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Therapeutic Interventions for Children in a Hospital Setting

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THERAPEUTIC INTERVENTIONS FOR CHILDREN IN A HOSPITAL SETTING

by

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VITA

The author, Patricia Almeida, is the daughter of Carlos Almeida and Gladys (Murillo) Almeida. She was born February 28, 1953 in Cuenca, Ecuador.

Her secondary education was obtained in Springfield, Illinois, where she graduated in 1971.

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CHAPTER I

INTRODUCTION

Play therapy has emerged from attempts to provide children an avenue for growth using their most natural language, play (Freud, A., 1954). It is based upon the fact that play is their natural medium of self-expression and thus affords an opportunity for them to "play out" their feelings and problems. Initially, play therapy was conceived as a method which generally corresponded to the method of psychoanalysis in adult psychotherapy. In play therapy, children reveal themselves to the therapist by means of play rather than verbalization of thoughts. Eric Erickson (1950) thinks of playing as a child's universe, in which conditions are simplified and one can assume many roles, test expectations and think through present and past failures.

Freud (1955) explained play and fantasy as the means at a child's disposal to gain control and mastery over reality. In psychoanalytic terms, the ego gains strength through play, mediating in a safe way between the symbols of the id and external reality (superego).

Rousseau (1955) was one of the first writers to advocate the study of children's play in order to understand and educate them. In essence, he suggested that a child's teacher become a child in order to have a better understanding of the child.

Piaget (1951) also recognized the process of play in cognitive development, and concluded that children must begin at the concrete level of experience before they are able to develop to the abstract. Hence, using play as a medium, children can concretize their emotional experiences and then generalize them to a more abstract level.

Recognizing the unique therapeutic needs of children, professionals developed approaches which encompassed play as a learning process for them. Through the medium of play, much can be learned about children and help can be given to them by interpreting the meanings of their play activities, at a variety of levels, symbolic and generic, as well as immediate.

The therapist's role, through this kind of analysis and interaction, was largely to assist the child in facing various feelings of anxiety, hostility, and insecurity, and in learning better ways of dealing with these feelings. Child counselors tend to agree that play therapy is an accepted mode of treatment (Hendricks, 1971). Younger children experience difficulty at times and discomfort in family interviews that are conducted in an office where the primary mode of communication is verbal and on the adult level. A playroom and play materials are condusive for children in communicating their conflicts and feelings. By meeting through the activity of play the adult communicates willingness to listen to the child. One enters the children's world and meets them on their level (Orgun, 1973).

Play therapy is most generally utilized, however, in the rehabilitation of the emotionally disturbed and the mentally deficient, and more recently there has been an attempt to incorporate it within the hospital setting (Adams, 1976). It can also be used in a school setting with normal children. For example, in kindergarten, play therapy can be used to discuss a new baby, quarrelling parents, and sibling rivalry (Ortiz, 1970).

Play observation can also be a diagnostic tool to supplement psychological testing.

Hence, play therapy is a therapeutic method, in which playing serves as a symbolic representation of the child's psychological dynamics. Given the traumatic experience often associated with hospitalization it becomes important to communicate with the child, through the world of play.

At some point in their lives, many children will contract an illness which can carry with it a probability of one period of hospitalization. This encounter with hospitalization can be brief or prolonged, pleasant or disturbing, isolated or repeated. Hospitalization is a traumatic experience for children. It is known that children's fears and fantasies about it are important, not just in themselves, but also as it affects their illness and its course. For a child with a potentially fatal disease, such as cancer, hospitalization can be all the more anxiety-provoking (Adams, 1976).

Since hospitalization does create radical changes in the environment of the child along with insecurities and

separation from the family, hospitals across the nations are developing play therapy programs to help children face and master the associated anxiety. Play therapy in the hospital is a tool to assist children in exploring and understanding their feelings and to aid in developing more adaptive patterns of behavior. Its function in the hospital is to maintain a normal outlet for the anxiety, anger and fear which the child must face and deal.

PURPOSE OF THIS STUDY

The purpose of this study was to intensively review the current research concerning play therapy. More specifically, to examine play therapy and other interventions as a treatment approach for relieving the anxiety of hospitalized children.

PROCEDURE FOR COLLECTION OF DATA

The procedure included locating and acquiring the literature through various resources. Data was gathered from Psychological Abstracts, Dissertation Abstracts, journals, textbooks, and bibliographies. Data was gathered from the following places: Loyola University, Northwestern University, Children's Memorial Hospital Library, University of Chicago, and University of Illinois.

The material was indexed according to topics (theoretical approaches, setting, parental involvement, etc.) Each topic was then researched and if necessary sub-categorized

into appropriate topics. After the topics were indexed and cross-referenced according to their respective authors, the chapters were organized and the data placed accordingly.

The material on theory and approach was organized into Chapter II. The material on children and hospitalization and attempted interventions is organized in Chapter III, with discussion, summary and conclusion following in Chapter IV.

CHAPTER II

REVIEW OF THE RELATED LITERATURE

This chapter includes an overview of the development of some child therapy practices.

Originally therapists working with children tended to work within the framwork of a viewpoint defined for adult clients and to modify their approach for their work with children.

A historical basis for some of the theories of child therapy is described.

PSYCHOANALYTIC VIEWPOINT

The psychoanalytic method for working with children grew from the teachings of Sigmund Freud. Freud, S. (1938) referred to child's play and compared it to "poetic creation". He suggested that children at play create a world of their own, or rearrange things of their world in a new way that pleases them. Freud stressed that the objects used in play were significant, not in terms of symbols, but rather in the use the child makes of them, which can shed light on feelings or representations.

The psychoanalytic tenet of repression indicates that children have an unconscious storehouse of memories and feelings. According to Freud, childhood memories assumed importance in that in reconstructing one's childood, the

persons could reorganize their past according to their current desires. This is like small children at play who reorganize their past or present world to suit their fancy. Freud also stressed that verbal accounts of children, like adults, often refer not so much to realities, as to worlds of desires and dreams (Mannoni, 1970). Freud, however, did not work directly with children. His interest lay in observation of them as an aid to learning more about personality dynamics and development. He often worked with parents who worked with their children.

Hug-Hellmuth's (1929) work was observed closely by Freud. In her work, she stressed that play was essential in child-analysis when treating children seven years of age or younger. She did not develop a technique of play therapy, but used play as a substitute for free association by arranging for play situations rather than depending on the emergence of spontaneous incidents. Her work was supplemented by trying to see children at home and to become familiar with their day-to-day life. Her work did not take into account the psychoanalytic tents of repression or the oedipal problem.

The analytical model of Freud was translated differently by both Anna Freud and Melanie Klein. Their basic difference revolved around the development of the child's ego and super-ego and they also differed in their techniques of analysis (Kessler, 1966). To further clarify their impact on psychoanalysis for children, the author has described each of their theories and approaches.

ANNA FREUD

Anna Freud's work began in Vienna in the 1920's, and later continued in London. Her approach has developed among her followers into the "Vienna School of Child Psychoanalysis."

Anna Frued indicated that psychoanalysis with children requires special modification and adjustments and can only be undertaken subject to precautions as well as learning from the various cases, both their successes and failures. She developed a technique which encompasses basic psychoanalytic tenets, yet had as its focus not the technique, nor the theory, but the child.

In adult analysis, the client hopefully allies with the therapist to work against an ineffective inner being. However, with children, who generally do not perceive the trouble in themselves, the alignment is not easily accomplished. The adult, usually comes voluntarily with some insight into the malady, but Anna Freud stresses that the child comes to therapy with none of these, and these must be induced in the child by "wooing" (Freud, 1928, 1951). "Wooing" involves inducing insight into the trouble; gaining confidence in the analyst; and turning the decision of analysis into the child's own. She stated it is simply used to convert an unsuitable situation into a desirable one. She strongly believed that as a basis for futher work, the analyst must establish a rapport and a relationship. During this period Anna Freud stressed the use of toys and play material. This time was essential

in developing "readiness on the part of the child." Anna Freud also felt that the therapist should use oneself in providing the child with security from the very beginning and if necessary to give the child the "promise of cure" (Freud, 1951).

She took great pains to establish a strong attachment and a relationship of real dependence between the child and the therapist. This was important, in that the concept of analysis could be carried out only in the presence of a strong transference. She stressed that the analyst must succeed in putting oneself in the place of the child's "ego ideal" for the duration of the analysis (Freud, 1951). She aligned herself strongly with the child and became a strong ego ideal. Since she was not a "shadow" the children did not displace their feelings for parents and others onto the analyst, but saw the analyst as the strongest person in their life. Children form no transference neurosis in that they are never able to see analysts other than as persons in their own right (Freud, 1954). Hence, this enabled the child to display reactions to the parents because this original relationship still existed and was not transferred to the analyst (Murphy, 1960).

Anna Freud's approach involved the basic techniques of adult psychoanalysis. For example, she used the techniques of history taking, free associations, drawings, and dream interpretations.

The case history is usually taken from the parents of

the child as the child's memory does not reach far and because the child's life revolves around the perceptions of the parent.

She contends that a child dreams neither more nor less than an adult. In the dreams of a child, one can find the same resistances and distortions of wish-fulfillment as in adults. She stated "no dream can make itself out of nothing; it must have fetched every bit from somewhere." (Freud, 1951). Being fully involved with the child she "sets off" with the child in search of the origins of the dream. She contends that the "child stands nearer to his dreams" than the adult and hence can easily get into the interpretation.

