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Play therapy for children with aggressive behavior

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Abstract

The purpose of this literature review was to investigate the effectiveness of various play therapy interventions for decreasing developmentally inappropriate aggression of children. Psychoanalytic, cognitive-behavioral, and person-centered approaches of play therapy were reviewed. Each of the three theoretical approaches to therapy was described in relation to the aggressive behaviors of children. Similarities and differences among the three therapies were discussed. Efficacy of the interventions was presented based on published literature only. More studies of the various types of play therapy, particularly in relation to the aggressive behaviors of children, need to be conducted and results disseminated.

PLAY THERAPY FOR CHILDREN WITH AGGRESSIVE BEHAVIOR

An Abstract of a Master's Paper

Submitted

In Partial Fulfillment

Of the Requirements for the Degree

Master of Arts in Education

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Play Therapy for Children with Aggressive Behavior

CHAPTER ONE
INTRODUCTION

The purpose of this literature review is to investigate the effectiveness of various play

therapy interventions in decreasing developmentally inappropriate aggression of children.

Various theoretical approaches to play therapy will be described in detail. Research evidence of

the efficacy of these theoretically based interventions to decrease aggression in children will be

presented.

The psychoanalytic definition of aggression suggests that it is an indirect or direct act in

the child's play and other interactions(Klein, 1982). The cognitive-behavioral definition of

aggression is a behavior that results in personal injury or destruction of property (Bandura,

1973). The person-centered definition of aggression is impossible demands on those who care for

children, including violence (Carroll, 1998). Play therapy is used to assist children with

aggressive behavior. It focuses on teaching them new methods for managing their aggressive

feelings and demonstrating more socially appropriate behaviors.

As professionals we must assist the intellectual, emotional, physical, and social

development of children by providing adequate learning opportunities. A major objective with

children is to help them get ready to profit from the learning experiences offered. Play therapy is

an adjunct to the learning environment, an experience that assists children in maximizing their

opportunities to learn. This paper will address these issues by looking at three different play

therapy perspectives: psychoanalytic, cognitive-behavioral, and person-centered.

Psychoanalytic, cognitive-behavioral, and person-centered approaches provide competing

views on the etiology and treatment of aggression. Knowing which approach is the best for each

presenting problems is a must for professionals who want to use play therapy in their practice.

To date, only one study has been published in the literature on the efficacy of play therapy for reducing aggression in children.

CHAPTER TWO
LITERATURE REVIEW

In this chapter, an overview of various forms of play therapy will be presented. A definition of aggression will be presented from each of the following approaches: psychoanalytic therapy, cognitive-behavior therapy, and person-centered therapy. A general description of play therapy will be discussed next, followed by descriptions of psychoanalytic play therapy, cognitive-behavior play therapy, and lastly, person-centered play therapy. For each form of play therapy, efficacy studies will be presented.

Aggression

Psychoanalytic Definition

Causation and character of aggressive behavior can have many forms. Freud postulated the presence of two drives or instincts present in all individuals. Eros is the instinct of life, and Thanatos is the instinct of death (Eron, Walder, & Lefkowitz, 1971). Aggression is considered to be the expression of Thanatos. Psychoanalytic theory assumes that every person is genetically endowed with a given quantum of energy that is directed toward destructiveness and must be expressed in one form or another. If it is blocked in its external manifestation, then it seeks to express itself indirectly. For example, if all external expression is blocked, aggression is turned back on the individual.

Melanie Klein is a follower of Freud's theory. Klein stated (Eron, Walder, & Lefkowitz, 1971):

Innate aggressiveness is bound to be increased by unfavorable external circumstances and, conversely, is mitigated by the love and understanding that the young child receives, and these factors continue to operate throughout development. But although the importance of external circumstances is by now increasingly recognized, the importance

of internal factors is still underrated. Destructive impulses, varying from individual to individual, are an integral part of mental life, even in favorable circumstances (p. 19).

According to psychoanalytic theory, aggressiveness is expressed in various ways in the child's play, either directly or indirectly (Klein, 1982). Often a toy is broken, water or paint is splashed about and the room generally becomes a battlefield. When the child is more aggressive, attacks may be made with knives or scissors on the table or on pieces of wood. It is essential to enable the child to bring out his or her aggressiveness. The therapist must try to understand why at the particular moment the destructive impulses come up and observe their consequences in the child's mind (Klein, 1982).

