named these disadvantages: (1) lack of space for a regular playroom, (2) limited school facilities, (3) difficulty in transporting play equipment from school to school, (4) having to share the playroom with other groups, (5) being able to reach only a few children at a time, and (6) length of time it takes for results to become apparent.

### Advantages Of Play Therapy

These advantages were named by the counselors: (1) helps rid a child of fears and anger; (2) provides developmental opportunities for a child who has difficulty in social adjustments; (3) makes reducing tension, opening up communication, and establishing rapport easier; and (4) provides a natural medium of expression for a non-verbal child.

### Recommendations

The following recommendations were made by the counselors:

1. The play therapy program should be thoroughly explained to parents, faculty members and administrators before it is started.
2. Play therapy is for all children, not just those with intense psychological problems. Parents should be helped to understand this.

3. The playroom should be set apart from other classrooms so the children are free to make noise while they play.
4. The playroom should be used only for counseling purposes.
5. The playroom should be large enough for small groups of children and it should have ample table, shelf, and counter space so play materials can be displayed.

#### PLAY THERAPY AS VIEWED BY COUNSELOR EDUCATORS

The following analysis is based on the responses of counselor educators in the four South Dakota counselor education institutions. All have a graduate course of study which qualifies one to counsel in the elementary schools.

#### Elementary School Counseling Courses

The programs which prepare students to counsel in the elementary schools are the same as those which prepare them to counsel in the secondary schools. However, certain courses may be taken which are more specifically related to elementary school counseling. Three colleges offer Counseling Practicum in the Elementary School and three colleges offer Elementary School Guidance. One institution offers Introduction to Counseling Techniques to those interested in elementary school counseling, and another institution offers the Psychology of Elementary School Children.

The maximum number of hours which may be obtained in specific elementary guidance and counseling courses is six in one college, eight in another, and no hours in another. One educator listed 31 hours, but these courses included those offered to candidates for secondary school

counseling also. Many of these courses are also found in the other colleges, for example, Individual Mental Testing, Learning Disabilities of Children, and Psychological Testing.

#### Plans For Specialized Training

All of the counselor educators indicated a need for more specialized training of elementary school counselors. Three of the respondents said that plans are being made to offer more courses for those who are interested in the elementary school counseling field. The moratorium enacted by the Board of Regents on new courses has restricted the addition of courses in at least one institution. Another one has plans in the future to add courses in human development, personality theory, and pre-practicum. In two institutions, further course development depends on the Master Plan Study being conducted.

Estimates of the number of people in counselor education programs who entered elementary school counseling situations in September 1969, were: zero, two, five and fifteen.

#### Play Therapy Training

One institution includes instruction in play therapy techniques as part of the elementary courses. The remaining counselor educators indicated that instruction in play therapy techniques is not a part of any course.

#### Expression Through Play

All the educators feel that play as a medium of expression is as effective as an interview situation is with most elementary school

children. One qualified his answer; he advocates play for children under eight years old.

### Counselor Techniques Versus The Relationship

Two of the educators consider the techniques of the counselor (what he says and does) and the relationship that is established between the counselor and child as equally important to the success of the therapeutic situation with children. However, two educators believe that the relationship is the more important characteristic of the two.

### Work With Parents

Three educators believe it is often necessary for one or both parents to receive counseling if the counselor is to work effectively with the child. One feels consulting is more appropriate than counseling.

Counseling the parents is thought by three educators to be a function of the elementary school counselor. One of them qualifies his response with, "if no one else is available."

### Playroom Limits

Concerning limits that should be set in the playroom, two educators believe there should be none; the child should have complete freedom. Two feel a few limits must be imposed but that a permissive atmosphere should still be maintained.

### Advantages of Play Therapy

Some of the major advantages of having an elementary school play therapy program, as indicated by the counselor educators include:

(1) opportunities for free expression, (2) the facilitation of communication, (3) opportunities for young children to work out their concerns in an acceptable way, (4) learning to make decisions and choices, (5) being allowed to do things without interference by an adult, even though they may be difficult, and (6) opportunities to spot brain-damaged children.

### Recommendations

Recommendations made concerning play therapy in the establishment of a play therapy program are:

1. Be sure to have qualified, trained personnel.
2. Invest thoughtfully in proper equipment.
3. Provide a room to be used for that purpose only.
4. Make the playroom "child-proof" so children can really feel comfortable in it.
5. Provide the freedom so they can really "mess."
6. Provide opportunities for plenty of activities.
7. Allow freedom of choice in activities.

## CHAPTER V

## A RECOMMENDED PROGRAM OF PLAY THERAPY

Based on a thorough review of the literature concerning play therapy and the responses from the questionnaires sent to counselor educators in four counselor training institutions and to eight elementary school counselors in South Dakota, the following model is proposed. It was designed for use by elementary school counselors who have probably had no special training in the play therapy process, but who have a need, at times, for another approach with children other than the interview situation.

Play therapy is not new but it has not been extensively used. There is a hesitancy to use the term therapy because of the various connotations it has to many people, such as "disease" and "sickness." Counselors often assume the word means to "do something to" someone, and thus, may object to the usage of the term "therapy" for that reason. It suggests to some, interpretation and analysis of behavior, which they do not agree with or do not feel qualified to do. This writer would like to suggest that, call it what you will, play therapy is within the capabilities of the school counselor and completely in line with the principles of nondirective counseling. It simply must be understood that in child-centered, nondirective play therapy there is no diagnosing, interpreting, analyzing or directing of the play situation by the counselor. With this in mind, the counselor should be on familiar ground.

Play therapy is an opportunity for a child to freely express through play media, any problems and feelings he has by acting them out



in an acceptant and permissive atmosphere. In this way, he gradually develops self-respect, acceptance, and understanding and starts to take more responsibility for his actions. He becomes more self-actualizing.

