PLAY THERAPY: AN EFFECTIVE TECHNIQUE FOR COUNSELING WITH CHILDREN

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PLAY THERAPY: AN EFFECTIVE TECHNIQUE FOR COUNSELING WITH CHILDREN

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Master of Science

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by

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To the Graduate Council:

I am submitting herewith a Research Paper written by Barbara A. Grogan entitled "Play Therapy: An Effective Technique for Counseling with Children." I recommend that it be accepted in partial fulfillment of the requirement for the degree of Master of Science, with a major in Guidance and Counseling.

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Major Professor

Accepted for the
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Chapter 1

INTRODUCTION

Play therapy is a counseling technique that utilizes play for rapport building and one that enables the child to express feelings and emotions. Play therapy may also be a useful technique for diagnosing the source of a child's difficulty. Virginia Axline (1969) points out that play therapy is based on the fact that play is the child's natural medium of self-expression. The underlying assumption of play therapy is that when children are given the opportunity and permissiveness to be themselves, to learn to know themselves and to assume the responsibility for their own behavior, they acquire the necessary feelings of personal worth. In the play therapy room the children are the most important persons, and it is here that they can express themselves fully and be accepted completely. The children are in command of the situation as well as of themselves. They can behave as they desire without an authority figure giving commands or criticizing. They can display hate or love in their own terms and be accepted completely regardless of what they say or do. Through this free play, the children take responsibility for their own actions and gain respect for being thinking, constructive, independent human beings. When children have a sense

of personal worth, they feel free to explore, attempt, and test more than they were able to previously (Axline, 1969).

Purpose of Play

Jackson and Todd (1950) suggest that play is an activity which is undertaken for its own sake. Since children play spontaneously without encouragement and play appears to be unlearned, the impulse to play could be regarded as a human instinct. However, this theory of instinct is considered controversial by authorities in the field of play. Some of the pioneers in the field of play (Dr. Jean Piaget, Dr. Anna Freud, Dr. Maria Montessori, Milton Bradley, Karl Groos, and Dr. Arnold L. Gesell) suggest that a child's ability to "play out" situations is the most natural, self-healing measure childhood offers. Play provides children with an opportunity to "play out" their feelings and problems, similar to the way adults "talk out" their difficulties and troubles. Some of the major contributors to the fields of child development and learning through play propose that play is genuinely a productive and necessary means for children to attain their potentialities at their own rate of progression. Therefore, play is a method "Nature" uses to teach children (human beings) how to use their capacities to grow and learn to accept themselves and their world through experience (Caplan and Caplan, 1973).

Research also indicates that children practice everything they have learned through play; thus, play contributes to the development of children's intelligence. Actions during play may be a better indicator of the level of children's understanding than what is revealed through their verbalizations. It seems, then, that play is very important to the mental development and personality development of children and is considered to be one of the most powerful learning tools for children. A child's play is much more than just fun (Caplan and Caplan, 1973).

Types of Play

Caplan and Caplan (1973) and Jackson and Todd (1950) suggest that there are basically two types of play: imitative play and dramatic play. Imitative play appears first in children. It is the kind of play in which children will try to reproduce the actions of those around them such as pretending to perform the activities of their mother and/or father. However, the concept of imitation has been a long-standing controversy in psychology. It has been argued that of all the things around us that we might imitate, we select a few that appeal to us for either obvious or unconscious reasons. Because of this, it might be correct to state that imitative play is never purely imitative or that imitation is never practiced for its own sake. However, it is almost impossible for children to avoid reproducing what they see

around them since their environment is the major stimulus for learning during their early years. Their selection may be influenced by preferences of certain instinctive trends as well as certain unconscious motives; i.e., a little boy who imitates his father's behavior or a little girl who reproduces the actions of her older sister.

Caplan and Caplan (1973) state that dramatic play appears at a later age (three to five year olds) and helps children relive important life experiences. In dramatic play children reflect their interpersonal relationships, express their needs, and try out solutions to their problems. A child who acts out a painful scene over and over is not doing so to perpetuate the pain, but to try to make the situation understandable and bearable and eventually acceptable. Adults relive experiences in thoughts or words; children play and replay the important happenings in their lives. Often in dramatic play children may be acting out situations to satisfy a need for power--something which they have little chance of administering in real life. They may do to imaginary people or animals what others have done to or inflicted upon them. Through this play children may learn the control of emotions which they are forced to repress in their everyday relationships. Through dramatic play, children are able to put themselves in the place of persons in their environment, and they often

reverse their usual life role. This enables them to experience imaginative identification and intuitive understanding. They are able to test the strength and quality of their emotions as well as their control of them. Thus, the children can improve their personality by developing emotionally, which will help them succeed in their future relationships with other human beings.