Free association was used as she encouraged the child to verbalize daydreams or fantasies. If children were having difficulty in discussing their feelings and attitudes she encouraged them to sit quietly and "see pictures." By using this technique the children were able to verbalize their innermost thoughts and using the interpretations of the analyst, discover the meaning of these thoughts (Freud, 1951).

Besides the use of toys in the "wooing" period, Anna Freud saw the use of toys being particularly valuable in working with small children. Through toys, children who are still limited in verbal skills, are able to create an environment in miniature. They are able to carry out all the actions which, in the real world, remains confined to a fantasy existence. Through the use of toys, the therapist has the opportunity to get to know the child's various reac-

tions; the strength of aggressive impulses or of their sympathies, as well as an attitude toward the various things and persons represented by the toys (Freud, 1951).

In summary, Anna Freud, modified her father's work as she developed an approach for working with children. She used dream analysis and interpretation, but did not always feel that interpretation was relevant to children. Her approach also modified the technique of free association. Then as she and child worked through the "let's 'see' a picture" experience, the child was able to describe the "picture" as well as to understand its meaning. This allowed the child "insight" into the unconcious.

The work, theory and approach of Anna Freud seemed to indicate that she was moving from a very humanistic orientation.

MELANIE KLEIN

Melanie Klein began her work in Berlin in 1926 and later went to London to continue her study and therapy with children. She developed the psychoanalytic play technique referred to as the "English School of Psychoanalysis." (Murphy, 1960). She was influenced in the forming of her approach by Karl Abraham and Sigmund Freud. Her initial work with psychotic children emphasized the concept of the oedipal fear, which she felt the child internalized and projected onto the outside "threatening" world. She disregarded the effect of reality almost entirely, and operated on biological and

innate factors. She attributed complicated psychological conflicts to the infant and stressed that the oedipal complex exists in the first year of life (Lebo, 1958). This was, hence, the basis for her opinion that all children can profit from analysis.

Klein stressed that the superego developed in the second quarter of the first year (Klein, 1955). She contended that there exists in the child a full superego of the utmost harshness before the resolution of the oedipus complex. She held, that there was an intricate psychic system elaborated soon after birth and capable of highly sophisticated fantasies (Kessler, 1966).

She stressed that the fantasy aspect of the mother-child link was a matter of much importance. She, hence tended to emphasize the fierceness of the destructive tension that accompanies the love drive (Klein, 1932).

Klein held that the child's mental health, when undergoing phases of abnormality can best be safeguarded by early and universal child analysis. According to her view, the "individual" experience of the child is not crucial in the production of a neurosis (Klein, 1927).

Klein's approach in the psychoanalytic play technique was guided by three basic tenets of psychoanalysis: (1) Free association being the most accurate avenue to the unconcious of an individual. (2) The exploration of the unconcious as the main task of the psychoanalystic procedure. (3) The analysis of the transference as the means of achieving this (Klein, 1932).

Klein assumed that to the child, play activities were like free associations of the adult. These associations were interpreted to find its underlying symbolic function. Klein felt that actions were more natural than speech to children (Freud, Anna, 1928). She stressed the use of toys and dramatizations as avenues for discovering the fantasy world of the child.

In the beginning work with children, she first saw the children in their own home using their nursery full of toys. She later, however, felt that the children were inhibited in their home setting and that transference could only be established and maintained if the patient could feel that the playroom was something separate from ordinary home life. Hopefully, under these conditions, the child would be able to overcome the resistance against experiencing and expressing thoughts, feelings, and desires which are incompatible with what they had been taught (Murphy, 1960).

Klein's technique involved gathering toys and placing them in a cardboard box. The children were aware of the uniqueness of themselves and that no one had access to these toys. The box was explored only within the context of the psychoanalytic session (Klein, 1932). She stressed that the actions which the child carried out through play were like the adult's spoken ideas. Hence, she interpreted this play just as analysts do with adult verbal statements (Klein, 1932).

Klein (1932) described the value of interpretation. The following is an example of this technique: a child picked up a few toy figures and surrounded them with bricks, and

the analyst interpreted the figures to symbolize people who were in a room. This, Klein felt, presented the first contact with the child's unconcious. Through the interpretation, the child came to realize that the toys stood for people and therefore, the feelings expressed toward the toys related to people.

Children, thus, gain insight into the fact that one part of their mind is unknown to them; or the unconcious state exists. This does not mean however that children will necessarily be able to express verbally what they experienced (Klein, 1932).

The focus of analysis, was often centered on anxieties and on the defenses against them. Klein contended that by focusing attention of the anxieties, revealed through play, and by interpreting the content, she was able to diminish the anxiety within the child. She thus made use of "symbolism" which she felt was an essential part of the child's mode of expression. The symbolic meanings are usually bound up in the child's fantasies, wishes, and actual experiences.

The interpretation of these symbols is analagous to Freud's interpretation of dreams. Anna Freud (1951), criticized Klein's use of interpretation with children. Klein, held that the child's capacity of insight was greater than that of an adult. She attributed this to the fact that the connections between the concious and the unconcious are closer in young children than they are in adults, and that infantile repressions are less powerful (Murphy, 1960).

Klein believed that patients transfer their early experiences, feelings and thoughts about their parents and other people, onto the psychoanalyst. In analyzing the transference the past as well as the unconcious part of the mind can be explored (Klein, 1955).

By using these three psychoanalytic tenets, Klein felt children could revise their early relation (mother and father) and thus effectively diminish their anxieties (Klein, 1932).

In the second portion of Chapter II, a brief overview of the client-centered viewpoint in relation to play therapy will be reviewed.

CLIENT-CENTERED VIEWPOINT

Carl Rogers, developed a theory of personality around 1940 which came out of a growing dissatisfaction with the then current treatment of emotional problems. His work was based on experiences in working with individuals and not specifically developed for application to play therapy. His theoretical orientation, which came to be known as client-centered therapy, had some significant impact on others who applied some of his premises for their use in play therapy. Virginia Axline interpreted Rogers' theory for work with children.

In describing the development of client-centered play therapy, Elaine Dorfman, (1965) states:

> ...it is apparent that from the Freudians have been retained the concepts of meaningfulness of apparently unmotivated behavior, of permissiveness and catharsis, of repression, and of play as being the natural language of the child ... From these concepts client-centered play

> therapy has gone on to develop in terms of its own experiences. (p. 237)

The part of Rogers' theory which fits with most relevance to the work of play therapy is presented in the following summary.

1. Characteristics of the infant: infants perceive their experiences as reality and are predisposed toward activation in this reality. They behave wholistically and engage in a valuing process, moving toward things that are positively valued.

2. Development of the self: as children grow older it becomes important for them to differentiate and identify various bodily senses. This is described as self-experience. These experiences become elaborated through interaction with the environment. Self-concept begins as they experience their physical self as separate from the environment and they begin to interact with significant others.

3. Need for positive regard: once the self-concept is formed, a need for positive regard from others develops. Rogers believes this need is universal. Hence when one person satisfies another, it can become self-satisfying. One's self-concept is increasingly differentiated in terms of others, given the need for positive regard.

4. Development of need of self-regard: self-regard is a learned need developing out of a need for positive regard and self-experience. Both needs are "social manifestations of actualizing tendencies" (Corsini, 1977). Hence it's important to be liked by others, but eventually to like oneself,

so that one's self-regard or self worth is not always based on the regard of others.

5. Development of conditions of worth: positive regard from others can be provided either unconditionally or conditionally. This is termed conditions of worth. When one receives unconditional positive regard, one will regard oneself positively and evaluate ones experiences in terms of ones valuing process. However, frequently in life one receives conditional regard. If the regard of significant others is important the individual comes to disregard personal experiencing and adopts the view of the significant other. "He cannot regard himself positively, as having worth, unless he lives in terms of these conditions" (Rogers, 1959).

6. Development of incongruence between self and experience: experiences are perceived selectively. Those that are congruent with self concept lead to awareness, those that are not inhibit awareness.

7. Development of discrepancies in behavior: some behaviors maintain self-concept so that both experience and concept are congruent. When behaviors are incongruent, these experiences create anxiety and arouse defense-mechanisms which either distort or deny the experiences. Hence the individual can maintain a consistent perception of the self. Incongruence can lead to increasingly rigid perceptions and behavior.

8. Process of breakdown and disorganization: when a person has a large degree of incongruence between self and experience and the defense systems are inadequate, the self-

concept will break down resulting in disorganization of behavior.

9. Process of reintegration: reintegration occurs when the person is able to experience conditions of worth in an atmosphere of unconditional positive regard (Rogers, 1959).

The next section of Chapter II will give an overview of the work of Virginia Axline and Clark Moustakas. These individuals have laid basic principles in guiding therapists in their work with children through play therapy.

VIRGINIA AXLINE

Axline, studied under Carl Rogers, and developed her technique of non-directive play therapy based on Rogers' client-centered therapy. In translating Rogers' theory, Axline suggested that as children begin to differentiate themselves from their environment, they almost immediately begin a reciprocal relationship with that environment. They form their sense of self because of the way in which they perceive the perceptions of significant others.

There are two basic premises held by Axline (1) the child loves growing and strives for it continuously (2) there are certain basic needs within each individual, which the organism is constantly striving to satisfy.

This ever changing development is described by Axline (1947) in the following way:

> ... The dynamics of life are such that every experience and attitude and thought of every individual is constantly changing in relation

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

Axline (1947) further adds that "the behavior of the individual at all times seems to be caused by one drive, the drive of complete realizations" (p. 12).