Feelings of guilt may follow after the child has broken an object in the playroom. The guilt refers not only to the actual damage done, but also to what the toy stands for in the child's unconscious (e.g., a brother, sister, parent). Often the child will put aside the toy he or she has broken, showing dislike of the damaged object, due to a fear that the attacked person (represented by the toy) has become retaliatory and dangerous. The sense of persecution may be so strong that it covers up feelings of guilt and depression that are aroused by the damage done. One day the child may search for the damaged toy and try to repair it. When this occurs there will be a noticeable change in the child's relation to the particular person the toy represents (Klein, 1982).

Children with aggressive behavior will often attack the therapist in various ways. For example, the child will spill water on the therapist, threaten to throw things at him or her, or physically attack the therapist (Levy, 1982). Psychoanalytic play therapists do not allow the child to inhibit their aggressive fantasies. They do not show disapproval or annoyance at the child's

aggressive desires but rather try to interpret the deeper motives and keep the situation under

control (Klein, 1982).

Cognitive-Behavior Definition

Cognitive-behaviorists do not believe that people are born with preformed repertoires of

aggressive behavior. Instead, they must learn to be aggressive via one of two major processes. In

the first process behavior is shaped into new patterns via its consequences. During trial and error

experimentation, unsuccessful responses are discarded and rewarded responses are progressively

strengthened. Learning appropriate behavior is a process of discerning different consequences

that accompany various actions. It is a less efficient process than having a good example to

follow, a second major learning process.

According to cognitive-behavior theory, aggression is seen as a behavior that results in

personal injury and/or in destruction of property (Bandura, 1973). The injury may be physical as

well as psychological. Children are often confronted with provocative situations that precipitate

some type of aggressive action. Aggressive actions tend to occur at certain times, in certain

settings, toward certain objects or individuals, and in response to certain forms of provocation.

Performance of injurious actions is extensively regulated by environmental cues (Bandura,

1973).

In determining the nature and extent of future aggressive behavior, it is important to look

at the learning conditions attendant upon the initial responses to frustration and the subsequent

reinforcement history of those responses. Reinforcing factors are accorded an important role in

the development of aggression. In trying to help children, psychologists also observe the

frequency of the child's aggressive behavior, its duration and intensity, and the behavior

sequence as a whole (e.g., the precipitating event, the consequent event). (Varma, 1996).

Psychologists must also help children learn cognitive strategies for controlling their anger. Various self-monitoring methods should be taught to the child, followed by progress monitoring to determine effectiveness.

Person-Centered Definition

According to person-centered theory, aggression is a heightened form of frustration. Children with aggressive behavior can be difficult to live with, making impossible demands on those who care for them. Children with aggressive behavior often have a history of physical violence. Often there is a link between harsh or inconsistent parenting and children with aggressive behavior (Landreth & Sweeney, 1997). They can be unhappy and confused yet unable to recognize their own need for help. They may have feelings of anxiety, temper tantrums, verbal outbursts, become withdrawn and distant, defiant, unresponsive, and have an inability to concentrate. Children with aggressive behavior have learned to see the world as hostile and they respond with hostile, aggressive behavior. The last thing they can recognize or respond to positively is someone offering help (Carroll, 1998).

Some children will exhibit feelings of rage and violence during play therapy. These feelings of the child pertain to other relationships, not the therapeutic relationship. At such time it may be difficult for the therapist to remain objective. It is easy to sympathize with a child who has encountered traumatic experiences but to engage therapeutically in anger with him or her is difficult. At some point in therapy, most children will show the extent of their unhappiness by acting out. Children with aggressive behavior tend to do this by ensuring that the therapist feels it. One action is to insist that the therapist is useless and that it is a waste of time coming to therapy. The therapist is to remain affective, not get his or her feelings hurt, and focus on helping

the child. Person-centered techniques that begin by accepting the child's hostility as a valid response to his or her circumstances may be more successful (Carroll, 1998).