For these reasons, imitative play does not have the same degree of diagnostic value as dramatic play. Dramatic play is very important because of its therapeutic possibilities. However, both dramatic and imitative play begin at an age when children are still far from possessing the "equipment" required for their full realization of the reason for their behavior. Both types of play are very complex because they may be an expression of a variety of the child's needs. Either type, though, provides children with an opportunity to explore themselves more fully as they develop their personalities through the media of play (Jackson and Todd, 1950).

History and Development of Play Therapy

With these basic principles in mind, the use of child's play was developed into the helping process of counseling or psychotherapy. Although the approaches and viewpoints regarding play therapy have expanded and have become somewhat diverse throughout the past thirty years, each counseling

approach is essentially based on the principles of play therapy developed by Virginia Axline around 1947. Axline's eight basic principles to guide the counselor in play therapy are: (1) the counselor must establish a positive relationship; (2) the counselor must accept the children as they are; (3) there must be permissiveness by the counselor to allow the children the freedom to explore and express their feelings; (4) the counselor must recognize and reflect the children's feelings so that they may gain insight into their behavior; (5) the counselor must have deep respect for the children to allow them to become responsible for their own choices and problem-solving behaviors; (6) the counselor must allow the children to lead the way; (7) there should be no rush--the process is gradual; and (8) certain limits must be established by the counselor to keep therapy in the world of reality and to make the children aware of their responsibility in the relationship (Axline, 1969).

Axline applies these principles to play therapy while employing Carl R. Rogers' technique of non-directive counseling. During the play sessions, the responsibility and direction of the play is left up to the children to enable them to become their idealized persons. This form of free play enables the children to express what they want to do and what they feel by taking charge of their own world. The result of successful non-directive play therapy is that the children

gain respect for themselves as persons of value, utilizing their potentialities to assume responsibility for themselves. This, in turn, is carried over to the child's relationships with others and it is expected that the children will become happier individuals, willing to accept and respect others. Axline's philosophy for non-directive play therapy is to utilize a method of helping problem children help themselves. However, play therapy may also be directive--the counselor may assume responsibility for guidance and interpretation. This form of play therapy is usually effected by structuring the play materials for diagnostic purposes and for catharsis (Axline, 1969).

Generally speaking, Axline's model of therapy results in two positive outcomes. First, through play the children project their inner thoughts and feelings. Therefore, their play becomes a diagnostic tool to better understand the child's world. Second, when the children come to play therapy sessions full of hostility and anger, they are more likely to leave much more relaxed and tranquil. Through Axline's procedures, play therapy provides the children with socially acceptable means to displace their angry feelings. After this type of play, the children have less need to exhibit this maladaptive behavior outside of the play session. Play therapy provides children with an opportunity to "play out" their feelings and thus direct fewer emotional

outbursts at their parents, siblings, teachers, and peers. By doing so, the children are able to avoid further interpersonal conflicts. Axline's non-directive approach of observing children during play in a room full of play materials free from suggestive use enables a child to be himself or herself. Her method allows the children to become happy, self-realizing, independent individuals through the therapeutic use of play. She also believes that even though parents or guardians are often a contributing factor in the case of a maladjusted child, it is not necessary for the adults to receive therapy or counseling for successful play therapy results. Therapy might progress faster if they were also being helped, but it is not essential (Axline, 1969).

Other Models of Play Therapy

There is a diversity of opinion about whether parents or guardians should be involved in therapy with their children. Nystul (1980) and other counselors contend that unless an effort is directed to the source (parents or guardians) of the child's problem, long-term success will be minimal. These counselors think that events happen outside of the play session (in the child's home or classroom) that could disrupt the child's equilibrium achieved from therapy. This assumption has led to additional strategies for a more comprehensive model than

Axline's for children involved in play therapy. One such strategy, developed by Michael S. Nystul and used by other counselors, employs the philosophy of Adlerian psychology. This Adlerian approach was designed to help children find their place in their family or group and to determine the purpose behind children's misbehavior in their quest for personal need-fulfillment. Using this method, the counselor serves as a consultant to the child's parents and teachers to provide the child with support outside the therapy in order to reinforce and internalize the learning from therapy. Parents and teachers attempt to offer these children an environment that is similar to, and consistent with, their newly acquired ideas and experiences gained through play therapy.