According to Axline (1947) well adjusted children are children who are able to direct their behaviors by evaluation, selectivity and appreciation to achieve their ultimate goal of self-realization. In maladjusted children, one observes children who have not been able in their efforts to gain the necessary requirements for the satisfaction of their needs. They have learned devious methods for obtaining what they want. In other words, the inner struggle for growth within the child continues, yet the environment may often times block their effort. This creates incongruity within the self, leading the child to depart from realism, both in their perceptions and in their experiences (Axline, 1955).

The emotionally disturbed child is one who is in a state of incongruence between self and experience. They have developed a defensiveness toward their environment which results in rigidity and distortion. The extreme end of this continuum is a stage of complete disorganization.

Children, according to Axline, (1955) can move from disorganization to reorganization if they are allowed to experience conditions of worth in an atmosphere of unconditional

acceptance, which leads to an increase in unconditional self-regard. Using this philosophy of personality reorganization, Axline believed that children have within them all the necessary components for growing and becoming. Hence, Axline (1947) stressed the nondirective approach stating "the client will move where he needs to when he is ready if the conditions are right." (p. 32)

The focus of the therapist becomes making sure the conditions are there. The basic premise of the nondirective therapist, is that the therapeutic experience should be different than any other experience the child has had.

Axline (1964) describes her view of therapy in the following way:

> nondirective therapy is based on the assumption that the individual has within himself, not only the ability to solve his own problems satisfactorily, but also this growth impulse that makes mature behavior more satisfying than immature behavior (p. 34).

The process of reintegration is allowed to occur within the context of the playroom and the therapeutic relationship which allows for experiencing of the self within this setting. When the conditions are different than those that contributed to the disorganization, the child is able to make a new synthesis and continue forward in a well-adjusted way (Axline, 1964, 1947).

An important point to remember, in understanding the concepts of client-centered therapy, is that the awareness is not a technique but is a philosophy or a set of attitudes in reference to the significance and worth of each individual.

The process occurs because the therapist has incorporated a certain set of values into their personality. Rogers (1965) states:

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

The therapist described by Rogers holds a basic belief that the individual has the capacity for growth, decision making, and motivation for forward movement. Their basic goal is to provide a relationship with the child that will enable children to use the capacities within themselves and move toward constructive living. An opportunity for experiencing growth under the most favorable conditions is offered to the child through the play therapy experience (Rogers, 1965).

Play is to the child what verbalization is to the adult. It is the most natural language of the child. When children are allowed to express themselves naturally, feelings surface. The child, within the acceptance and permissiveness of the playroom is provided the safety of a nonconditional relationship. Children, with the help of the therapist are able to realize the power within themselves to be individuals in their own right, to think for themselves, to make their own decisions and hence become psychologically more mature. This allows them to realize selfhood (Axline, 1964). Children do not have to practice devious methods in order to fill their needs. This allows their real self to unfold. As children are freed of the anxiety and tension produced and maintained by the

incongruence and disorganization within their sense of self, they have more energy for forward moving growth. As they become more congruent and realistic in their orientation to their environment, the significant others begin to respond differently (Axline, 1964, 1947).

Axline (1947) describes eight basic principles which should guide a therapist in nondirective play therapy. They include the following:

> 1. The therapist must develop a warm friendly relationship with the child, in which good rapport is established as soon as possible.
> 2. The therapist accepts the child exactly as he is.
> 3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express feelings completely.
> 4. The therapist is alert to recognize the feelings the child is expressing and reflects those back in such a manner that insight is gained into their behavior.
> 5. The therapist maintains a deep respect for the child's ability to solve problems if given the 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 the responsibility in the relationship (p. 75-76).

Hence the therapeutic relationship is structured within the framework of these eight basic principles, which the therapist attempts to strive for from the beginning of the relationship. Axline (1947) states that the therapist attempts to recognize the child's feelings and reflects those

feelings to the child. They attempt from the start to establish their individuality and personhood. This is accomplished by acknowledging to the child that their feelings are understood and accepted.

Axline (1947) stressed that complete acceptance of the child seems to be of primary importance to the success of the therapy.

The therapist must strive to establish a relationship that is entirely different from the ones which have led the child to disorganization. They accept the children's right to be where they are in their development; their right to move at their own rate; and the right to express their feelings. This involves recognizing children's right to be themselves and not necessarily the approval of what they are doing. The therapist respects children, allowing them to make choices. They are nondirective and nonsuggestive.

According to Axline (1947), "the therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely" (p. 93).

The therapist does not structure the therapy session. "The therapy hour is the child's hour to be used as he wants to" (Axline, 1947, p. 93). Therapists by their verbal statements can structure the attitude of the environment (i.e. "You may play with these toys in any way you like.") Allowing permissiveness, does not imply children are free from limits, but that they are permitted to express themselves in their own way. They are free to remain silent, or search for themselves

in any way they need to without the interference of a directive, authoritarian adult. Thus, therapists focus their attention on the center of the child, on their needs.

Axline (1947) further states that "the therapist is alert to recognize the feelings the child is expressing and reflects back those feelings in such a manner that the child gains insight into his behavior" (p. 99). She stresses a distinction between reflection and interpretation. Interpretation, according to Axline (1947), implies explaining to them the symbolism they expressed in their play. Reflection deals with verbalizing what they are feeling so that they will know that they are being understood. Interpretation has to do with explaining the meaning of the child's play to him, while reflection has to do with sharing with the child the attitude "I hear your feelings." As children learn that they are understood, they are likely to gain insight from the interaction with the therapist. This enables them to "see" their feelings out in the open, and to learn to deal with them while in the safety of the relationship. The feelings have been clarified, so that they can realistically see and understand them for themselves and, are no longer diffuse, when placed in the proper context. They recognize the feelings of anger, love, hate, jealousy and connect them with the experience. "The responsibility to make choices and to institute change is the child's." (Axline, 1947).

The atmosphere of the playroom is nonthreatening, nondirective and accepting, which allows the child to experience emotional peace.

Axline (1947) states:

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

Thus, the power for change and growth is within the child. They will grow when the environment is such that their emotional energies are not being used in anxiety and fear. They will continue with their maladjusted defenses, until the therapist sets the conditions of empathy, warmth and permissive understanding in the playroom. They will hopefully, face themselves realistically, and begin to perceive accurately that which was distorted in the beginning of their development.

The feeling for the individual seeking a warm empathic relationship is encompassed in the client-centered philosophy described by Rogers and interpreted for work with children by Virginia Axline.

RELATIONSHIP VIEWPOINT

CLARK MOUSTAKAS

Relationship viewpoint evolved from Otto Rank's theories and philosophy. He emphasized that the source of therapy lies in the understanding and constructive use of the patient's reaction to the therapeutic situation.

The relationship-therapist does not stress transference as being relevant in treatment, but stresses the development of the relationship as crucial and curative in its own right.

The relationship viewpoint also emphasizes the present and the use of the therapy hour as the patient chooses. Rank's theories have been interpreted by Moustakas and others with specific focus on play therapy and the child. Moustakas' approach stems from his work with children at the Merrill-Palmer Institute in Detroit. This section gives a view of Moustakas' theory and approach in regards to principles of play therapy.

Moustakas (1959) described therapy as being a unique growth experience which involved not only the person seeking help, but also the person who accepts the responsibility for offering that help. He states that the integrity and vitality of the relationship between the child and the therapist provides the potency for the growth experience.

He contends that the therapist provides for growth and experiences as a result of the living relationship with the child. In order for this to occur, therapists must be aware of their own strengths and limitations in this "here and now" experience. Moustakas (1959) also stressed that the relationship can be no more honest than the two members involved. The child cannot experience a meaningful process while in the presence of a dishonest relationship. The therapist actively participates in the living process with the child. By opening up the self to the growth experience, the therapist finds greater meaning.

Moustakas (1959) contends that this relationship must also be one in which each participant is regarded as an indi-

vidual. There are no rulers in life, only companions and participants. Children are people, having resources of their own, which will contribute to their living experience. These resources will bring about their development as part of the process.

Moustakas (1959) discounts the concept of illness or neurosis, and does not view the relationship as one which encourages dependency. He views the process of self-growth as involving an internal struggle between dependency needs and strivings for autonomy. He further states that individuals eventually feel free to face themselves if they are in a relationship where their human capacity is recognized and cherished within the context of acceptance. The therapist, always focuses on the present and deals with feelings rather than symtoms or causes. This is in accordance with the "here and now" philosphy.

The role of the therapist according to Moustakas (1959) involves self-awareness and continued openness for growth. The importance of beginning with children where they are and conveying unqualified acceptance and respect is also stressed.

There are different ways to convey respect, which is all a part of the therapeutic process. One way, is by allowing children to make their own decisions. The play time is not structured, nor does the therapist choose the toys, interpret or guide the play. The child leads the way.

Another form of indicating respect for the child is by really listening. Listening, entails more than just

reiterating what the child has said, but to be able to listen for the feelings and attitudes behind the words of the child. The therapist does not interpret these feelings nor directs the child's activities. The children have a right to cherish and express their feelings in their own way.

Moustakas (1959) does not stress for passivity within the playroom setting. Although, therapists do not direct activities, they actively participate in the plans the child makes. Hence, there are times the child may want the therapist to become actively involved in the planning and in playing.

Thus, Clark Moustakas maintains that the central focus is the emergence of a significant relationship in which the therapist expresses a deep concern for the growth of the child. Included in this relationship is the concept of individuality of the child and an understanding of the capacity for self-growth within the child. There is also an educated talent for sensing feelings, understanding, and exploring the child's experience with the therapist. It is a mutually living and enlivening relationship.