The basic principles to guide the therapist are stated very well by

Axline (1969, p. 73):

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 do 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.

#### THE CHILD IN PLAY THERAPY

Play therapy, like elementary counseling in general, should be for all children who attend a regular elementary school. It should not be regarded as a remedial measure to be used only for those with severe problems; it should be preventive. "Normal" children with temporary problems such as a new baby at home, a parent in the hospital, or a divorce in the family can experience a release of tension through the playroom experience. Other problems that can be worked through in

therapy are nail biting, tics, eating problems, nightmares, behavior problems, speech difficulties, reading problems, and other problems with an emotional basis. Children who are physically handicapped often have emotional disturbances along with their handicaps, and can profit from the playroom experience too.

Behavior problems would include the withdrawn, anxious, frightened and silent children as well as the aggressive, uncontrollable, cruel, demanding and moody children. Children with reading problems, especially the non-readers, often release tension and work through fears and anxieties that help them improve their reading skills. For these children, the play experience is the same. The reading problem may not even be mentioned and the counselor does not attempt reading instruction of any kind. This is true for children who have speech problems with an emotional basis such as stuttering, stammering, baby talk and other language problems. Many times these children will talk through dolls, puppets, and other toys. However, the therapist does not attempt actual speech instruction.

Each child will use the play sessions differently, and there is a great difference in the uses that normal and disturbed children make of the playroom. Normal children are more spontaneous, happier in their play, and their feelings about themselves and their activities are not as serious and intense. They express anger and other strong emotions more clearly and specifically. Disturbed children are more likely to express their feelings in a diffused way and are more suspicious of the counselor. It is more difficult for them to establish trusting relationships with the counselor. Normal children tend to work through their

problems faster, probably because they are able to discuss them and express them more directly. They feel free to explore their own attitudes, frustrations, and fears, completely.

There is little agreement as to what ages children profit most from play therapy. In the elementary school situation it is generally helpful for children in kindergarten through sixth grade. The younger children usually feel more at home with the toys. Children in fifth grade or above should be allowed to look over the playroom and the counselor's office and spend the hour in whichever room they choose. If the toys seem too babyish, an interview in the office might be more appealing. The decision should be the child's.

Although ideally, we counselors may favor the developmental approach to counseling and plan to work with normal children who have normal, developmental problems, the reality of the situation is that there are many children in our schools who have serious problems. Sometimes referrals made to other agencies end in disappointment, since it may take weeks or months for an appointment to be made or for the child's case to be considered and accepted. In the meantime, these children can find some release in the playroom and perhaps, make some progress through counseling there.

The counselor who feels he has not had sufficient training to work in play therapy should keep in mind the similarities between play therapy and the counseling interview. In either approach, if the counselor has the proper attitudes and feelings toward children in general, and if he can establish a good relationship with a particular child, he has set the stage for successful counseling. Then he must live the

experience with the child for that period of time, so that he can see the experience as the child sees it. If he treats the child with respect and shows him that he understands and accepts him as he is, and that he has confidence in the child's ability to solve his own problems, progress will be underway. Specific problems need not be mentioned during the course of counseling, but the stabilizing effect of play therapy tends to help the child work them through. The child may not even know why he is in the playroom. He may only know that it is a special room, that the counselor is a different kind of adult than he has met before, and that the play experience is going to be unlike anything he has enjoyed before because he may do anything he likes. In this room, he is "running the show."

#### PROVIDING STRUCTURE

There are two important ways of providing structure. The first is in the child's first introduction to the counselor and the playroom. He may be afraid and confused, and has probably been referred by an anxious adult. The counselor will structure the situation by saying, "We have an hour together in this room. You may do what you like to do here. I will not tell you what to do; the choice is yours." If the child is hesitant or unwilling, the counselor might say, "You don't know me yet and you're not sure what you would like to do." The counselor might add, "Perhaps you would like to look around." If the child makes no move, the counselor should honor his decision to do nothing and say, "You may stand if you would like. Whatever you decide is alright with me." In this simple beginning, the counselor has let

the child know what to expect and has outlined most of the basic principles of play therapy mentioned earlier. Progress in counseling can occur when these principles have been conveyed to the child and as the counselor keeps responding with sensitivity to the child's feelings and attitudes.

The second important way to lend structure to the play situation is in the use of limits. This is in no way contradictory to the freedom and permissiveness that we strive to maintain in the playroom. Limits are few but are necessary for progress, since they provide the necessary structure to tie the life in the playroom to the real world. When limits are consistently enforced, they also give the child a feeling of security and safety. The necessary limits include: (1) destruction of play media and the playroom, (2) harming himself or the counselor, (3) time limits and (4) situational limits.

The destruction of play media or the playroom is imposed as a limit for two reasons; it is socially unrealistic and ignores budgetary considerations of the school. The counselor should try to provide for the child a more socially acceptable way of venting his feelings. When the child indicates his intention to participate in destructive behavior, the counselor should tell him of the limitation before he decides to follow-through. When toys are broken accidentally or deliberately, the counselor must recognize the child's feelings by maintaining a calm, accepting manner.

Obviously, the child cannot be allowed to harm himself or the counselor. The room is made as safe as possible to protect the child from hurting himself and thus omitting the necessity of constant

counselor intervention. If there are windows, a protective cover over them will prevent the possibility of the child leaning and falling out of the window. If the child is allowed to harm the counselor, it will be difficult for the counselor to keep from being hurt or angered. It will also be difficult to be acceptant and understanding. Another concern is the child's assessment of the effect of his destructive behavior on the relationship. Irreparable harm could be done to the child and his progress in counseling, due to the guilt feelings that he might have after harming the one person who has accepted him completely.