Another facet of Axline's model which presents conflicting counselor views is the use of unstructured versus structured use of play materials. Axline suggests that the playroom always be free from the suggestive use of materials. Materials are considered structured if they have a specific shape, form, or content and are used for specific purposes. Unstructured materials have no specific form or function. However, the consensus of the research regarding materials is that all playthings should be rather simple in construction and easy to handle so they will not cause the children frustration if they are unable to manipulate them. Research

also suggests that mechanical toys not be used in play therapy because the mechanics often get in the way of the child's creative play. Some play materials which have proven to be successful include: doll families, toy animals, nursing bottles, sand boxes, playhouse materials, finger paints, clay, telephones, water, toy guns, rag dolls, puppets, little cars, brooms, mops, drawing paper, tables, easels, toy airplanes, and old newspapers (Axline, 1969).

Counselors who follow Axline's guide for the use of unstructured play materials feel that the children should be free to use the play materials in any way they want in order to express themselves fully. This self-expression is achieved within the few limitations of the play session that have been set up without fear of "messing up" clothes or the room (Axline, 1969). Other counselors think that structured materials, such as Dinkmeyer's Developing and Understanding of Self and Others programs (DUSO), provide children with information and learning experiences necessary for their growth and development. Structuring the play materials also includes the counselor presenting children things such as clay, paints, puppets, or any other form of creative material for the specific purpose of having them express themselves creatively. With this type of play, the counselor often encourages the children to participate through social modeling. Another example of structured play is when the

counselor presents a family of dolls to a child having difficulty getting along with other family members. Interpretations of the child's play are then made to determine the underlying reasons for the child's behavior at home. Some play materials can be used as both structured and unstructured play, depending upon the counselor's use of the item. For example, if children have paper and paint available to them and are permitted to use them as they choose, the use of the paint is considered unstructured. However, if children are required to paint a picture of themselves, the use of the paint is now structured. The use of structured or unstructured play material varies with the age of the child, the type of developmental concern, and the counselor's individual preference (Nystul, 1980)

No matter what approach a counselor uses during play therapy, research indicates that the majority of counselors use limits in their playroom (Ginott and Lebo, 1963). During play therapy, the counselor allows permissiveness in the playroom so that the children feel free to express their feelings completely. Permissiveness implies the choice by the children to use or not to use the materials according to their wishes. However, the children do have limitations set. The general consensus of counselors regarding the most widely used limits pertain to: (1) the protection of the playroom property (breaking windows,

furniture and fixtures, and painting on the walls or doors); (2) the children's safety (drinking dirty water and climbing on high window sills or structures); (3) the counselor's safety (attacking the counselor or painting on the counselor's clothes); and (4) socially unacceptable behavior (urinating or defecating on the floor or yelling profanities at passers-by). The least used limits pertain to: (1) symbolic expressions of socially unacceptable behavior (racial slurs, speaking or writing profanities, and making obscene objects); and (2) playroom routines (bringing food to the playroom, reading books in the playroom, and taking home paintings or clay objects made there). Most counselors also allow the children to sit on their laps, throw rubber toys and paint their own faces. Some counselors have stated that they find it advisable to take the time to point out and explain the use of the materials when they first go into the playroom with the children. Within these limits the children are still able to experience self-exploration in the playroom, and they learn to accept and respect not only themselves but others as well.

Chapter II

CURRENT TRENDS AND USES OF PLAY THERAPY

Appropriate Clients for Play Therapy

As Virginia Axline (1969) and other researchers state, play therapy is a method of helping problem children help themselves. Youngsters who are so often termed problem children include children with behavior problems, study problems, speech problems and even some children with somatic problems who have been referred by a physician. Aggressive, disturbing, noisy children are the most readily identified as the children with problems because they continuously create new problems for themselves and those around them. However, this problem group also includes children who withdraw from their "miserable world" of human relationships; and because they are quiet and are not a disturbing element, they are left alone. Withdrawn children also need therapy and can benefit from it. There are nervous children who bite their nails, have nightmares, wet the bed, have tics, refuse to eat, and manifest other types of behavior which are good indicators of anxiety and turmoil with self. Client-centered play therapy provides these children with an opportunity to work through their problems, learn to know themselves, and to accept themselves (Axline, 1969). Axline states that

children with problems manifest all types of behaviors which may constitute problems with adjustment, including repressed children, withdrawn and inhibited children, as well as aggressive, uninhibited children.