SUMMARY

In this chapter, the writer has presented an overview of some of the major influences in play therapy. Parts of their individual theory and techniques were attended to.

The psychoanalytic viewpoint has been represented by brief summaries in the writings of Sigmund Freud, Anna Freud and Melanie Klein.

The client-centered philosophy of Rogers was also briefly noted, and an adaptation of this theory for work with children was represented by the writings of Virginia Axline. In addition, the philosophy of the relationship theorist Otto Rank and its application by Clark Moustakas to play therapy was summarized.

There exist strong similarities among the psychodynamic theories. First, they function on the assumption that what has been done to the child can be undone. Also, psychodynamic theorists stressed the crucial nature of the relationship between the therapist and the child.

The psychoanalytic theories assume that the therapist is cognizant enough of the dynamics and needs of the personality of the client that one can define the deficiencies. They also assume that the plan for the therapy lies within the therapist and not the client. In this case, the client is the recipient, while the therapist does "something" to cause a cure.

Rogers, Axline, and Moustakas stressed that the power for growth and development is within the client. The client has the potential for growth and development. The therapist provides an atmosphere (Rogers, Axline) or a relationship (Moustakas) which allows the client to feel safe so that the process can occur. Unlike the psychoanalytic viewpoint the client-centered and relationship viewpoint do not see the therapist as teacher. They feel that the answer lies in the client rather than in the therapist.

The humanistic philosophy is apparent in the writings of Carl Rogers and Virginia Axline. Rogers' philosophy has grown out of his work with people in therapeutic relationships. His philosophy has been a living one, growing and changing as a result of his life experiences and of the integration of these experiences as they have affected his perceptions, attitudes, values, and finally his sense of self. The theory he describes in reference to the development of personality, for each individual to grow and become is evidenced in his writings and in his work. Rogers theory is a living philosophy, not a stagnant one.

Both Rogers and Axline in their writings make reference to and give consideration to the client in the development of their theories. For example Carl Rogers (1965) states:

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

Virginia Axline (1947) expressed the relationship of the child in application to Rogers' theory in the following way:

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

Hence these theorists emphasized the need for a warm and empathic relationship.

The psychoanalytic, client-centered and relationship theory discussed work with the child in a setting which allows the use of media. However, each makes different use of play media. The approach of Anna Freud involves media in part as a technique to produce the child's attachment to the therapist. Melanie Klein used it to enable her to interpret the unconcious processes of the child. Moustakas and nondirective therapists used the media so that the child will have a comfortable, natural means of expression.

The various viewpoints also express differences in the use of the counselor-client relationship. Anna Freud stressed the need to develop strong ties between the child and the therapist, but not reciprocated by the therapist. She described this in terms of respect not transference. Melanie Klein felt that the transference neurosis had to develop in order for therapy to occur. These ties she saw as making the child very dependant on the therapist during the course of treatment.

Moustakas (1959) stressed that the relationship was crucial to the progress of the child and the progress during each hour. He viewed the relationship as one in which both the child and the therapist were involved in a mutually growing developing experience. Axline (1947, 1964), indicated that the relationship was used to provide a setting of safety. She did not indicate the mutual growth as Moustakas, but stated that by the responses and attitude of the therapist,

the children would become aware of acceptance and hence, begin to accept themselves. In the context of this relationship the child hopefully re-established congruence which had been lost as a result of experiencing other types of relationships with significant others.

This chapter has thus indicated some of the major viewpoints which have allowed for the basic framework of the development of play therapy.

CHAPTER III

RESEARCH RELEVANT TO AREA OF FOCUS: EFFECTS OF HOSPITALIZATION ON CHILDREN

This chapter reviews the literature on application of play therapy and other interventions for hospitalized children. It is further subdivided into effects of hospitalization, possible interventions, descriptive play programs and research studies.

Hospitalization tends to cause a radical change in many children's life. They become separated from their familiar world of parents, siblings, peers, school, and enjoyed activities. At the same time, they are subject to strangers, loss of privacy, freedom, and sense of control (Adams, 1976).

Hospitalization can lead to varying degrees of depression and anxiety. Jackson (1942) notes that neurotic anxiety in children, at times, may be due to the following two conditions: (1) situations in which children become insecure because they fear the loss of a love object, and, (2) situations in which they risk the possibility of injury, particularly in the hands of another person. Anna Freud (1942) also suggests that illness or hospitalization, may precipitate neurotic disturbances in children, which can have lasting effects into adulthood.

Erickson, (1950) points out that the child's response to hospitalization depends to a large extent on maturational

factors. For example, very young children are primarily concerned with physical comfort and material security; pre-school children are preoccupied with shame, autonomy, the invasion of the body, guilt, growing sense of independence, and fears of mutilation; and school-age children are concerned mainly with their sense of mastery and competence, and are distressed by a loss of function or control and by separation from school and playmates.

Many children have difficulty coping with the anxiety created by the hospital experience. A few of these coping behaviors according to Clatworthy (1978) include, anger, withdrawal, regression, sleep disorders, and acting out.

Adams, (1976) recognizes all the stresses associated with hospitalization and suggests that, in addition, there are problems specifically related to the diagnosis and treatment of the child with cancer. To begin with, there is the stress, that the diagnosis is a potentially fatal disease, as well as an unpredictable and prolonged treatment period, with multiple hospitalizations and outpatient visits. Second, there are severe side effects of chemotherapy, weight loss, hair loss, nausea, disfigurement. Not only are there disruptions in the child's family but also stress on the siblings and the marital relationship.

Natterson and Knudson (1960), in their study of fatally ill children, found three major fears to be prevalent; fear of separation, fear of mutilation, and fear of death.

The fear of death was most evident in children ten and

older, although it can be present in younger children, but tended to be overshadowed by the more age specific fear, i.e. separation - under five years, mutilation, six years.

Morrissey (1963), in his work with children facing imminent death, found that a majority of the children had a high degree of anxiety about their illness and respective hospitalization.

The anxiety was expressed in four ways: verbally, physiologically, symbolically, and behaviorally. He concluded that children in this situation need specific therapeutic services in relation to the emotional factors, associated with this illness.

POTENTIAL INTERVENTIONS

Therapeutic play, or play programs in a hospital setting may allow the children to "verbalize" their feelings, develop increased understanding of their environment, and explore behaviors which may be more helpful for them in a crisis situation. The use of play programs therapeutically was perceived as a potential method of intervention with children who were experiencing hospitalization.

Group play is also important to maintain socialization. Ginott, (1958), pointed out that the group play provides for multilateral relationships that are not available in individual play therapy. He also states that the group provides more opportunity for reality testing, for catharsis, and the development of insight.

It is not necessary to establish group goals. Each child may engage in activities unrelated to other members. The group "induces" spontaneity and the children relate to the therapist and develop a feeling of trust.

It is important to acknowledge the role of the play therapist in helping the child cope with hospitalization, as the therapist can be viewed as a major source of intervention.

Hugh Jolly (1978) in discussing the role of the play specialist stresses three important functions of the therapist. These include reducing stress and meeting needs communicated through play, eliciting information from play relevant to medical treatment and making illness an opportunity for positive learning and the hospital environment less threatening.

He also points out that the playroom should not be a "sanctuary" where pediatricians are not allowed as aspects may well be learned observing the child in play that could never be learned by examining the child on the bed.

The play therapist is not a mother substitute but helps to supplement the mother's care when the mother is unable to be on the ward. The play specialist can also teach the parents the importance of play in the development of the child, as well as helping them understand the behavior problems that may develop and the reasons for these.

In addition to group therapy, use of psychodrama within the group may be helpful as the children are able to dramatize the roles of doctors and nurses and focus on feelings of anger, mutilation and fear of separation.

Children's Memorial Hospital in Chicago uses the Ronald McDonald house as an intervention for hospitalized children. The house allows the parents to take an active role in understanding and accepting their child's illness and its possible emotional effects. Together with staff and child, and parents with other parents, emotional support can be received and maintained throughout the hospital stay.

One can also consider other interventions such as the physical environment of the child's room (i.e. color, brightness, use of bulletin boards and stuffed animals) as well as nursing staff's uniforms as contributing to the positive adjustment of the child to the hospital. However, the author has primarily selected to focus on some specific play programs that have been developed as possible intervention for the hospitalized child.

SPECIFIC PLAY PROGRAMS

One such preventive plan was developed in a general pediatric hospital, the Boston Floating Hospital of the New England Medical Center, and part of this project was the development of a play program. (Tisza and Richardson, 1956). The play program, supervised by pre-school teachers and centered around a large playroom, attempted to meet the needs of every hospitalized child.

The rationale, for the development of such a play program according to Tisza and Angoff (1957) was as follows:

> The freedom and activity of the playroom places

> the emphasis on the healthy part of the child... He is mobilized to the extent his physical condition permits and he is given adequate space and play material with a freedom of choice to use them according to his needs. From the passive sufferer confined within the narrow boundaries of his bed, the child becomes an active agent. He gets the opportunity to gradually master through play activity, his anxiety over illness, bodily injury, and separation. p. 52.

Hence, the project focused on the possible use of play as a device for the gradual mastery and assimilation of the anxiety producing aspects of hospitalization.

It became apparent through observations that the children tended to use play to deal with the anxiety caused by the illness, the threat of medical procedures, and the separation from the parents. Since the style, and range of play are functions of age Tisza, Hurwitz, and Angoff (1970) decided the subjects would include those in the age range of three to eight years, a range which includes children who are presumably capable of verbal dramatic play. The 1970 study focused on the examination of the child's feelings, needs, and emerging relationships which eventually could lead to development of the ability to play.