Time limits should be maintained, even if the child introduces something significant toward the end of the session. It is a practical limit considering other appointments the counselor may have. Also, the predictability of the counseling hour provides security for the child. Fifty minutes or an hour should be set as the limit. In many cases, a tentative number of visits might be determined at the first session. A reluctant child will often agree to come a certain number of times, "but that's all." Should he change his mind, or should there be a need for more or less therapy, it is understood that a change may be decided upon later, by the child and the counselor.

Situational limits vary from child to child and situation to situation. It may seem that this could become a very long list of "don'ts" but this is not necessary. Situational limits include common sense limitations that arise from time to time, e.g., a child deciding purposely to defecate on the floor. It also includes special problems, such as removing scissors from the room for the overly aggressive child and certain other materials that prove to be too stimulating for a very

hyperactive child.

Situational limits should not be mentioned until they are needed. They might suggest behavior that the child has not considered. Usually, even aggressive children have a general idea of what they should not do. There is a good chance that the need for many of the limits will never arise.

### COUNSELOR TECHNIQUES

There has been a tendency in nondirective counseling to de-emphasize the "technique" part of counseling and to emphasize the process and the relationship that is established between client and counselor. The same is true of play therapy with children. The relationship is more important but the techniques merit discussion. The two basic techniques are recognition of feelings and reflection of feelings.

Recognition of feelings is being alert to what the child is feeling, i.e., knowing what he feels through verbal or nonverbal communication. Reflecting feelings is the counselor's immediate reaction to having recognized the feeling expressed by the child. It may be expressed in simple restatement of what the child said, or it may be rephrased to say the same thing in different words. If the feeling was expressed nonverbally, the counselor will react to it as if it was spoken. If the child beats on a mother doll, the counselor might say, "You really feel like hitting the doll." It would be interpretation if he assumes the doll is the child's mother and says, "You are really angry with your mother." This should be avoided. Interpretation is any attempt by the counselor to translate symbolic behavior of play

into words. It is reflection of feeling if the actual behavior is recognized, rather than what the counselor thinks that behavior symbolizes.

Ordinarily, when reflecting the child's feelings, the counselor uses the key words used by the child. However, if the child's remarks are obscene or offensive, the counselor should substitute his own words without changing the meaning of the remark. If the counselor uses the same words as the child, it may seem like approval or agreement with the remark.

Rarely should the counselor become involved in actual play with the child. Such involvement tends to hinder the therapy. "It enables the child to exploit the adult mercilessly." (Ginott, 1961, p. 92) The counselor may find himself retrieving darts, running for balls, or whatever the child fancies. Although there may be times when the counselor slips out of his role, according to Ginott (1961, p. 93):

such sessions do not create warmth in the therapist or security in the child. There can be little healing value in allowing a child to manipulate an adult. Effective therapy must be based on mutual respect between the child and the therapist, without the therapist's ever abdicating his adult therapeutic role.

Another reason for not entering into the child's play is that such involvement tends to prevent concentration on the child.

It is especially useful to have a tape recorder available to record the play session. Taking notes during the sessions and afterwards, supplements the recordings. Frequently, the child asks to hear some parts of his verbalization and is surprised or disgusted at the way he sounds. He often gains insight into certain types of behavior in this way. Generally, the taping is for the counselor's use. He can constantly check his responses, motives and other techniques. The tape



should not be played for the parents. This would be a violation of confidentiality.

#### PLAY MEDIA AND THE PLAYROOM

The environmental situation will vary from school to school. The following suggestions will be concerned with what the play therapy situation should be. Suggestions concerning the playroom include:

1. The room size must be large enough to accommodate small groups of children (three or four), but small enough to be "safe" and cozy for an individual child. Suggested size: 175 square feet for individual play therapy room and 350 square feet if used for group play therapy room.
2. It is best to have a soundproof room so that other classrooms aren't disturbed by the noise.
3. Floors must be protected with a material that is easily cleaned and will withstand water, paint, clay, and pounding. Carpeted floors are unsuitable.
4. Walls must be of a material that is sturdy and easily cleaned.
5. The room should be well-lighted and the lights well-protected with a mesh covering. Small, high windows are desirable, also protected with a mesh covering.
6. The playroom should adjoin the counselor's office and be available for children who decide to "just talk."
7. A stage with an eight or nine inch elevation could be built at one end of the room.

8. There should be a sink with hot and cold water that is low enough for small children to play in.

Suggested furnishings in the playroom are:

1. Two tables with washable tops for activities such as finger painting and clay modeling. There should be a sufficient number of children's chairs to seat a whole group at each table.
2. Enough sturdy shelves and tables to display toys easily.
3. One large chalkboard fastened to the wall.
4. At least one low table which features the doll house and puppets.
5. A large sandbox on the floor with room for more than one child to play in it.
6. A tape recorder system in a protected area of the playroom, or with the microphone built into the wall and the recorder in the counselor's office. This makes the equipment less obvious to the child as well as protecting it from flying toys.
7. A chair or two for the counselor. (In her office would be another chair, a child's chair, a desk, and filing cabinets.)

It is important that toys are chosen for a playroom with care.

Even a playroom with many toys may not have the right toys for a certain type child. Too many toys can be as useless as too few. There should be a variety of both structured and unstructured toys. Some will be selected to encourage verbal expression; i.e., feelings of hostility, aggression, and fear. Other toys should be available simply because they may

have been denied at home, thus the feeling of freedom and permissiveness. Some unstructured media should be provided to allow a child to express his attitudes in an indirect way, when he is not yet ready to face his feelings openly.