Children with study problems often have interfering emotional conflicts and tensions (Axline, 1969). By enabling these children to explore their feelings and attitudes and to release pent-up emotions through the process of play therapy, they are able to attain the psychological growth necessary for satisfactory school work. Play therapy sessions have proven to be helpful in solving study problems.

Children's conflicts and troubles with their feelings often show up as a language difficulty. Speech problems, such as stammering, stuttering, baby talk, repetitious language, and garbled language seem to be alleviated by play therapy (Axline, 1969). Research indicates that quite often a non-talker will begin to verbalize after play therapy sessions have begun.

Axline (1969) states that reading problems have improved (and in some cases replaced remedial-reading instruction) when play therapy has been a part of treatment. Quite often, non-readers are obviously disturbed children and at other times the disturbance is so slight

that it is not considered a contributing element in the reading disability. However, in play therapy, tensions, fears, and anxieties can be worked through and resolved by these children. The children then are able to achieve greater equilibrium with self and improvement in their reading abilities.

Axline (1969), Guerney (1979) and others have stressed the potentialities and successes of play therapy with children with various types of problems. They state that there is no justification for waiting until children are seriously maladjusted before attempting to help them deal with their problems. Because this method is a play experience, all types of children (whether disturbed or not) could enjoy the experience tremendously. For this reason, play therapy experiences could provide children with a preventive mental hygiene program. Axline (1969) suggests that the implications of play therapy are exciting. Therefore, it would seem worthy to pursue the possibility of incorporating play therapy into regular elementary school curricula.

Although play therapy has proven to be an accepted treatment for years for children with emotional problems, more recently play therapy has been employed for children

with adjustment difficulties secondary to primary disorders of a physical origin (Guerney, 1979). These secondary adjustment problems include children with learning disabilities, hyperactivity syndrome, physical handicaps, and retardation. Research provides evidence that play therapy has proven to be just as successful with these types of children as with children whose problems are purely emotional and interpersonal in origin. Both groups of children are capable of moving from negative feelings toward the self to positive feelings, from dependence to independence, and from impaired impulse control to the ability for greater self-regulation through the method of play therapy. It seems that concentration on the deficits created by the primary problem (physical) frequently result in overlooking or ignoring the total development of these children with secondary adjustment problems.

Handicapped children have within themselves the same feelings and desires as other children. Quite often, the handicap is a frustrating and blocking experience that creates intolerable tensions within these children. It is not uncommon to find handicapped children living at home (or a home) where they receive no understanding, experience feelings of inadequacy, and have no sense of personal worth. Play therapy provides these children with

an opportunity to bring about maximum adjustment; they have the same rights as other individuals to acquire the necessary feeling of personal worth and self-esteem (Axline, 1969).

Past research has demonstrated that play therapy has vast advantages and has been an accepted treatment for years for children whose problems are purely emotional and interpersonal in origin. For these reasons, the remainder of this chapter will be devoted to the positive results of play therapy for children with adjustment difficulties secondary to primary disorders of an essentially physical origin. Even though some adjustments must be made in the usual play therapy techniques, research suggests that the children are able to gain respect for themselves as individuals of value through play therapy sessions.

Learning Disabled Children and Play Therapy

Wender states that it is quite common that children with learning disabilities (L.D.) will experience secondary problems of an emotional nature in reaction to their own feelings of incompetence from the feedback they are given from their environment (cited in Guerney, 1979). Because these children have histories of poor performance, impulsivity, inadequate judgment, and impatience, adults constantly warn against mistakes the children might make. Guerney (1979) states that, "It takes only a small amount

of negative feedback from either the physical or social environment to convince children that they cannot control outcomes as required or desired" (p. 244). Often, this feedback is a part of the everyday routine for children with learning disabilities. The children also learn to function at a very low trust level and begin to feel they are not worthy and thus develop "I can't" attitudes. It is essential that L.D. children have a program to meet their developmental, social and emotional needs along with rigorous academic programs to overcome their primary problems. Client-centered play therapy sessions are an ideal means of accomplishing this goal (Guerney, 1979).