Tisza, et al, (1970) formulated three hypothesis in this study; (1) Hospitalized children three to four year olds are grieving over the loss of the love object. They need active reaching out by the adults and do not play until object relationships are re-established. (2) Hospitalized four to six year olds suffer from heightened anxiety. They actively reach out for adult relationships and their play activity is

primarily directed toward this goal. Since the adult is the primary focus, there is little or no spontaneous group play with peers (3) Hospitalized six to eight year olds play actively to master their anxiety and use the peer group in the playroom for support.

The children, had a wide variety of diagnosed illnesses. Hospital procedures included blood tests, x-rays, enemas, blood transfusions and frequent "needles".

The playroom was defined as a place which offered (1) adults who were "constant" and ready to anticipate the needs of the children, and who gave the children an opportunity for consistent interaction with one person; (2) other children; (3) play material; (4) space and freedom of movement; (5) minimum set routine and a permissive giving atmosphere. The children were observed in the playroom over a period of three consecutive days.

The findings of the study of Tisza, et al, (1970) show that when three to four year old children are hospitalized without the constant presence of their parents there is a marked emotional reaction of sadness and anxiety. However, under the three day observation period the children who exhibited regression and withdrawal began a process of "restitution". The crucial factor in this process was the playroom teacher, the constantly available and actively reach-out mother substitute, who accepted the child's grief and offered an alternative relationship. The children showed a change in affect and an increasing ability to use toys.

Some of the children brought their "treasured possessions" to the hospital. One child carried the transitional object constantly and entrusted it occasionally to a favorite playroom teacher. The children also appeared to use little speech for communication.

Hence, it appears that the playroom teacher helped the children work through their grief and served as a bridge between child and parent.

The observations of the four to six year old group demonstrated that the children were far more controlled, responsive and outwardly oriented than the younger age group. They handled the impact of separation and hospitalization through the active use of inanimate objects and people. These children strove to be accepted and their primary focus was the adult relationship.

The behavioral and affective reactions of the six to eight year old group can be viewed in terms of their developmental level. They had entered the latency age period and had moved beyond the family orbit, experimenting patterns of broader social skills. However, illness and hospitalization represents a threat and the anxiety may bring about the occurrence of regression. Tisza, et al (1970) report that there is an "ebb and flow of anxiety in these children, and the exact patterning of defenses depends on each child's personality structure."

The children in this group quickly paired off in friendships of a complementary nature. They used each other

for self-assertion and tended to identify with one another for a sense of bigness, mastery, and adequacy. It is important to note that these friendships came about due to a stressful situation and hence tended to serve an ego-strengthening function.

Their play was more structured and organized; they supported each other and could afford to become more aggressive with each other as well as with adults.

In summary the study by Tisza, et al (1970) indicated the importance of the continuity of supportive relationships for young hospitalized children. If relationships are offered, the experience of the absence of a parent is not so profound a loss, due the relative stability of the image of the parent. However, the study also pointed out that the external and internal threats inherent in the hospital experience create so much anxiety that during the first three days, children do not master the hospitalization through dramatic play. Initially, the children appear to regress, or struggle with regression usually in the absence of play activity.

Margaret Adams, (1976), describes a play therapy program designed to facillitate the child's expression of feelings and to enhance their sense of mastery.

In her study, she states that in addition to recreational play, a therapeutic play program is a means of aiding the child to express anxiety.

In the hospital setting, play allows the child to engage in activity that is reminiscent of life outside the

hospital.

Petrillo and Sarger (1972) are in accord with this and indicate that for the hospitalized child,

> . . . play restores, in part, normal aspects of living and prevents further disturbance. Also it provides the child with an opportunity to reorganize his life; thus, it reduces anxiety and establishes a sense of persepctive. p. 37

Hospitalization can enforce passivity, but in play the child can become active, and as Peller (1952) stated:

> . . . play can inflict upon another person what has previously been done to him. The change from a passive to an active role is the basic mechanism of many play activities . . . It mitigates the traumatic effect of a recent experience and it leaves the player better equiped to undergo the passive role again when necessary. This accounts for a great deal of the healing power of play. p. 29

Adams, (1976), describes the purpose of the play program at Memorial Sloan-Kettering Cancer Center in New York as follows: (1) to prevent social isolation of children by assisting them to maintain interaction with their peers (2) to provide an educational experience that will facilitate their ability to cope with the demands of illness, treatment, and hospitalizations (3) to obtain a better understanding of them as individuals and within the context of their family

Adams also describes the goals of the child as an enhanced sense of mastery and competence, an increase in trust, increased self-control, the resolution of frightening experiences, and a more adaptive and co-operative response to treatment.

The group program is the preferred modality of treat-

ment, so as to prevent social isolation and to maintain peer interaction. No one is forced to attend, but a special effort is made to engage the newly admitted child, the child who is far from home, and those who are recuperating or facing surgery, who have a tendency to withdraw and suppress their feelings (Woodruff, 1957).

Surgery represents an interference with the child's body and is "likey to arouse his fantasies and fears of being attacked, mutilated, deprived of a valuable part of his own self." (Bergman, 1965). These fantasies may dominate and overwhelm the child unless they are expressed and are dealt with in a therapeutic situation.

The social worker, at the hospital is a constant figure in the program, and a staff nurse, is selected on a rotating basis, to be co-leader. The social worker and nurse made bedside rounds to invite the children to the session, at times with the help of children who have already attended. The play group allows the children to experience the nurse as a pleasurable companion, who can relate to them in their own medium of expression. The social worker's diagnostic abilities are important in assessing the needs, defenses, and strengths of children an in interpreting their behavior during the session and their growth in the program over time. Another essential skill of the social worker is forming a therapeutic relationship, in being sensitive to both verbal and nonverbal communication, an in implementing a treatment approach to the child within the context of the

group. The staff nurses use observations made at the sessions to supplement and broaden their daily care of the children.

The materials used in this project included various hospital equipment such as; needles, syringes, suture sets, intravenous tubing, tongue depressors, stethoscopes, surgical masks, bandages, etc. There was a "play hospital" built to resemble the pediatric unit. The play hospital consisted of small dolls to represent patients, parents and staff.

The results of Adams (1976) project indicated that for very young children, trust is of the essence, and they must be approached gently, and preferably with their mothers present, or their anxiety may become too overwhelming. This is done by limiting the stimuli to one doll or puppet and using less threatening materials. Mother's presence helps to establish the trust. This approach with very young children results in marked adjustment to medical procedures.

The pre-school and early school children need many opportunities to express their angry feelings, but also need some limit setting. Setting limits does not force children to deny their feelings; rather it is to help them acknowledge it in a more socially appropriate manner.

Children in this age group find gratification in venting their rage upon the puppets, especially those representing the doctors and nurses. The puppets provide a vehicle not just for ventilation but for reality testing. It was also noted that children who are quiet and perhaps fearful of their own feelings can benfit vicariously from another child's catharsis in the group.

Schowalter (1970) stated that often children in this age group conclude that hospitalization is a punishment for their sexual and aggressive impulses. For example, five year old Sam said to his puppet, "I told you not to hit your brother, just for that, you're going to get a shot." It becomes important to clarify for him that people get injections because they need medicine and not because of anything they do.

The latency age children have more control over their impulsive behavior. The results indicated the importance for latency age children to feel competent and to expand their understanding.

Participation in the play group allows the child to talk out as well as act out conflicts. The child uses the session to ventilate as well as reflect feelings and to explore new ways of expressing them. In this study the children became more co-operative with medical and nursing personnel, and became more involved in their own care on the unit; they learned the names of their medications and how they worked, and they recorded their own temperatures and fluid intake. One child remarked, "Understanding this stuff doesn't make it hurt less, but it does make it easier to accept. After all, it's my life and I don't want to waste it."

Children in this latency age group not only have a better intellectual grasp of their disease, they also have a more mature understanding of death.

In the therapeutic situation the children's participa-

tion had a direct influence on the overall adjustment to their illness and its treatment. It is important to maintain a positive and hopeful outlook about treatment, but when children persist about death, it is equally important to deal with it and to communicate to them that they were understood and one would listen and try to help them.

Hence, the play therapy program at Memorial Sloan-Kettering Cancer Center is designed to provide an outlet for anxiety and anger, to educate the child in the interest of their own care and to maintain adequate patterns of coping. Making the hospital experience a productive and growing one aids in longterm adjustment for children with good prognoses and helps those with poorer prognoses express feelings about their eventual death. Adam's (1976) experience with children who have cancer supports the belief that this program is essential to the emotional adjustment of young patients with serious illness.

The department of Psychiatry conjointly with the department of Pediatrics at Beth Israel Medical Center in New York introduced a program of group intervention aimed at ameliorating negative effects of hospitalization in children (Cofer and Nir, 1975).

The program consisted of group meetings that had both counseling and guidance characteristics. The guidance aspect is the exposure of attitudes and feelings related to the hospital experience as well as the impaired functioning of the child. When the group focuses on realistic difficulties,

counseling techniques are utilized.

These group meetings were also theme focused. The theme is the hospital experience and the lack of, or distortion of, factual information and fantasies, fears, and anxieties related to hospitalizations.

The patients at Beth Israel are composed mainly of children from Puerto Rican and Black families receiving welfare. The age range of children is from early childhood through adolescence.

The theme-centered group sessions are held three times a week on the pediatric ward, for 30 minutes. Sessions are held in a patient's room, with the average child attending three to four groups during the hospital stay.