Anger and aggression are understood, but violence is not tolerated. Destructive urges are acceptable but acting them out is not (Carroll, 1998). Once negative feelings have been expressed and accepted in the playroom, it is assumed the child can exhibit more positive behaviors (Landreth & Sweeney, 1997). The therapist allows the child to manage the unmanageable, to control in the fantasy of play what seems out of control in the real world. It is assumed that any aggression that is expressed in the playroom does not transfer to increased aggression outside of the playroom.

Psychoanalytic, cognitive-behavioral, and person-centered approaches look at aggression in different manners. However, all three techniques see aggression as a destructive action or behavior that can result in violence or destruction. Psychoanalytic therapy recognizes broken objects and attacks made on persons, with or without weapons, as aggressive acts (Klein, 1982; Levy, 1982). Cognitive-behavioral therapy sees aggression as a behavior that can result in personal injury and/or destruction of property that is regulated by environmental cues (Bandura, 1973). Person-centered therapy sees aggression as a heightened form of frustration which can either be physical, psychological, or both.

<center>Psychoanalytic Approaches to Play Therapy</center>

In this section the step-by-step process of psychoanalytic play therapy will be outlined, followed by primary purposes for using psychoanalytic play therapy. The roles of therapists and characteristics of children with aggressive behavior will be described. Qualifications deemed necessary for therapists to conduct psychoanalytic play therapy will also be reviewed. Lastly, a

research study conducted with children with aggressive behaviors who attended psychoanalytic play therapy sessions will be critiqued.

Psychoanalysis consists of a step-by-step process when working with child clients. Initial contacts are not made with the child. Rather the psychoanalyst gains insight into the existing and prospective problems of the child through investigation of the child's past and current circumstances, along with interviews and file reviews of information gathered by various professionals (Lee, 1997; Pearson, 1968). The therapist studies the child's past, including family, school, medical conditions, and any other factors that would help the therapist understand the child and the problem. At this time, the psychoanalyst also contacts the parents to see what proposed problems they want therapy to include. The support of parents is necessary for treatment to occur. They must agree to the treatment administered and be supportive in the process for both their child and the professionals working with their child. This allows the therapy process to go smoothly.

The next step consists of the initial interviews, conducted separately with the child and the parents. There are various reasons for this (Pearson, 1968). First, the child may personalize the parents' statements. This could result in an increase in the child's insecurities and fear of the therapist. Second, the child's presence could hinder the free expression of the parents' account. Finally, the emotional reactions of the parents to their discussion with the therapist could increase the child's bewilderment and guilt. It is important in the preliminary data gathering that both parents are interviewed separately and also together. The therapist must be alert to evaluate the true significance of what the parents say about their child's behavior. Numerous subsequent interviews will need to be conducted throughout the child's therapy.

After preliminary data is gathered, a history of the child's life will be available for study, arranged around important developmental patterns and relationships (Lee, 1997). The therapist must determine which data are most needed in order for an evaluation and diagnosis of the specific problem to occur (Pearson, 1968).

After parent interviews and data collection, the therapist conducts an interview or play therapy session with the child. It is valuable for the therapist to work with the parents and their understanding of what might occur when the child is approached, what those reactions will indicate, and how the parents can best elicit the child's interest and willing cooperation (Pearson, 1968). The purpose of the child interview or play therapy session is for the therapist to gather data on the child's problems and struggles to decide what treatment is advisable. The contacts with the child give an opportunity to supplement and better understand the history the parents gave about the child. Data may be gathered over a span of child interviews. Play therapy is advisable since it is a child's natural mode of communication and will give the therapist more information than asking a young child questions.

The next step for the psychoanalyst is to determine recommendations for treatment and to ensure their implementation. At this point, both parents should be seen and talked with together (Pearson, 1968). More than one method of therapy should be mentioned along with the advantages and disadvantages of each. The therapist should indicate his or her preferred method to the parents and describe why. Once the interventions are determined, they must be carried out. The therapist is responsible for ensuring that the necessary services are provided.

Follow-up interviews are the final step in psychoanalysis. Once treatment has been decided, the therapist and parents must formulate a schedule of regular, frequent interviews. The purpose will be for the parents to give information on how things are going for the child at home,

the child's relationship with the parents and other significant persons, the child's emotional variations in different settings, and the expressions of thoughts and attitudes of the child (Pearson, 1968).