Guerney (1979) suggests that it is particularly valuable if the parents (or other significant adults in the child's life, such as teachers or guardians) are the ones who offer these children the special, quality-relationship times of the play therapy sessions, and that they be trained under the supervision of professionals. This form of treatment is referred to as Filial Therapy. The reasons for this parental involvement are: (1) the client-centered play therapist's behavior conveys the message that the adults care about how the children feel at least as much as how they perform; (2) the children receive acceptance that is desparately needed from people whose opinion is already highly influential in shaping children's self-

images; (3) these significant adults are with the children most of the time, and therefore can best utilize the positive behaviors and attitudes of the play therapist which can be carried over in relating to the children on a reality-oriented basis. By doing so, the danger of the children thinking of these adults as only being capable of making demands which indirectly communicate non-acceptance is avoided. Adults are much more influential if children can see them as being capable of responding with a wide range of responses (Guerney, 1979). Guerney (1979) and Stollak (cited in Guerney, 1979) believe that the resulting benefits can be enormous (and empirically demonstrated) when an adult provides non-contingent acceptance through play therapy sessions.

The play therapy environment (following Virginia Axline's model) allows L.D. children to express parts of themselves that are ordinarily hidden from others and possibly from themselves. Feelings that are most commonly expressed are those which are disapproved of outside the play session. The first feeling which appears is usually aggression, followed by feelings of dependence, helplessness, and the desire for nurturance (Guerney, 1979).

For children with learning disabilities, the need for dependence in relation to independence is an extremely troublesome area. Teachers and parents of these children

are often confused about the degree of assistance L.D. children require. These children may need more help than others but at the same time reject it. However, through play therapy sessions, L.D. children are given an opportunity to resolve this conflict realistically for themselves. Parents participating in the play sessions develop an appreciation of the struggle the children encounter in problem-solving as well as the amazement the children experience with self-solutions (Guerney, 1979).

Sywulak (cited in Guerney, 1979) states that through these play therapy sessions, parental permission for greater child autonomy and respect for individuality have been shown in significant score changes on the Porter Parental Acceptance Scale. Parents make different statements about their children. Instead of saying, "She simply refuses to take any suggestion," they can say, "I'd let her go on her own rather than checking to see how she's doing all the time as I used to" (p. 243).

Play therapy sessions conducted by parents or other significant adults (the Filial Therapy method) when working with learning disabled children result in positive effects (Guerney, 1979). Living out experiences of "I can" in the presence of a significant other in the child's life, especially a parent who may be associated with the judgment of the child as a failure, tends to disrupt the

"failure cycle" and gives the child the self-confidence to attempt more difficult tasks. Hopefully, these children will receive some positive feedback from the environment for their efforts and will continue to venture further attempts at a task. Parents are also encouraged to be supportive and reinforcing to their children for their efforts outside of the playroom in order to continue the children's new awareness of self and acquired responsibility for their actions.

Play Therapy with Severely Handicapped Children

Play therapy has been utilized to help severely handicapped children of normal intellect deal with some of their limitations (Salomon and Garner, 1978). MacDonald and Hall state that the reactions of others to children with severe physical handicaps impair the children's picture of themselves (cited in Salomon and Garner, 1978). These children may also be uncertain as to the effects their physical limitations place upon their parents and siblings and may therefore conclude that they are the cause of any family disagreements that develop. The conflict between the children's need for independence and the dependency which their condition forces upon them creates an additional source of frustration for physically handicapped children. Salomon and Garner (1978) state that workers with severely handicapped children frequently recommend

that the children be involved in some form of intervention to help them deal with the meaning of their condition. Since the problems usually exist early in these children's lives and involve feelings which may be widely spread or unacceptable, it is recommended that they be encouraged to express (either directly or indirectly) their troublesome concerns and/or fears. Quite often the children develop a strong dependence upon the adults in their lives and learn to employ dictatorial, manipulative techniques as a means of obtaining others' help instead of using socially appropriate means to do so. Through the process of play therapy, it is hoped that these children will increase their independence and learn to be responsible for their own behavior. Additionally, handicapped children usually have very limited contacts with other children. Play therapy could provide opportunities for them to play with other children in structured or unstructured situations and in individual and group settings. The basic techniques and underlying assumptions of play therapy may therefore be an accepted treatment for helping motorically handicapped children learn to view themselves as capable, whole persons.