The issue most commonly introduced by children according to Cofer and Nir (1975), is concern about medical procedures. The therapists invite the children to give answers to correct the distortions. A frequent distortion is that constant sample of blood will diminish the child's blood supply.

The lack of factual information increases the child's fears. The fears diminish in intensity when the facts become known. If the distortions persist and appear to interfere with the medical management of the patient, the child is referred for brief individual therapy.

The issue of illness is more difficult to discuss and the use of denial is quite prevalant. Schowalter's (1970) experience in dealing with this problem, indicates that the group is effective in exploring the denial, and the fact that

all the children are ill does not force the issue "allowing everyone to reach their own acceptable level of denial."

Another major concern is separation anxiety. However this is inferred from regressive behavior, oral concerns and dependency needs. These defenses are not directly dealt with in group; rather support is given to help contain the anxiety.

The central themes of the groups (1) separation anxiety, (2) fear of procedures and (3) concern about illness suggests a parallel of a group of fatally ill children who manifested behavioral changes in response to: separation from mother, traumatic procedures and deaths of other children (Natterson and Knudson, 1960).

Natterson and Knudson (1960) indicated that these fears tend to be age dependent. The groups at Beth Israel tend to be latency age which may accout for the common group concerns of the fears of procedure. The death fear appears to occur in cases where the child is severely ill.

Cofer and Nir, (1975), state that there are a growing number of reports of successful intervention with latency children on the group level. On the level of group dynamics the authors feel that the group "offers the children opportunity for a cathartic expression of fears, complaints, worries, and grudges in an atmosphere of mutual emotional support." However not all dynamics are present in all groups due to their short term nature. One of the factors which facilitates the therapeutic intervention is the fact that the children live together on the wards. This allows for a faster interaction due to the development of bonds and mutual understanding.

Cofer and Nir (1975) also point out the effect of the group's setting in a pediatric unit. These include the increased conciousness of mental health problems among medical and nursing personnel. This in turn helps to improve the daily functioning of the ward. The ward is managed more effectively by the staff's increased awareness of the children's psychological problems and by the reduction of the children's anxiety and the elimination of aggressive behavior.

Hence, in this program it appears that the group, due to its therapeutic, diagnostic, and educational aspects acts as an intervention in the treatment of children in the hospital setting (Cofer and Nir, 1975).

John L. Frank (1978) describes a setting where school aged hospitalized children held weekly group meetings. The program was established at the Hahnemann Pediatric Ward in Philadelphia. The floor is divided into an 18 bed section for young children up to six, and a 17 bed unit for children seven and older. As it was a general teaching hospital, the overall pediatric care of the child was provided by the pediatric residents and an attending physician. About half of the population consisted of Black and Puerto Rican children from the ghetto sections of Philadelphia. About 15 percent of the group came from foster homes or residential centers. Integrated with this group of children were patients from predominantly white suburban middle class families, most of these children were hospitalized for diagnostic problems or ongoing treatment of chronic respiratory, endocrine, gastro-

intestinal, or hematological diseases.

Frank, (1978) describes the purpose of the weekly meetings as four fold. First, it is a time when the children can speak openly about what is on their minds: the hospital, their illness, home or themselves. Second, the group encourages the children to bring out their partial and fragmentary understanding of their hospital experience, their fantasies and misconceptions. Third, the group enables the child psychiatrist on the ward to meet face to face with a large number of hospitalized children. Finally, the group is an excellent source for teaching aspects of normal and pathological child development. These discussions have been found to be helpful guidelines for patient management on the ward.

At a specific time each week, staff members notify the children that the weekly group meetings will begin. They are strongly encouraged but not forced to attend. Children in wheelchairs or stretchers are helped to come when possible. Meetings have been held in younster's rooms when on occassion the child has expressed a desire to attend the meetings but couldn't because of immobilization. Generally five to fifteen children attend. The group composition varies from week to week, although several children attend a second or third meeting.

The most common opening complaints in order of frequency are:

1. The food is poor (too cold, too hard, not tasty, too late in coming, "not the kind I have at home," square hamburgers instead of round).

> 2. The hospitalization is too long (nothing to do, miss friends and family, uncertainty of length of stay).
> 3. There is an imposition of an alien daily routine (wake up too early and abruptly, can't eat breakfast because it will interfere with a test that is being performed, "teacher pressures you to work when you don't feel well") p. 27.

Close attention is paid to the complaints since they are a natural rallying point for children of different ages and backrounds as well as learning how different children are managing their feelings about hospitalization. Often children's physical and emotional discomfort in the hospital is associated in their minds with parental neglect, punishment, and/or blame, but this is redirected from close family members toward the staff. The sequence of subjects criticized follows a pattern from food to the school teacher to the nurses and finally to the doctors. The need to express and the effort to master painful and distressing feelings is as natural to the child as their sleeping and playing. They openly express their fright of injections or other penetrations of their body, and from what they say the actual pain they feel may be insignificant compared to the anxiety-laden fantasies they have around the procedure. The younger children seem to demonstrate greater excitement and anxiety in their verbal and motor activity in the group than to the older children.

The younger child may regress to a silly childishness state more readily than the adolescent who seems more threatened by regression. Adolescents do not display their feelings so openly. The youngest are least critical of the adults and most concerned about their medical tests and procedures and

when they will return home to their families.

Those children that do no say anything during the group are nevertheless quite attentive and who feel that most of the children that participated, appreciate, accept, and understand their feelings and curiosity. Occassionally, a child will become anxious during the group and leave before the group is over.

Frank (1978) found that rehospitalized children who had previously attended a group meeting, express fond memories and look forward to the next meeting. After the death of a child, at times a special meeting is held to allow those children who were close to the child express their feelings in a supportive setting.

The children's group on the pediatric ward offers a wealth of natural observational data on how children cope with stress. It offers the child psychiatrist an excellent opportunity for promoting the principle of preventitive and supportive mental health.

An innovative method to help a child adjust to hospitalization is "plant play therapy" which has been utilized in a child life program at Saint Joseph Mercy Hospital in Pontiac, Michigan. Rae and Stieber (1976) describe the program in which the child can role play medical procedures and can use the plant to symbolize growth, healing, and the constructive resolution of parent separation fears.

The program involves all children age four and up with both short and long term hospital stays. Depending on the child's mobility and diagnosis, the child participates in

either a group setting (playroom) or individual setting (bedside).

When children enter the hospital, they become totally dependent on nursing and medical staff for meeting their emotional and physical needs. Through plant therapy the child is able to care for a "living" plant. Reverse dependency becomes evident in which the plant becomes dependent upon the child for watering, sunlight and other life supporting needs. Transference also becomes apparent as children through the use of play become the surrogate doctor or nurse caring for their plant/patient. Children are encouraged to express verbally or nonverbally feelings about their illness. In a non-threatening play setting children are able to release fears, frustrations, tensions and anger and with guidance and supervision by the play therapist are able to gain some control over thier fears.

In the playroom or at the bedside children are given a styrofoam plant pot to print a name for their plant. Rae and Stieber (1976) point out that this procedure coincides with their admission to the hospital when a name bracelet is attached to the wrist.

Children then mix dirt and various plant materials in a large basin analogous to the way the nursing staff prepares them when they entered the hospital. The type of plant is selected and potted by the child.

Hospitalized children, as previously mentioned, are often fearful about injections and having to take special medications. During plant play therapy, the child (doctor) is allowed to fill a syringe with liquid fertilizer (medicine)

and give the plant (patient) a shot. This procedure helps children recognize their need for medication as the plant's need for fertilizer.

A child undergoing intravenous (IV) infusion is frightened by the procedure and restricted from normal play activities. In plant play therapy an IV filled with liquid fertilizer is placed on a pole above the child's own plant. The child-life therapist can then focus on the importance of the IV solution in order to provide life giving nutrients to the plant (patient).

The use of plant play therapy can be used to allay fears in the orthopedic patient, the child who goes to surgery and children who have experienced the oxygen tent. For example Rae and Stieber (1976) point out that terrariums are used for children with pneumonia or asthma who need the oxygen tent. Children often feel isolated after such an ordeal and need reassurance that their remaining inside the tent is necessary to their health. Allowing the child to make the terrarium enables the play therapist to discuss with the child the importance of proper moisture and oxygen levels to the proper growth of the plant.

Grafting a plant stem and relating the growth and healing process of the plant eases the fears for a child who has a cast or is in traction.

Plant play therapy can also deal with children's separation anxiety. Through the use of a spider plant or a strawberry begonia and their "offspring" the therapist assists the child in the realization that the parents still love the

child, but they are separated during their hospitalization. For example, a mother spider plant could be potted in one container and the baby in another without the stem being cut between them. The therapist then explains how the stem attaching the mother and the baby is like the love and caring parents have toward their children.

Parental paricipation is considered an essential aspect of plant play therapy. Parents are encouraged to become "therapists." Through observations parents often develop their own skills in constructively interacting with children long after the child has been discharged.

Play therapy programs with plants indicate an innovative way of reducing the child's psychological trauma of hospitalization and allowing this experience to become a positive one for the child.

Byers, (1972) presents an interview with a five year old boy using play to help him cope with the psychological problems encountered during his hospitalization.

Robby was hospitalized for 11 days with chief health problem as smoke inhalation. He had small second-degree burns on both feet and on one hand. This was not severe enough, physically, to lead to permanent disability.

During his hospitalization, two major themes were identified in his play activities. One theme concerned his injuries, the fire and the medical equipment used for treatments. The second theme seemed to be related to his concerns about his family, their interrelationships, and their separa-

tion from each other.