Psychoanalytic play therapy is a means of establishing contact with the child. It is a medium of observation, a source of data and, at times, a device that promotes interpretive communication (Esman, 1983). On the other hand, play therapy is not used as a medium of educating the child. Rather, its function is to help the child resolve conflicts that may interfere with the child's ability to use the regular educational resources to maximal capacity (Esman, 1983; O'Connor, 1991). The play therapist plays an important role in helping the child overcome any obstacles.

The therapist's ultimate therapeutic tool is interpretation (Esman, 1983; Lee, 1997; O'Connor, 1991) of the unconscious dynamics represented in children's play activity and verbal comments (Newcomer, 1993). The therapist's goal of interpretation is to release unconscious thoughts and feelings and make them part of the child's consciousness so that they might eventually be altered. The therapist is there to represent significant individuals in the child's life. The therapist must use skill, tact, and empathic sensitivity to best express thoughts so the child will accept and make use of them (Lee, 1997). Such communication may be relatively simple. Therefore, tact, skill, and recognition of the child's cognitive capacities will dictate which level of communication the therapist will choose and the degree to which he or she frames the communication within the play metaphor or in direct language.

The best way to facilitate the child's engagement in the treatment process is by meeting him or her at the level at which the child can best communicate. For the young child, this level is that of play. Toys should be readily available; however, the therapist should guard against

suggesting their use. Rather, the therapist's position should be indirect and permissive, bearing in mind that the ultimate aim of the treatment is to help the child verbalize conflicts and make use of the therapist's interpretive (Esman, 1983). Sigmund Freud suggested that "children repeat in their play everything that has made a great impression on them in actual life, that they thereby abreact the strength of the impression and so to speak make themselves masters of the situation" (Knell, 1995, p. 9). The therapist must work on these impressions the child has built and help the child overcome them.

The therapist must enter into the child's fantasy life. The therapist must encourage the child to give pleasurable elaboration of the fantasy-dramatization-free play by going along with the child's make believe (Lee, 1997). The therapist must interpret within the medium of the play. However, the therapist must not interpret directly from the material to the reality situation. This may disrupt the play before it is fully elaborated, thus limiting what can be understood from the play (Solnit, 1987).

Psychotherapeutic communication with the child must be attuned to his or her level of affective and cognitive development. Materials and toys must be appropriate for various age levels. The materials must also be consistent with the therapist's own sense of comfort and the realities of the available space. Recommended play materials include paper for drawing and cutting; crayons and markers; Play-Doh for modeling; blocks of various sizes for building; small, flexible family dolls and a few pieces of furniture; hand puppets for dramatic play; a toy nursing bottle and a doll that can be dressed and undressed; a few cars and trucks; toy guns; and a soft rubber or plastic ball (Esman, 1983). Toy soldiers and Indians, cars, trucks, tanks, and airplanes are useful in eliciting the child's phallic and aggressive struggles. Rubber animals, baby dolls, police, doctor, and nurse dolls serve a purpose in the aggressive fantasies of children (Pearson,

1968). Complex board games and construction toys should be avoided since they tend to facilitate resistance rather than communication. Materials should encourage rather than restrict free play of the child's imagination, and should promote rather than retard the verbalization of fantasy, the expression of affect, and the revelation of characteristic defense mechanisms (Esman, 1983).

Psychoanalytic play therapy usually depends upon the child expressing various configurations of impulse and defense through combinations of verbalization and play, while allowing the therapist to make observations, inquiries, or interpretations (Lee, 1997). The child responds to the therapist's interventions either by producing further significant material or by becoming more defensive and defiant. The therapist may then comment on the child's response, and so the therapeutic dialogue proceeds. Unfortunately, children with aggressive behavior have little capacity for expressive or reflective verbalization, or for dramatic, imaginative play (Willock, 1983). In addition, they tend to feel intensely threatened by the slightest inquiry or observation on the part of the therapist. Therefore, they present several obstacles to the viability of play therapy as a means of helping them.