Due to these children's severe physical limitations, play sessions are quite different from those play sessions with other types of children. Many adjustments have to be

made in the usual play therapy techniques. It is necessary to choose play materials with care. Only the smallest and lightest materials can be handled by these children without help in the therapy situations; a family of flexible, light dolls, some ping-pong balls, tiny pieces of clay, very small blocks, and facial tissues. The therapist must therefore manipulate, arrange, and move many of the other play materials. Because of the children's inability to handle most of the play materials directly, they are forced to imagine play situations and to give the therapist specific directions as to the placement and use of the equipment (Salomon and Garner, 1978).

The children's use of language and fantasy is encouraged. In these play situations, language is used to a much greater extent than it would be for other types of children involved with play therapy. The children's verbal capacities are used to direct the therapist in arranging equipment to display their superiority to others, to play at sports indirectly, and to exercise their creative capacities. Although these children do need assistance in arranging equipment and carrying out tasks, research indicates that through play therapy they increase their independence to strive for achievement. Since motoric responses are denied to these children, they use language and fantasy with great effectiveness to fulfill their

needs. It is quite common for the children to carry on conversations with the toys, taking both parts and changing their voices appropriately (Salomon and Garner, 1978).

Given the opportunity, severely handicapped children who are capable of communicating with the play therapist are able to utilize vicarious play experiences successfully. Skills in verbalizing and fantasizing have proven to be sufficient to allow physically handicapped children the ability to benefit from play therapy even though several modifications have to be made in the usual play procedures. It is very likely that the severity of the children's handicaps will continue to create new problems for them as they grow. However, it is inspiring to know that through play therapy intervention, the children are given an opportunity to deal with and come to terms with some of their limitations in order to help improve their self-images (Salomon and Garner, 1978).

Play Therapy and Children with Hyperactivity Syndrome

Guerney (1979) states that until play therapy was tried with aggressive, uncontrolled children (i.e., those with hyperactivity syndrome), it was assumed that a thorough tightening up of the permissive, child-centered playroom rules would be required. However, research has demonstrated that no such changes are necessary with the

exception of more concrete structuring; for example, the children are told that nothing may be thrown at the one-way mirrors in the room. The therapist says to the child, "You may throw objects at this wall, this wall, and this wall," pointing to the acceptable ones and excluding the one with the mirrors. Whenever it is possible, all limits of the playroom are outlined and stated in a positive way to enable hyperactive children to focus on what is permitted (Guerney, 1979).

Research has demonstrated that after a few play therapy sessions in which hyperactive children hopped from one object to another, they were able to focus for rather extended periods of time on distinct activities--in complete contrast to their real-life activities (Guerney, 1979). Quite often, this single activity will be a very physical one (defeating the Darth Vador bop-bag in many ways). However, there is also a generous amount of play with objects that require quiet, purposeful arranging (playing with toy soldiers and dinosaurs). Guerney (1979) states that as the play sessions continue, motor activity eventually decreases and more creative use of the toys is made by these hyperactive children. Guerney also reports that after the first few sessions, the children rarely exhibit aggressive tendencies toward the parent therapists (employing the Filial Therapy method) or the professional

therapist. Generally, their aggression is expressed in symbolic ways with the play materials. Guerney (1979) suggests that, "It is almost as though these children are able to behave in the playroom in a way that they and the parents would like them to be, if the demands of ordinary life were removed" (p. 243).

Through the use of Filial Therapy with hyperactive children, observed differences in the children's behavior are specified and cited to help the parents identify the elements of the play therapy sessions which seem to account for the more desirable behaviors expressed by the children. Once the parents see their children's improved behavior and see them assuming the responsibility for their own behavior, they are generally pleased as well as relieved to share greater responsibility for self-control with their children outside of the playroom. Thus, the ability to control one's environment achieved through play therapy sessions seems to be effective in increasing hyperactive children's ability to concentrate on a task for longer periods of time than were previously possible (Guerney, 1979).