The parents were hospitalized on the adult unit and Robby talked with each of his parents on the telephone at least once a day and his paintings were sent to his parents.

The play materials consisted of material for dressings, a doll figure of a fireman, a stethoscope, paper and crayons. He played with the fireman claiming his feet had been burned and attempted to bandage him. At times Robby's play with figures was minimal and he requested to play with animal figures which seemed to be a safer mode for expressing his concerns. Robby was creative in the use of material and his ability to express himself was exceptional. These efforts to work through the stress caused by his injuries led him toward mastery of a crisis situation.

Thus far the studies documented have dealt with children in treatment for physical ailments. However children and adolescents are hospitalized for brief or extended periods of time for psychiatric problems.

Irving Berlin, (1978) describes the importance of assessing a child's developmental issues so as to plan for hospital care of the child.

The most frequent causes of hospitalization are psychotic withdrawal, aggressive or hostile behavior, suicidal attempts (adolescents) and at times psychosomatic disorder such as anorexia neurosis.

In the last decade, the milieu program has become an important part of the hospital care of children. This program

involves all of the child care staff and specialists in child psychiatric-nursing, a teacher, an occupational therapist, a physical therapist, child therapists, and a child psychiatrist. They plan each days activities, which are geared to the developmental needs and abilities of a particular age group. One of the critical issues is that the program is paced to provide a variety of treatment elements without any great gaps of time that leave the child isolated, and time for self-absorption and psychotic thinking and behavior.

A good physical therapy program is geared toward helping children increase their mastery over their bodies and the environment. The use of an occupational therapist along with group therapy programs are important in aiding children to understand their behavior as well as developing relationships with adults, which can provide a vehicle for focusing on specific conflicts.

Most inpatient settings do not include parents in therapeutic work. Berlin (1978) states that "unless parents are involved in some collaborative effort the inpatient treatment may not be effective in returning the child to the community or home."

Parents, gradually are helped to understand and to work on family prolems. Parents may work first with other children who have similar problems and as they become more effective they learn to work with their children more effectively in a hospital setting, they also become better able to deal with them more effectively when they take them home.

Hence, Berlin's article indicates that as inpatient settings become more involved in developmental efforts, they can more clearly define their areas of experience and their capacity for helping children.

The research presented in this section focuses on descriptive play programs that have been developed as interventions to meet the needs of the hospitalized child. The next section specifies a couple of research studies dealing with the hospitalized child.

RESEARCH STUDIES

Clatworthy, (1978) investigated the effects of therapeutic play on five to twelve year old hospitalized children.

The anxiety levels of hospitalized children were obtained from the pre/post measurements of the Missouri Children's Picture Series.

The parents completed a checklist at both admission and discharge to determine the child's baseline anxiety. Additional data was collected from the children, parents, and assigned nurses. This information included parent-child interviews, nurses ratings of behavior and child drawings of the hospital. This data helped to demonstrate the child's behavior and their projected feelings.

This study had both an experimental and control group. A research assistant conducted three-30 minute therapeutic play sessions with the experimental children.

The results of this study indicated an increase in

regression, anxiety, and withdrawal of the control group, whereas the experimental group maintained the same measured level of anxiety. The experimental group were reported, by both parents and nurses, to be active, engaged in social activities, and verbally expressed their feelings regarding hospitalization.

Clatworthy's study gives evidence and supports the need for some type of therapeutic play for hospitalized children.

Cataldo, et al (1979) conducted two studies to analyze behaviors of staff and patients on a Pediatric Intensive Care Unit (PICU).

In the first study, behavioral observation procedures were employed to assess patient state, physical position, affect, verbal behaviors, visual attention and activity engagement and staff verbal behavior.

There were 99 patients ranging in age from two days to twenty-two years and they were observed over a two month period on the PICU of the John Hopkins Hospital. The results indicated that on the average, one-third of the patients were judged to be conscious and alert but markedly non-engaged with their environment. The majority of verbalizations to alert children were by nurses. The majority of the time children did not verbalize and when they did, it was most often to parents.

Given these results Cataldo, et al (1979) wanted to assess whether environmental manipulations could positively affect children's behavior and a second study was conducted.

In this study, eleven of the patients included in the first study, ranging in age from one to twenty-one years served as subjects. The hospital staff provided alert patients with individual activities. The activity intervention was found to increase attention and engagement and positive affect, and to decrease inappropriate behavior.

While staff on a PICU may not interact with children to the extent possible and the children may appear too ill to appreciate any nonmedical intervention, the results from study II indicate that an activity intervention can engage children's attention and participation. This type of intervention on PICU can be an effective method to avoid converting a medical necessity into a psychological trauma.

This chapter presented various factors that contributed to the implementation of specific play programs within a hospital setting. It was organized into effects of hospitalization on children, potential interventions, with the major thrust of the chapter describing play programs. The review of the literature in this specific area revealed to be quite limited. The available literature focuses on post hospitalization events as well as the psychological trauma dependent on the psychosocial development of the child during hospitalization. However, the focus of specific programs as well as research outcome studies dealing with the needs of the hospitalized child is minimal.

The research presented favors and indicates the value of play therapy programs in helping the child cope with the

traumatic emotional and physical experiences of hospitalization.

CHAPTER IV

SUMMARY, DISCUSSION AND CONCLUSIONS:

SUMMARY

This thesis, first, reviewed the literature on some of the theoretical approaches: psychoanalytic viewpoint, the client-centered viewpoint and relationship viewpoint. These theories served as a framework for interpretation by others in application to play therapy. Some specific play programs and other interventions for treatment of the emotional experiences of the hospitalized child were also reviewed.

The materials gathered were acquired through the sources provided by the library services.

The literature favors the development of play programs to alleviate the stress and anxiety of the child; but the available literature indicates a growing need for more research studies.

The material of "play" was scattered throughout many volumes of journals and books. Observation showed that the bulk of writing in the literature appears when child therapy first became popular.

The focus consisted of theory, technique and case studies. This work tended to tie into a theory which had been developed for working with adults.

Recent literature reveals a trend toward documentation and research methods in the area of play therapy. However, it

appeared that very little research in any focus area was identified.

This is evident in the documented research of hospitalized children and specific play programs. Although much research has been done to account for post-hospitalization traumas, as well as the effects of the child's psychosocial development upon hospitalization, the literature appears scarce in focusing on the potential intervention of play programs.

This may be reflective of an embryonic stage of development in the area of focus of hospital play programs.

It seems that persons working in play therapy have started at a theory stage, instead of following the usual pattern of a scientific model which includes movement from hypothetical, to research, to theory.

This paper has attempted to stress the value of intervention, more specifically play programs in relieving the anxiety of hospitalized children. Frequently sick children will ask to have their bed moved from the quiet ward, where they do not feel at ease, to a playroom where they can relax among familiar objects and activities (Jolly, 1978). One observes that with the young child "his work is his play, and, his play is his work" and as Wuntheiler (1976) so aptly stated:

> Play is after all less final than reality. It can be changed as long as the child's emotion calls for change. Yet it is also more consequential than thoughts or fantasies as it provides a means for experimenting with the responses of others. p. 489

DISCUSSION

The literature on play has demonstrated that it has a crucial role in the mental health of children. Piaget (1951) stated that play:

> . . . allows the ego to assimilate the whole of reality, to integrate it in order to relive it, to dominate it or to compensate for it. p. 12

From a psychoanalytic point of view a child plays to deny or solve a conflict. It is also a source of pleasure. Play helps children cope with frustrations, fears and disappointments of the situation they are in. It is the externalized expression of their emotional life and a natural mode for self-exploration and communication.

The humanistic viewpoint and the relationship viewpoint emhasize the importance of the growth and development of the child within themselves. The therapist provides an atmosphere or relationship by which the child can express their feelings, through the media, play.

Play is the children's universe and allows them to gain control over reality. The child is assisted in dealing with feelings of anxiety, hostility and insecurity. By meeting the child through the acitivity of play the adult communicates willingness to listen to the child.

When a child is hospitalized and/or threatened by a terminal disease, the mode of communication, through play becomes even more important.

Since hospitalization does create such radical changes, the importance of providing an atmosphere for the child's expression of fears is essential.

The playroom allows for an environment in which children can feel free to express their concerns. The application of group therapy allows for support among children and allows for reality testing and diagnostic evaluation.

The literature also indicates that play is age dependent in the aspect that very young age children are primarily concerned with separation from mother and will tend to re-establish trust with an adult therapist engaged in play. Pre-school children are preoccupied with mutilation and their play is more active in "acting out" their anger. The latency age child is concerned about mastery and competence. They possess developed language skills and can benefit in a group setting with specific discussion of themes.

The development of specific play programs and other interventions indicates that participation of play techniques is useful in decreasing the intensity of feelings of anger, regression, withdrawal, acting out behavior and some sleep disorders. The programs are also useful in terms of educating staff to the needs of children for an environment in which to express their feelings.

The literature points out the extensive application of play therapy to the types of children seen. For example play therapy in the treatment of blind children, children with

learning disabilities and children who have experienced other problems.

Hospitalization is a significant psychological event in childhood. In the child psychiatric literature dealing with hositalized children, there is a recurrent theme, that they be permitted to actively "work through" their hospital experiences. The concept of "working through" is the psychodynamic understanding of the child's successful mastery of stressful life experiences.

During hospitalizations the child experiences many sources of threat: the separation from loved ones, the fantasies of hurt and mutilation associated with medical procedures, the invasion of privacy and the uncertainty about the future. Depending on the child's age and social skills, the ability to master or "work through" the hospital experiences, can be achieved through many avenues: by dramatic play in the pre-school child or communication in writing in the older child.