According to Kleinian theory, the child's play is considered equivalent to the adult's free associations and equally available for interpretation and symptom formation (Esman, 1983; Lee, 1997). Freud, on the other hand, linked play to the creative function. In play the child is the creator of his or her world, enacting indirectly the pleasures and conflicts of his or her unconscious life (Lee, 1997). The child expresses a wish, for example to be big and grown up, and in games the child imitates what he or she knows of the lives of surrounding adults. Play is seen as an ego-mediated mode of behavior. It serves a variety of psychological purposes and yields a substantial body of data. It requires supplementation from a variety of additional

sources, including the parents (Esman, 1983; Lee, 1997). Therefore, play is only one source from which the therapist derives insights to help the child decrease aggressive acts.

Child's play serves three primary purposes in psychoanalytic play therapy (O'Connor, 1991). First, it allows the therapist to establish contact with the child and gain a working relationship with the child. This relationship is extremely important in the child's success in therapy because it is assumed that the child must have an alternate relationship to carry them through the painful periods of the analysis. Second, play allows the therapist to observe the child and gather information. Based on the observations and information gathered, hypotheses regarding the child's intrapsychic functioning will be made. Lastly, play is a medium for communication between the child and the therapist. Not only can the child present to the therapist information that he or she might otherwise be unable to convey, but the therapist may use the play and descriptions of the play to present information to the child. "Interpreting within" the play is an example. The analyst delivers an interpretation framed to apply to the characters or objects in the child's play rather than directly to the child, This facilitates the child's tolerance of complex interpretations from both a cognitive and an emotional standpoint.

Ostow (1987) believes that play "provides a mechanism for disengaging from frustration and disappointment in the real world by providing illusory gratification, thereby reducing tension and stress" (p. 200) It provides relief from intrapsychic conflict by offering pleasurable alternatives. Play also allows for the exposure to realistic or unrealistic challenges, the overcoming of which relaxes tension and replaces it with pleasure (Ostow, 1987). When the pain becomes too great, the play can be terminated.

Children with aggressive behavior have enormous difficulty in maintaining any kind of safe area in which they can talk or play out their concerns (Willock, 1983). These children flee

from the anxiety-arousing material and throw themselves into acting out. This enables the child

to feel in control of the therapist. By creating total chaos and struggle, the child makes it difficult

for the therapist to address any of the truly salient issues in a therapeutic manner.

When the therapist thinks he or she has made some amount of progress with the child, the

therapist may begin making interpretations on why this behavior is occurring and begin talking

them over with the child. However, while making such comments, the therapist must be attuned

to how the child is reacting, being careful not to flood them with interpretation and being ready

to step back if the child becomes too anxious (Willock, 1983). If the therapist does not proceed

with caution, the child may learn new defenses and ways of acting out their inappropriate

behaviors. Since these children have problems in symbolically communicating their concerns,

they usually abandon the attempt to do so. They feel safer in more structured activities, which are

less likely to activate such intense drives and anxieties.

At first, children with aggressive behavior may appear to be running away from the

therapist or defying him or her, while in actuality they may be trying to hold onto the therapist's

attention in a controlling manner. If the therapist does not play this unacknowledged game of

chase me, the child will escalate the implicit demand to be pursued and add increasingly

provocative, destructive elements to the game. The child obtains the therapist's attention by

using new, destructive methods. In turn, the therapist learns that if he does not play the proper

part in the game by pursuing the child, he or she may be faced with some very undesirable

consequences (Willock, 1983).

Much of the action that dominates play therapy with children with aggressive behavior

can be understood as a manifestation of arrested and distorted development in the sphere of

object relationships and in the development of interactive play (Willock, 1983). During therapy,

the therapist often sees aggressive manifestations of blocked play development. If treatment

continues long enough, the therapist can observe these issues being worked through such that

healthier versions of early developmental play emerge and eventually begin to progress along a

more normal developmental track. Children will begin to learn and demonstrate more

appropriate and socially acceptable behaviors. Understanding some of the antisocial behaviors

of these children and their relative inability to play in terms of blocked play development can

open up avenues of interpretation for therapists whose interventions might otherwise be

restricted to behavior management.

Psychoanalytic Clients

Play therapy can be used as an intervention for children as young as two-years-old. It

usually is not started earlier since children's language and gross motor skills are not fully

developed. Most 2 to 3-year-old children are brought to play therapists for two primary reasons.