Many toys are useful in different ways. The doll house family may encourage verbalization, hostility, aggression, or even fear. When the toy budget is limited, relatively unstructured toys are preferred over structured toys because of their flexibility. Sand in a sandbox is one of the best unstructured toys. Another essential unstructured media is running water.

Play media are arranged in an unstructured fashion; i.e., the counselor does not try to anticipate the child's problem and set out suitable toys so that progress will be faster. The child chooses what he wants to play with. If he chooses not to play, the counselor does not urge him to play or suggest that he play with certain things. If he wants to sit the whole hour without playing or talking, this should be permitted. If the counselor believes that the child has the capability to solve his own problems, he will allow the child to select the method of "playing it out."

Although all toys will not be suitable for all children at all age levels, there should be some toys that each child can experience success with and others that the child finds more challenging.

Fancy toys and expensive furniture are not appropriate. The child should not have to be constantly reminded to "be careful" or "don't pound that." He should not have to feel guilt over broken toys or marred furniture. He should be able to play with the water, paint, clay,

and sand without fear of getting the floor dirty. The fact that he has this freedom, is one of the ways in which the experience in the playroom is unique. It is a freedom he may never have felt before. When permitted this freedom, the child will often take the initiative to clean up what he spills without being told to do so.

The location of the room should be such that the child can freely move and make noise without fear of disturbing other people in the school. The door should be kept closed and there should be no interruptions from outside. If this is allowed, the counselor is not showing the child appropriate respect. If he knows it is his room for that hour, it can be a very comforting and important feeling for the child.

The stage in the playroom can have many uses. Possible uses include: group presentation of puppet shows, individual use for acting, and playhouse use with child-sized furniture on it.

The dollhouse should be lightweight, large and furnished with sturdy wooden furniture. There should be dolls with removable clothes that could be used to depict male and female adults, children, and babies. These figures may be "drowned" or "buried" or "run over" by a truck, so they should be of durable, bendable rubber. Puppets should also be chosen to represent all members possible in a child's family.

Sand is suitable for many activities, depending on the child's imagination. It can be desert, snow, water, bombs, quicksand, or anything the child can conjure up. It can even dispose of siblings, parents, and teachers, at times, to the child's delight. Sand is very helpful to children who are not yet able to direct their hostilities to doll figures or in the form of verbalization. It is a safe way of releasing

certain feelings known only to the child, without being specific and revealing.

Water play is probably one of the most fascinating media to children in the playroom. It is inexpensive and requires no special skills. Every child can experience success in his play at the sink. It is an unstructured material, like sand, that can be used in many ways. Water will get splashed on the floor. After each session, a custodian should help clean and prepare the room for the next session. Part of this clean-up should be to remove broken toys and put the playroom back in order so as not to suggest certain activities to a child that were carried on the hour before.

The psychoanalysts would classify finger painting as part of the need to mess, "an extension of the repressed desire to explore body products." (Ginott, 1961, p. 68) Whatever the explanation, children do, indeed, have a "need to mess." Finger painting satisfies this need very well. The soft paint moves so easily about the paper that children can readily translate feelings into color and design. Finger painting encourages spontaneity and is suggested for inhibited children. It tends to over-excite aggressive children and should not be used.

Clay is a material that can be used by all children. Aggressive children can punch and pound it, thus venting some hostile feelings. As in the other unstructured media, no tools and no special skills are required to experience success. From the psychoanalytic view, clay ". . . enables children to communicate dramatically, their hidden curiosity about body shape, body products, and genital parts." (Ginott, 1961, p. 69)

A few essential play media for a play therapy room have been discussed. Other selections should include: doll house, family and furniture; easel, finger, and water paints; easel, brushes, and paper; sandbox and shovels; chalkboard with white and colored chalk; guns; hand puppets; nursing bottles; films and viewer; pictures; plastic pan, sponges, and dishes for water play; bubble goo; animal figures; balls of various sizes; crayons; baby dolls; clay; toy soldiers; cars, trucks, and airplanes; scissors; telephones; dress-up play clothes and shoes; blocks; housekeeping sets which include dishes, pots, pans, coffee pot, broom and mop; pounding boards; punching bags; drums, cymbals, and other rhythm instruments.

#### GROUP PLAY THERAPY

Group play therapy will be discussed less extensively, since the basic principles of individual play therapy also apply to group therapy. The counselor still focuses on the individual child in the playroom, the aims of counseling are the same, and the role of the counselor is basically the same. The playroom and play media are similar, except that more children must be accommodated.

The counselor may decide that some children can profit more from one type of therapy than another, or he may decide a combination of individual and group therapy is best. Whichever type is used, one or two sessions a week is suggested.

The child should rarely be allowed to choose his own groups, mainly because the waiting list of children is too long to be able to afford having three children in the group who do not have a real need.

The selection of a group is very important and not a decision within the understanding of the child. Certain things must be considered in the selection of groups (Ginott, 1961):

1. Siblings and very close friends should not be in the same group. This inhibits trying out new behaviors and one child may feel a responsibility to take care of another or behave in a manner customary outside the playroom.
2. In a group of aggressive boys, one or two girls added have a calming effect. Play is less aggressive, there is more of a variety in the types of play, and the boys begin taking their aggressions out on the toys instead of each other.
3. Children should be nearly the same age. Exceptions to this might be an extremely "tough guy" who is a bully in his own group. If he is put in with older children, he usually sees that he is not so powerful as he thought, and often sees his behavior in a different light.
4. Children with different temperaments and symptoms should be placed together. Occasionally a wrong combination will result, but usually, having different types of children together gives the children a chance to identify with personalities different from their own.
5. Children with a wide range of intelligence can be grouped together because they all use the same media to work through their problems.
6. No more than three to five children should be selected for a group. More than this can result in chaotic activity and

gives the counselor less opportunity to observe each child.