The Use of Play Therapy with Mentally Retarded Children

Although play is considered to be an important medium for facilitating the psychological development of mentally retarded children as well as for children with average

intellectual capacities, there has been relatively little published on the use of play therapy with this population of children (Newcomer & Morrison, 1974 and Bernhardt & Mackler, 1975). "For instance, between 1927 and June of 1972, only 10 articles and one book have been published dealing with the use of play therapy with the mentally retarded" (Bernhardt & Mackler, 1975, p. 409). The little research that has been done on play therapy with retarded children has produced encouraging results (Newcomer & Morrison, 1974). Because of Maisner's success with play therapy intervention, he suggests that play therapy be incorporated into the general rehabilitative programs of institutions for mentally retarded children (cited in Bernhardt & Mackler, 1975).

In discussing play therapy for such children, Newcomer & Morrison (1974) state that there are some important aspects of retarded children's play that must be taken into consideration. Many of the play materials designed for nonretarded children are unsuited for retarded children of the same chronological age. Play materials that are ordinarily considered to be safe can be dangerous and destructive when used by children who are mentally handicapped or developmentally delayed. By the time mentally retarded children are able to negotiate play materials, they are chronologically older and stronger than nonretarded

children of the same mental age. Also, many such handicapped children have deficiencies that make play difficult; they learn slowly, require much repetition, depend on examples rather than words, and attend to things rather than ideas (Benoit, cited in Newcomer & Morrison, 1974). For these reasons, Newcomer and Morrison (1974) suggest that games for retarded children be simply structured, concrete, and require little thinking or language facility.

Despite the need and importance of play for psychological development, Benoit (cited in Newcomer & Morrison, 1974) and Mulick, Hoyt, Rojahn, and Schroeder (1978) have found that retarded children, especially those in institutions or training schools, do not receive sufficient play opportunities. Too often, solitary play (unstructured activity times on institutional wards) is not successful for retarded children to obtain the beneficial stimulation necessary for their optimal development. It is mostly through group play that these children attain the required stimulation. However, there are conditions present within institutions and training schools which must be taken into consideration when studying the children's psychological development through play activity; for example, understaffing, overcrowding, lack of play equipment, and a need to safeguard the equipment which is easily broken.

The available literature on play therapy with retarded

children has produced several hypotheses. Because of the limited research completed in this area, the evidence to support these hypotheses is far from conclusive (Newcomer & Morrison, 1974). Newcomer and Morrison cite the hypotheses as: (1) play therapy has a beneficial effect on the functioning of mentally retarded children, including intellectual and social functioning (i.e., the categories of gross motor skills, fine motor-adaptive skills, language skills, and personal-social skills); (2) group play therapy and individual play therapy have different effects on the functioning of retarded children; and (3) directive play therapy is more effective than nondirective therapy in producing changes in a retarded child's level of functioning (p. 728).

Newcomer and Morrison (1974) designed a study to test the first two hypotheses (as stated above) and to provide some preliminary data relevant to the third. The subjects for this study consisted of institutionalized mentally retarded children only. Their study confirmed the hypothesis that play therapy stimulation given to the children has a beneficial effect on their social and intellectual functioning. This investigation showed that play therapy was effective in increasing the children's developmental level.

However, Newcomer and Morrison (1974) caution that

their investigation "raised several questions that must be considered and that can be answered only by subsequent research" (p. 731). These questions concern the children's institutionalized status. Many researchers have found that the socially depriving effect of institutionalization leads to increased motivation to receive social reinforcement, and in this study's situation, the play therapist had the potential to be highly socially reinforcing to the children (McCandless; Sarason & Doris; Zigler; Butterfield & Zigler; Zigler, Butterfield, & Capobianco, cited in Newcomer & Morrison, 1974). For this reason, Newcomer and Morrison (1974) suggest that further research is necessary to determine whether changes similar to the ones found in their study occur in noninstitutionalized retarded children seen in play therapy.

The second hypothesis that group play therapy and individual play therapy would have different effects on the functioning of retarded children was not supported by Newcomer and Morrison's (1974) findings.

Newcomer and Morrison (1974) also found no noticeable change concerning directive therapy as a more effective means of therapy than nondirective therapy in increasing the developmental level of retarded children (hypothesis three). However, the area of language appeared to have a slower rate of growth during nondirective therapy.