First, their attachments and trust in adults have been interfered with. Second, due to the

separation-individuation process, problems are produced for both the child and parents to where

living together is intolerable (Berlin, 1987). Preadolescents and young adolescents can also

benefit from play therapy. Many come to therapy because of concerns such as aggressiveness,

competitiveness, loneliness, lack of friends, depression, or obsessive compulsive disorder.

Therapist Qualifications

Several qualifications are necessary for the practice of psychoanalytic play therapy. The

therapist must have a thorough grounding in child development and experience in observation of

normal and deviant children in varying situations. They must be familiar with the psychoanalytic

theory of personality development, structure, and function. The therapist must also have had

extensive supervised experience in the treatment of children in a clinical setting. Such training

must be on a graduate level, presuming adequate basic training and practical experience in the

basic clinical discipline (Esman, 1983).

In addition to training skills, the therapist must possess certain personality characteristics.

He or she must be mature and poised to be able to empathize without overidentifying, to permit a

measure of controlled regression without losing the capacity to observe and interpret, and to

endure intense affective pressures without loss of control (Esman, 1983). The therapist must be

able to deal with provocation without being provoked, with seduction without being seduced. He

or she must be sufficiently comfortable with the resolution of their own childhood conflicts to

tolerate the reawakening in the treatment situation and the reenactment in the child's play

(Esman, 1983). Above all, the play therapist must possess a genuine interest in children, sensitive

curiosity about what makes them tick, and a willingness to subordinate doctrinaire judgments to

actual clinical observation. Finally, they must be willing and able to be completely honest with

both patients and self (Esman, 1983).

Research

There are only a few studies conducted on psychoanalytic play therapy. Most research

was conducted in the 1940s and 1950s. From 1960 to 1990 there was very little research on play

therapy. Studies of psychoanalytic play therapy with aggressive children are even more limited.

Only one study was conducted of the outcomes of psychoanalytic play therapy with

children who display aggressive behaviors (Abramson, Hoffman, & Johns, 1979). Abramson et.

al. (1979) analyzed the treatment of severely disturbed, impulsive children in a short-term

inpatient psychiatric unit. A play group for early latency children was used as an intervention

twice weekly for forty-five minutes. Early latency children use numerous defenses and

resistances to prevent the surfacing of threatening unconscious material (Harter, 1983). They

have a tendency to externalize conflict. The play therapists did not initiate play with the children but engaged when approached. The play therapists attempted to help the children master their unpleasant feelings, overcome resistance to further play, reinforce positive behaviors, and deal with some of their inner conflicts and aggression (Abramson, Hoffman, & Johns, 1979). Therapists had to be careful not to over interpret play because direct interpretation of an impulse could lead to anxiety and regression, along with play disruption. The authors of the study were also the judges of the effectiveness of the therapy. They concluded that the play group was therapeutically effective because the stable leadership provided an appropriate atmosphere. No other evidence of the effectiveness of the therapeutic approach was affirmed..

Ideally, play therapists support and help channel the aggressive fantasies and impulses into play. However, if the play becomes destructive or harmful, and discussion does not stop the behavior, the therapists must set firm limits and enforce them. In setting limits for aggressive behavior within the play group, Abramson, Hoffman, and Johns (1979) concluded it was useful for the therapists to: (1) encourage the other group members to identify the individual's problem; (2) discuss and interpret the situation to the group; (3) set verbal limits to stop the disruptive behavior; (4) ask the disruptive child to take time out of the playroom in order for him or her to gain control; and (5) remove the child from the playroom until he or she has gained control.

In summary, no experimental analyses of psychoanalytic play therapy with children with aggressive behaviors have been published. One descriptive study based on researchers' personal evaluations concluded that play group sessions were therapeutically effective for severely disturbed, impulsive children. This conclusion was based on the researchers' personal evaluation of atmosphere and contained no other evidence to demonstrate improved outcomes for children (e.g., decreased intensity, frequency, and duration of aggression). Willock (1983) suggested that

children with aggressive behavior present numerous obstacles to the viability of play therapy including little capacity for imaginative play and defensiveness at the slightest therapist inquiry. If Willock is correct, effective therapy would require great skill and much time. Researchers would need to focus on integrity of treatment, both process and outcome.