Although the literature is scarce in implementation of specific hospital play programs, it does provide evidence that favors the outcome of such programs. There is a variance as to approach whether in a group or individual process and the importance of family participation.

CONCLUSION

Treatment of emotional distrubances in childhood can be of preventative nature, and early treatment may prevent the disorder in adulthood.

The field of psychotherapy has grown in scope and emphasis since the concept of the "child guidance" model. A specialized field of clinical child psychology emerged. The work undertaken tended to tie into a theory which had been developed for working with adults and served to translate adult theories to child theories. These theoretical approaches attempted to explain and at times predict play behavior.

The experience of hospitalization is often times traumatic for children. Oremland, (1973) points out that the newest knowledge and technologies have tended to dehumanize the care of the child, faster than one has been able to understand and cope with the psychological and social problems experienced by the child.

Koocher and Pedulla (1977) conducted a study to determine which therapeutic techniques and theoretical approaches are actually being used and found to be useful. The results were as follows: (1) family systems theory was rated useful by 60% of the therapists. (2) Psychoanalytic theory is still a very powerful force in child psychotherapy and accepted as useful more by psychiatrists than psychologists. (3) Application of learning theory and behavior modification is having an influence more so for psychologists than psychiatrists.

(4) The writings of Virginia Axline and Clark Moustakas or non-directive approaches were useful but not to the extent the authors had expected. The different techniques included art, doll, and puppet play.

Some questions raised in examination of the research presented in this paper is to look at whether more specific patterns of group behavior characterize certain subgroups of children, such as those facing major surgery, those with terminal illness, or those from varying demographic background.

In the research presented most of the meetings were of a weekly nature and were composed of the availability of the children on the ward. Would the process differ if all the children were of one medical or surgical diagnostic category? Would two or three daily group meetings make a significantly greater impact on the child's mastery of the hospital experience? Does the attitude of interest and inquiry into the children's feelings carry over to the staff and the children's families?

Hospital play programs are an important and positive intervention to aid the child in "working through" the hospital experience.

The playroom and the group of children offers a wealth of natural observational data on how children cope with stress and the research indicates that there has been much success in the integration of play in allaying a child's fears as well as in training the staff in becoming aware and dealing with the child's trauma.

FURTHER RESEARCH

The scarcity of available research on documented play programs, appears to indicate a need of initiating a general assessment of hospital provisions for children and their families regarding the emotional aspect of hospitalization. The program would allow for questionnaires to be developed and distributed to the families, to assess availability of staff and others regarding the emotional needs of the hospitalized child.

A consultant (counselor) would be a positive aspect in guiding both hospital staff and families through the specific traumatic and emotional setbacks of the child as well as the transitional shift among other family members.

Once, the assessment has been made, and an appropriate program developed, with the various therapeutic approaches, a follow-up study should be implemented. This would entail various problems of the child re-entering the home after hospitalization and any other emotional problems other family members may experience.

This would allow support for the parents and some guidance as to specific problems that may arise, given the change in lifestyle that a hospitalized child experiences. The ideas stated above, indicate the various possibilities of implementing play programs as further research in supporting the development of play programs in a hospital setting.

REFERENCE LIST

Adams, Margaret. A hospital play program: Helping children with serious illness. American Journal of Orthopsychiatry, 1976, 46, 416-424.

Axline, Virginia. Play therapy: The inner dynamics of childhood. Boston: Houghton, Mifflin Co., 1947.

Axline, Virginia. Play therapy procedures and results. American Journal of Orthopsychiatry, 1955, 25, 618-626.

Axline, Virginia. Child psychotherapy: Practice and theory. New York: Basic Books, 1964.

Bergman, T. Children in the hospitals. New York: International Universities Press, 1965.

Berlin, Irving. Developmental issues in the psychiatric hospitalization of children. American Journal of Psychiatry, 1978, 135, 1044-1047.

Byers, Mary Lou. Play interviews with a five-year old boy. Maternal-Child Nursing Journal, 1972, 1, 133-141.

Cataldo, Michael F., Bessman, Cindee, Parker, Lynn., Pearson Joyce., Rogers, Mark. Behavioral assessment for pediatric intensive care units. Journal of Applied Behavior Analysis, 1979, 1, 83-97.

Clatworthy, Stephanie M. The effect of therapeutic play on the anxiety behaviors of hospitalized children. Dissertation Abstracts International, 1978, 35-B, 9142.

Cofer, Dorcas., Nir, Yehuda. Theme-focused group therapy on a pediatric ward. International Journal of Psychiatry in Medicine. 1975, 6, 541-550.

Corsini, Raymond J. Current personality theories. Itasca, IL: Peacock Publishers Inc., 1977.

Dorfman, Elaine. Play therapy in Rogers' client-centered therapy. Boston: Houghton, Mifflin Co., 1965.

Erickson, Eric. Childhood and society. New York: Norton, 1950.

Frank, John. A weekly group meeting for children in a pediatric ward: Therapeutic and practical functions. International Journal of Psychiatry in Medicine, 1978, 8, 267-283

Freud, Anna. Introduction to the technique of child analysis. New York: International Universities Press, 1928.

Freud, Anna. The psychoanalytic treatment of children. New York: Anglo Books, 1951.

Freud, Anna. The role of bodily illness in the mental life of children. Psychoanalytic Study of the Child, 1952, 7, 69-81.

Freud, Anna. The ego and the mechanism of defense. London: Hogarth Press, 1954.

Freud, Sigmund. The basic writings of Sigmund Freud. New York: The Modern Library, 1938.

Freud, Sigmund. Analysis of a phobia in a five-year old boy. London: Hogarth Press, 1955.

Ginott, Haim. Play group therapy: A theoretical framework. International Journal of Group Psychotherapy, 1958, 8, 160-166.

Hall, Calvin., Gardner, Lindsay. Theories of personality. New York: John Wiley and Sons, Inc., 1957.

Hendricks, Shirley. A descriptive analysis of the process of client-centered play therapy with boys. Dissertation Abstracts International, 1971, 36-A, 1044.

Hug-Hellmuth, H. On the techniques of child analysis. International Journal of Psychoanalysis, 1929, 10, 287-305.

Jackson, Edith. Treatment of the young child in the hospital. American Journal of Orthopsychiatry, 1942, 12, 56-67.

Jolly, Hugh. The work of the play specialist in Charing Cross Hospital London. Journal of the Association for the Care of Children in Hospitals, 1978, 6, 4-10.

Kessler, Jane. The psychopathology of childhood. New Jersey: Prentice Hall, 1966.

Klein, Melanie. The psychological principles of infant analysis. International Journal of Psychoanalysis, 1927, 8, 23-37.

Klein, Melanie. The psychoanalysis of children. New York: Norton, 1932.

Klein, Melanie. The psychoanalytic play technique. American Journal of Orthopsychiatry, 1955, 25, 223-237.

Koocher, Herald., Pedulla, Barbara. Current practicies in child psychotherapy. Professional Psychology, 1977, 8, 275-287.

Lebo, Dell. The development of play as a form of therapy, from Rousseau to Rogers. American Journal of Psychiatry, 1955, 62, 418-422.

Mannoni, Maud. The child, his illness, and the others. New York: Pantheon Books, 1970.

Morrissey, J. Children's adaptation to fatal illness. Social Work, 1963, 8, 81-88.

Morrissey, J. A note on interviews with children facing imminent death. Social Casework, 1963, 44, 343-345.

Moustakas, Clark E. Psychotherapy with children: The living relationship. New York: Harper Brothers, 1959

Murphy, Albert., Fitz, Simons., Stuttering and personality dynamics: Play therapy projective therapy and counseling. New York: Ronald Press, 1960.

Natterson, J., Knudson, A. Observations concerning fear of death in fatally ill children and their mothers. Psychosomatic Medicine, 1960, 22, 456-465.

Oremland, E. The effects of hospitalizations on children. Springfield: Charles C. Thomas, 1973.

Orgun, Ibrahim. Play-room setting for diagnostic family interviews. American Journal of Psychiatry, 1973, 130, 540-542.

Ortiz, Jose., Blyth, Z. Play therapy: An individual prescription. Journal of Psychiatric Nursing and Mental Service, 1970, 8, 30-31.

Petrillo, M., Sanger, S. Emotional care of hospitalized children. Philadelphia: Lippincott, 1972.

Piaget, J. Play, dreams, and imitations in childhood. New York: Norton, 1951.

Rae, William., Stieber, Darlene. Plant play therapy: Growth through growth. Journal of Pediatric Psychology, 1976, 1, 18-20.

Rogers, Carl. A theory of therapy, personality and interpersonal relationships. New York: McGraw Hill, 1959.

Rogers, Carl. Client-centered therapy. Boston: Houghton, Mifflin Co., 1965.

Schowalter, J. In loss and grief: Psychological management in medical practice. New York: Columbia University Press, 1970.

Schowalter, J., Lord, R. Utilization of patient meetings on an adolescent ward. International Journal of Psychiatry in Medicine, 1970, 1, 197-206.

Tisza, Veronica., Richardson, M. The integration of a mental health program and a child psychiatry unit into a pediatric hospital. Pediatrics, 1956, 17, 104-110.

Woodruff, R. Group work in a children's hospital. Social Work, 1957, 2, 56-61.

Wunheiler, Lurtgard. Liberty boy: The play of a schizophrenic child. Journal of the American Academy of Child Psychiatry, 1976, 15, 475-490.

APPROVAL SHEET

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The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

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