The activity of each child in the group is observed by the counselor. He will not act as referee to arguments and skirmishes. He will try not to give more attention to one child than another, and for this reason will enter into the play very little.

From the first moment the child enters the playroom, the counselor should be aware of the child's feelings, i.e., whether the child is frightened of the counselor, afraid to leave his mother, or angry and belligerent at being there. The feelings should be reflected back to the child. Usually, the child finds out that the counselor and the playroom are not threatening and he is more anxious to participate at the next session. The counselor should also tell parents what to expect while their child is seeing the counselor, and give suggestions about what to say and not to say concerning counseling.

The group has no goals of its own. Always, the individual child is important. However, the members of the group provide the most important way of helping individuals. This occurs mainly through the process of identification. For example, withdrawn children may come to identify with active playmates, or effeminate boys may identify with a masculine playmate. Individual play therapy offers only the counselor for a model.

The group provides a chance for children to help, as well as be helped. Children sympathize with one another and know that they are understood by each other. As a child can lean a little on others, he also allows others to lean on him. A wonderful atmosphere of warmth, understanding and acceptance is built in this way.



## THE ROLE OF TEACHERS AND ADMINISTRATORS

Before a play therapy program is started, the detailed plans will be worked out with the administrators and representatives from the faculty. The guidelines for implementing the program should be explained to all the teachers, and the support and cooperation of both teachers and administrators needs to be obtained if the program is to be successful. It should be made clear what the purposes of play therapy are, how it is expected that those purposes be accomplished, and what part the teachers play in the implementation of such a program.

An important contribution of the counselor is his philosophy in the playroom and its application in the classroom situation. Since the establishment of a good relationship between teacher and child is so important to effective learning and good mental health (of both the teacher and child), Axline's basic principles of nondirective therapy take on meaning to the teacher as well as the counselor. Certainly, a teacher who is warm, friendly, patient and permissive and who accepts, respects and understands the child, will be likely to foster the same feelings in the child for the counselor. School will be more pleasant and learning will be easier.

Even the limitations or rules that are consistently maintained, help the child develop self-reliance, dependability, and initiative. When a very aggressive child is hitting those around him, the teacher will still expect him to go by the same rules as the others but she will also recognize his feelings. "Bob is feeling tough today. He thinks that if he uses force, he can get to the head of the line. But our rules, Bob, say that you will either take your turn fairly or get

out of line." (Axline, 1969, p. 152) In this case, the teacher reflected the attitudes Bob was expressing, and gave him a choice of abiding by the rules or getting out of line. This may not have been his direct choice, but is a school limitation that he learns to meet realistically.

In a classroom, there are many opportunities to make choices and they should be provided as often as possible. Of course, with any group of children, there will of necessity be fewer choices allowed than with an individual.

Fights between two children can be settled easier if the teacher recognizes the feelings of each child, thus allowing children to see the reasons for the conflict, and helping them to develop some insight into their behavior. Often, teachers use force to stop fights. Chances are, they will continue their fight later, off the school grounds. Axline (1969, p. 153) believes:

When a teacher respects the dignity of a child, whether he be six or sixteen, and treats the child with understanding, kindness, and constructive help, she is developing in him an ability to look within himself for the answers to his problems, and to become responsible for himself as an independent individual in his own right.

#### THE ROLE OF THE PARENTS

At the beginning of a school play therapy program, parents should be informed as to how it will operate. They need to come to an understanding of what it is, so no stigma will be attached to the children's sessions in the playroom.

There are times when the child's parents may complicate his case. If the parents can be helped also, the child's progress may be faster. However, most schools do not have the facilities or a large

enough counseling staff to deal extensively with parent counseling. Also, many counselors feel that this is not their responsibility. Children can be successfully counseled with or without their parents also seeking help. Children should not be refused the play therapy experience because their parents will not accept help or because the school is not staffed for this purpose.

When a child learns, through play therapy, to understand himself and his surroundings and comes to see himself as a more worthwhile person, his newly acquired insights may affect the behavior of his parents and may improve conditions at home. The parents may find him easier to live with, more responsible, and more mature. In short, they will see and treat him differently. This may or may not help them gain insight into their own problems but the child will have a new strength to cope with conditions as they are. The fact that the child can work out difficulties against odds like these, shows the power and inner strength that he possesses to be self-directive.

In a clinical setting and possibly in some schools, the parents could see a psychologist or counselor. Until provisions are made for more extensive counseling of parents, the elementary school counselor will have to do the best he can in his work with the child. He will consult with parents to elicit their cooperation in helping the child. A parent who repeatedly turns to the school counselor in search of personal help, probably should be referred to whatever other facilities are available in the city, such as counseling or mental health centers. This should be done diplomatically and without judgment.

Parents may be resentful and puzzled if suggestions are made for

them to undergo counseling, since they may feel that they are being blamed for the child's difficulties. Since parents are the main influence in their child's life, his problems often center around them and other home difficulties. (An extensive treatment is given to parents in counseling, by Halpern, 1963)

If time permits, counseling groups for parents might be formed. This would provide parents with an opportunity to discuss the problems that they have with their children and to help each other become aware of their own part in the child's problems. Again, this possibility depends on the counselor and the policy of the school.

Parents' attitudes toward play therapy can be a factor determining the degree of success that can be achieved with the child. If the parents feel there is a stigma attached to having the child see the counselor, and if they make remarks and complaints about the counselor and his methods, the child may become suspicious of the relationship and counseling, in general. Parents who feel jealous of the relationship that has been established between the counselor and their child, will show it in various ways. The child may even begin to feel guilty about coming to the playroom.