Newcomer and Morrison state that it could be argued that such children require directive rather than nondirective therapy because they have low ability to organize their efforts and their environment. With this in mind, unstructured therapy could be considered as contributing to these children's disorganization instead of helping them to become more competent socially and intellectually. No distinct differences in trend of growth between the two forms of therapy (directive and nondirective) were noticed in Newcomer and Morrison's (1974) findings.

Although little has been published, research indicates that play therapy is a potentially helpful technique to help mentally retarded children deal with their problems. There seems to be a general consensus among researchers in this area that play therapy is beneficial for retarded children's psychological development; however, little research can be found on the unanswered questions from one study to another. The available studies are limited to a specific segment of retarded children; i.e., institutionalized mentally retarded children.

Chapter III

CONCLUSIONS AND SUGGESTIONS FOR FURTHER RESEARCH

Available literature on play therapy concurs with the original principles of play therapy developed by Virginia Axline around 1947. Although some adaptations have been made to her model, all approaches of play therapy essentially evolve around client-centered therapy which is based upon a positive theory of the individual's ability. The children are the source of power that direct the growth from within themselves. Whether the therapy is nondirective (unstructured) or directive (structured), the underlying assumption of play therapy is that the children will acquire the necessary feelings of personal worth through play--their natural medium of self-expression.

For years, research has demonstrated that play therapy is an effective method of treatment for children with adjustment or emotional difficulties. However, available literature strongly suggests the need for further research concerning the effectiveness of play therapy for children with adjustment difficulties secondary to primary disorders of an essentially physical origin. Play therapy represents a technique to help children help themselves. Axline (1969) states that "Handicapped children have within themselves the same feelings and desires of all normal children,"

(p. 58), and other researchers in this field concur with Axline's sentiment.

Available research on the effectiveness of play therapy with learning disabled children demonstrates the vast possibilities of the play sessions. However, limited results prevent comparison with other studies to determine concrete generalizations concerning the benefits of play therapy with L.D. children. Considering the underlying assumptions of play therapy and the characteristics of children with learning disabilities, it seems apparent that play therapy would be an excellent technique to provide the children with an opportunity to acquire the necessary feelings of personal worth, an opportunity to express feelings they may be unable to verbalize, an opportunity to practice social skills, if needed, and an effective treatment modality for the variety of other problems that may affect L.D. children and their families.

There is even less research available on play therapy and children with hyperactivity syndrome. From the limited amount of research, the escape from the demands of real-life for the children in play sessions appears to be the primary benefit. However, it would seem that play therapy with hyperactive children could be helpful in allowing them to release pent-up feelings and energies and to learn reality-oriented behaviors. There is a need

for more evidence to demonstrate that the power to control one's environment and oneself (in fantasy through play therapy) can result in increased social competence for hyperactive children.

Available research on play therapy with mentally retarded children is most encouraging but far from conclusive. Research designed to specifically test the effects of play therapy on noninstitutionalized mentally retarded children is definitely needed. Research to test (1) the differential effectiveness of directive versus nondirective play therapy and (2) the different effects of group play therapy and individual play therapy on the functioning of retarded children is also warranted. Play therapy has been demonstrated to have a beneficial effect on institutionalized mentally handicapped children's social and intellectual functioning. Nevertheless, it would be helpful if the specific components of play therapy were researched further to provide congruency concerning the effectiveness of play therapy with the population of mentally retarded children as a whole.

Research is also encouraging for play therapy with severely handicapped children, but the literature is limited to severely handicapped children with normal intellect who are capable of verbalizing. The available literature in this area demonstrates play therapy's effectiveness

as a means for the children to learn to view themselves as capable, whole persons and to help them to deal with some of their limitations, even though many adjustments have to be made in the usual play therapy techniques. But once again, there is a lack of conclusive evidence concerning play therapy with severely handicapped children. No decisive generalizations can be drawn concerning the possibilities of incorporating play therapy intervention into the lives of the severely handicapped for development of their social and emotional needs.

Available literature concludes that if research is able to demonstrate play therapy as an accepted form of treatment for "normal" children to express their feelings and problems and to facilitate growth and understanding of self, the same could be done for other segments of the child population. Research in the area, although limited, provides encouraging results for children with adjustment difficulties secondary to primary disorders of an essentially physical origin. The need for more conclusive studies and evidence is warranted. Play therapy could be effective for <u>all</u> children.

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