Although parents are very deeply involved in the lives of their child, the counselor does not discuss what the child says in the sessions with the parents.

## CHAPTER VI

## SUMMARY AND CONCLUSIONS

This chapter presents a summary of the research and literature findings related to play therapy. Conclusions drawn from these findings are presented. The final section contains recommendations concerning the use of play therapy in elementary schools.

## SUMMARY

The purposes of the study were to explore research and literature findings related to play therapy and to propose, from the findings, a model of play therapy for use in elementary school counseling settings. This was accomplished through an analysis of theoretical literature and the use of questionnaires sent to counselor educators and elementary school counselors concerning play therapy.

Questionnaire responses from the counselors expressed frustration over heavy case loads, lack of adequate training in play therapy, and lack of properly furnished playrooms in their schools. They considered play therapy a good approach to counseling the child who does not verbalize readily.

Responses from counselor educators indicated a need for more extensive counselor preparation for elementary school counseling, and particularly in the area of play therapy. Plans are underway in some of the institutions to add more courses specifically for elementary school counseling.

A proposed model of client-centered play therapy for an

elementary school counseling program was presented. Specific guidelines were presented to facilitate the development of a play therapy program. Included in those guidelines were the following aspects of program development:

1. The child in play therapy
2. Providing structure
3. Counselor techniques
4. Play media and the playroom
5. Group play therapy
6. The role of teachers and administrators
7. The role of the parents

#### CONCLUSIONS

The following conclusions were reached concerning play therapy in elementary school counseling:

1. Play therapy can be a valuable addition to elementary school counseling programs.
2. Elementary school counselors in the study have viewpoints concerning play therapy similar to the theorists reviewed. Similarities included: limit setting, counseling parents, ages worked with most effectively, need for play therapy and need for persons well-trained in this field. Differences were mainly in the selection of toys and furnishing the playroom.
3. From the physical characteristics of play therapy rooms described in the responses from counselors, it appears there

are few special provisions to make them particularly suited for play therapy.

4. Relatively little has been written concerning the use of play therapy in the elementary school and there is a lack of emphasis in elementary counseling textbooks on play therapy.
5. Counselor training institutions need to re-evaluate their counseling programs and modify them to include more courses in elementary school counseling, particularly in play therapy.
6. There is a definite need for research concerning the feasibility of providing play therapy as a part of the elementary school counseling services.

#### RECOMMENDATIONS

Based upon the findings of the questionnaires from counselors and counselor educators and a thorough study of the literature, the following recommendations seem appropriate:

1. Elementary schools which do not have play therapy as part of their counseling program should establish them for children in grades kindergarten through six.
2. Schools who begin play therapy programs should set aside a room that is well-equipped and well-planned especially for play therapy and other counseling use.
3. Research should be done to determine the effects of play therapy in elementary school counseling programs on children with emotional problems.

4. With play therapy programs that are in operation, follow-up studies of a large number of cases at regular intervals should be done.
5. Investigation should be made into the assessment of personal adjustment before and after play therapy to determine if this type of counseling contributes significantly to a change in behavior.
6. Comparative studies of individual and group play therapy should be made.



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**APPENDIX A**

RANK ORDER ARRANGEMENT OF 28 BEST TOYS OF THE 62 TOYS EMPIRICALLY EXAMINED:  
 TOYS ARE RANKED ON THE BASIS OF THEIR OBTAINED VERBAL INDEX

Toy	Rec. By	VI	Toy	Rec. By	VI
Doll House, Family, and Furniture	A,Ax,M,W*	212	Bubble Goo	None	26
Poster Paints, Brushes, Paper, Easel, and Jars	A,Ax,M,W	186	Coffee Pot	None	24
Sandbox	Ax,M	99	Cord, Rope	None	23
Blackboard and Colored Chalk	**	80	Animals	A,Ax	18
Cap Guns and Caps	A,Ax,M,W	59	Wood, Asso.	M	16
Coloring Books	None	43	Balls, Asso.	None	17
Hand Puppets	Ax,M	36	Crayons	A,Ax,M,W	16
Balloons	M	36	Baby Dolls	A,Ax,M,W	16
Nursing Bottles	Ax,M	34	Bow and Arrows	W	15
Films and Viewer	None	34	Clay	A,Ax,M,W	14
Water in Basin	Ax,M	32	Cars	A,Ax,M	13
Pop Guns	A,Ax,M,W	29	Checkers	None	12
			Shovel	M	12
			Masks	M	11
			Toy Soldiers	A,Ax,M,W	10
			Water Colors	A,Ax,M,W	10

\*A-Arthur (2), Ax-Axline (3), M-Moustakas (24), W-Watson (33).

\*\*While blackboard and chalk are not specifically recommended, they are similar to crayons, paints, and paper which are all highly recommended.

APPENDIX B

After some modifications by Lebo (1955b, p. 376), the Finke categories for quantifying the play therapy process are as follows:

- A. Curiosity about the situation and things present in it. (Why did you choose me? Anyone else been here? Who owns these toys? Who drew that picture?)
- B. Simple descriptions, information, and comments about play and play-room. (This is an army. These are prisoners. More marbles. The room's different.)
- C. Statements indicating aggression. (All references to fighting, shooting, storms, burying, drowning, death, hurting, destroying, etc.)
- D. Story units. (1. Unconnected with play. Stories obviously far-fetched or too exaggerated and inconsistent to have occurred. 2. Any imaginary dialogue or story plot wound around the play, such as: He guards the opening. He's asleep. He doesn't know they're after him. I'm taking them to the army.)
- E. Definite decisions. (I'm going to build a bridge. I said I'd do it and I did. Just what I wanted. Did it.)
- F. Inconsistencies, confusion, indecision, and doubt. (My mother has two children, no, one. My brother is half my age and he's much taller. My sister's birthday was the day before mine last year but mine is before hers this year. I'm not sure what I should do. I wonder if this will work.)
- G. Exploring the limits of the playroom. (Can I take this home? Can I get water? Can I paint this? I'm going to take this. One second. I can stay longer.)
- H. Attempting to shift responsibility to the therapist. (What should I do next? Is this deep enough? Is this good? Do you like this?)
- I. Evidence of interest in the counselor. (Were you here yesterday? What do you do? How are you? Can I trust you? Have you read such and such a book?)
- J. Attempting to establish a relationship with the counselor. (Guess. Bet you can't guess. What's this? Look at that. See. Do you know what I'm going to do? Want to see how cars crash? Will you help me? You do this and I'll do that.)
- K. Negative statements about the self. (I'm dumb. I'm afraid. I never win.)
- L. Positive statements about the self. (I'm good in school. I can do that. I play marbles best. I'll win it back.)
- M. Negative statements about the family, school, things made or present in the playroom, the situation, activities, etc. (Is there going to be new sand? I wish this was bigger. I don't like my sister. I wish I had more toys at home.)
- N. Positive statements about the family, school, things made or present in the playroom, the situation, activities, etc. (I like it here. This doll is so pretty. We just got a



- wonderful new puppy at home.)
- O. Straight information and stories about the family, school, pets, teacher, self, etc. (We have a big house. I went to the park yesterday. I have a sister. I was waiting for you. I thought you were my mother.)
  - P. Asking for information. (Do birds have ears? Where is the paint? How does this work?)
  - Q. Questions or comments pertaining to time during the interview. (How much longer do we have? I bet there are fifteen minutes left. Do I have time to play?)
  - R. Exclamations. (Here we go again! Hey! Darn! Oh! Crazy! Ahhh!)
  - S. Unclassifiable. (Yes. Mmmmm. OK. Hello. Goodbye. Excuse me. Any answer to a question or a pure repetition of counselor's words.)
  - T. Insightful statements revealing self-understanding. (When I worried it made me steal. I wasn't loud but I was mean.)
  - U. Ambivalent statements. (I'm scared in here but I like to be here. I'd like to paint now and blow bubbles too.)
  - V. Sound effects. (Vocalizations which are not speech. Such noises as clucking, siren, machine gun, explosion, airplane, etc.)
  - W. Mumbling or talking to self in a voice too low to be heard. (Statements which cannot be heard and which the child does not direct to the therapist.)

**APPENDIX C**

1. Do you have a graduate course of study which qualifies one to be a counselor in the elementary schools?  Yes  No
2. If so, is it different in any way from the program which prepare one to counsel in the junior or senior high school?  Yes  No
3. Please list specific courses which are offered for elementary counseling.
4. Is instruction in play therapy techniques a part of any elementary counseling course?  Yes  No
5. What is the maximum number of hours that could be obtained in elementary guidance and counseling? \_\_\_\_\_
6. Are plans pending to offer more courses for those wishing to enter the elementary guidance and counseling field?  Yes  No  
Please explain.
7. Do you feel there is a need for more specialized training of elementary school counselors?  Yes  No
8. How many in your program do you estimate entered elementary school counseling situations in September 1969? \_\_\_\_\_
9. Play as a medium of expression is as effective as an interview situation with most elementary school children.   
Children verbalize so readily, the interview is as effective as the play situation with most children.   
One is more effective than another.  (Specify)
10. Most crucial to the success of the therapeutic situation are the techniques the counselor decides to use(what he says and does).   
Most crucial to the success of the therapeutic situation is the relationship that is established between the counselor and the child.

11. Play therapy is probably most effective with what ages? \_\_\_\_\_
12. Do you feel it is often necessary for the parent or parents to also receive counseling if you are to work effectively with the child? \_\_\_\_\_ Yes \_\_\_\_\_ No
13. Should counseling the parents be a function of the elementary school counselor? \_\_\_\_\_ Yes \_\_\_\_\_ No
14. Limits that should be set in the play therapy room:
- None. The child should have complete freedom. \_\_\_\_\_
- Few. A permissive atmosphere is maintained but certain limits must be imposed. \_\_\_\_\_
- Many. Restrictions are imposed to lend structure to the play therapy. \_\_\_\_\_
15. What do you consider the major advantage of an elementary school play therapy program?
16. What recommendations would you make concerning any aspect of play therapy in the establishment of a program for the first time?

DOES THE ELEMENTARY COUNSELING PROGRAM IN YOUR SCHOOL INCLUDE  
PLAY THERAPY? \_\_\_Yes\_\_\_No

If answer is Yes, please complete  
the entire questionnaire, 1 through  
11 and A through K.

1. Number of years play therapy has  
been a part of the school  
program \_\_\_\_\_.

2. Approximate number of children  
in play therapy each week. \_\_\_\_\_

3. (Please number the following in  
order of frequency--0 for never,  
to 3 for most frequent.)  
You counsel on the basis of

the one-to-one interview \_\_\_\_\_

group counseling \_\_\_\_\_

group play therapy \_\_\_\_\_

the one-to-one relation-  
ship in play therapy \_\_\_\_\_

4. Most children who come to the  
playroom

are referred by teachers, par-  
ents or administrators \_\_\_\_\_  
ask to come \_\_\_\_\_

are screened and se-  
lected by a counselor \_\_\_\_\_

5. Are there restrictions as to  
who is eligible? \_\_\_Yes\_\_\_No

If yes, explain. \_\_\_\_\_

6. Does your school attempt to  
counsel both parent and child?  
\_\_\_Yes\_\_\_No

7. Does the counselor set limits  
in the playroom? \_\_\_Yes\_\_\_No

If yes, explain. \_\_\_\_\_

8. The playroom is adjacent to  
what rooms? \_\_\_\_\_

If answer is No, please complete  
only this part of the question-  
naire, A through K.

A. Play as a medium of expression  
is as effective as an inter-  
view situation with most  
elementary children. \_\_\_\_\_

Children verbalize so readily,  
the interview is as effective  
as the play situation with  
most children. \_\_\_\_\_

One is more effective than  
another. \_\_\_\_\_

(specify) \_\_\_\_\_

B. Most crucial to the success of  
the therapeutic situation

are the techniques of the  
counselor (what he says and  
does) \_\_\_\_\_

is the relationship that is  
established between the coun-  
selor and child. \_\_\_\_\_

C. Play therapy is probably most  
effective with what ages? \_\_\_\_\_

D. Do you feel it is necessary  
for the parent or parents, in  
most cases, to also receive  
counseling if you are to work  
effectively with the child?  
\_\_\_Yes\_\_\_No

E. Should counseling the parents  
be a function of the ele-  
mentary school counselor?  
\_\_\_Yes\_\_\_No

F. The playroom should be fur-  
nished with

a wide variety of play media,  
any of which the child may

Is it exclusively for play therapy and counseling?

\_\_\_Yes\_\_\_No

9. Briefly describe the physical characteristics of the room. Exclude play media. \_\_\_\_\_  
\_\_\_\_\_
10. Which of these do you find helpful in play therapy?
- a tape recorder \_\_\_\_\_
- taking notes \_\_\_\_\_
- assistants in the room \_\_\_\_\_
- other \_\_\_\_\_  
\_\_\_\_\_
11. What do you consider the major advantages of an elementary school play therapy program?  
\_\_\_\_\_

choose \_\_\_\_\_

an arrangement of play media selected in advance for the child according to the nature of his problem \_\_\_\_\_

suit case of selected toys \_\_\_\_\_

other \_\_\_\_\_  
\_\_\_\_\_

- G. A well-equipped play therapy room should include:

doll house, family and furniture \_\_\_\_\_ airplanes \_\_\_\_\_ masks \_\_\_\_\_  
telephone \_\_\_\_\_ coloring book \_\_\_\_\_  
mallet \_\_\_\_\_ nursing bottles \_\_\_\_\_  
running water \_\_\_\_\_ sandbox \_\_\_\_\_  
paints, easel, brushes, paper \_\_\_\_\_  
clothesline and pins \_\_\_\_\_  
guns \_\_\_\_\_ broom \_\_\_\_\_ balloons \_\_\_\_\_  
hand puppets \_\_\_\_\_ checkers \_\_\_\_\_  
toy soldiers \_\_\_\_\_ crayons \_\_\_\_\_  
chalkboard \_\_\_\_\_ clay \_\_\_\_\_ balls \_\_\_\_\_  
baby dolls \_\_\_\_\_ scissors \_\_\_\_\_  
boats \_\_\_\_\_ punching clown \_\_\_\_\_  
others \_\_\_\_\_

- H. Limits that should be set in the play therapy room:

None. Child should have complete freedom. \_\_\_\_\_

Few. A permissive atmosphere is maintained but certain limits must be imposed. \_\_\_\_\_

Many. Restrictions are imposed to lend structure to the play therapy. \_\_\_\_\_

- I. Is there a sufficient number of children who could benefit from play therapy in your school to justify having a program?  
\_\_\_Yes\_\_\_No

- J. Do you feel a program of play

would be accepted by the  
administration, parents and  
other faculty members?

Yes  No

- K. What recommendations would  
you make concerning the room,  
procedures, or any aspect of  
play therapy in the establish-  
ment of a program for the  
first time. (Other than those  
you have indicated above.)
- 
-

## APPENDIX D



EDUCATION DEPARTMENT

1002 3rd. St.  
Brookings, South Dakota  
57006  
March 14, 1970

The enclosed questionnaire is designed to obtain information concerning the training of elementary school counselors in South Dakota. Specifically I am gathering information from South Dakota counselor education institutions to be used in setting up a model of play therapy for South Dakota elementary schools. This is being done in connection with my master's thesis.

I would appreciate your cooperation in completing the questionnaire and returning it by March 26, 1970, in the attached, addressed envelope.

Thank you for your assistance in this project.

Sincerely yours,

(Mrs.) Nancy King

EDUCATION DEPARTMENT

1002 3rd. St.  
Brookings, South Dakota  
57006  
March 14, 1970

The enclosed questionnaire is designed to obtain information concerning play therapy in the elementary schools of South Dakota. The specific purpose of the questionnaire is to gather information and recommendations from elementary school counselors which can be used to set up a model therapy program. This work is being done in connection with my master's thesis.

I would appreciate your cooperation in completing the questionnaire and returning it by March 26, 1970, using the attached, addressed envelope. You may be assured that all information will be used in a professional manner and no individual will be identified by name. I would be happy to send you a copy of the proposed model when it is completed.

Thank you for your assistance in this project. It will aid our profession in clarifying the use of play therapy in the elementary school guidance program.

Sincerely yours,

(Mrs.) Nancy King

EDUCATION DEPARTMENT

1002 3rd. St.  
Brookings, South Dakota  
57006  
April 1, 1970

A letter sent on March 14, 1970 explaining a project I am working on in connection with my master's thesis, possibly did not reach your school. I am enclosing a duplicate of the questionnaire, which I have asked all elementary counselors in South Dakota to complete. I am interested in your experiences, attitudes and opinions concerning play therapy in elementary schools. Please complete the questionnaire and return it in the self-addressed envelope.

Thank you for your cooperation in this project.

Sincerely yours,

(Mrs.) Nancy King