<div align="center">Cognitive-Behavioral Approaches to Play Therapy</div>

Cognitive-behavior theory offers a method for children to learn to change their own behavior and to become active participants in treatment. The significance of a child's involvement in their treatment may be understood from various perspectives. First, developmentally, children need to demonstrate a sense of mastery and control over their environment. This mastery will be seen as children exhibit increasing levels of management of their own behavior. Second, teaching the child self-control might be more efficient and more durable than parent-administered programs. It also might permit significant adults to engage in more positive activities with the child. Lastly, in parent-implemented programs where the child is not involved directly in treatment, the adult might become a discriminative cue for the child to emit or suppress an inappropriate behavior. Children may only behave in certain ways when these cues are present (Knell, 1994).

Cognitive-behavioral play therapy incorporates cognitive and behavioral interventions within a play therapy paradigm. Play activities, as well as verbal and nonverbal forms of communication, are used in resolving children's problems. Behavioral interventions may prepare the child to benefit from treatment by possibly influencing the child directly. For example, a behavioral intervention such as modeling may provide the child access to information that might not otherwise be available if the therapist needed to solely rely on verbal communication (Knell, 1995). Therefore, modeling may facilitate the child's access to treatment. On the other hand,

cognitive interventions may provide a framework for the child's involvement in treatment by addressing issues of control, mastery, and responsibility for one's own behavior change. By incorporating the cognitive interventions, the child may become an active participant in change. For example, a child who is helped to identify and modify irrational beliefs may experience a sense of personal understanding and empowerment (Knell, 1995).

Cognitive-behavioral strategies increase in value as children mature and are able to use reason to help them solve problems and function more effectively in their environments (Newcomer, 1993). Cognitive-behavioral techniques are applicable with groups of children, as well as with individual children. When groups are established, little concern is directed toward criteria for selecting participants. Children are admitted into the group, observed in the actual setting over time, and excluded if their participation is not beneficial to themselves and/or to others.

In cognitive-behavioral play therapy, play is the activity used to introduce well-established therapeutic procedures, such as reinforcement schedules, modeling, problem-solving exercises, and so forth (Newcomer, 1993). The therapist does not try to interpret the meaning of children's activities, to reflect their feelings, or to evaluate the extent to which they have been nurtured, challenged, or intruded upon. They do not attempt to analyze the motivation that underlies the activities. However, the therapist does provide structure, set limits, and assume a highly directive role in the therapeutic process (Newcomer, 1993).

There are six main components that underlie cognitive behavioral play therapy (CBPT). CBPT components consist of the following (a) involves the child in treatment via play; (b) focuses on the child's thoughts, feelings, fantasies, and environment; (c) provides a strategy or strategies for developing more adaptive thoughts and behaviors; (d) is structured, directive, and

goal-oriented, rather than open-ended; (e) incorporates empirically demonstrated techniques; and

(f) allows for an empirical examination of treatment (Knell, 1995). All of these components are

brought together to ensure a safe and comfortable therapeutic environment for children.

The major contributions of cognitive-behavioral play therapy are threefold. First,

cognitive and behavioral interventions are incorporated into a play therapy paradigm in a

systematic and goal-oriented manner. Second, cognitive-behavioral play therapy takes into

account developmental, and in particular cognitive-developmental, factors in assessment and

treatment planning. Lastly, cognitive-behavioral play therapy is empirically based, both in its use

of experimentally tested approaches and in its support of an empirical evaluation of treatment

effectiveness.

Although cognitive-behavioral play therapy is unique, it is similar to other play therapies

in its reliance on a positive therapeutic relationship, based on rapport and trust; the use of play

activities as a means of communicating between therapist and child; and the message that

therapy is a safe place (Knell, 1997). On the other hand, cognitive-behavioral play therapy

differs from other play therapies regarding philosophy about the establishment of goals, selection

of play materials and activities, use of therapy to educate, and the use of praise and

interpretations. Cognitive-behavioral play therapy is an active intervention in which the therapist

and child work together in establishing goals and choosing play materials and activities. In

contrast to other play therapies, the cognitive-behavioral play therapist may be a partial educator

to the child in that he or she teaches new skills to the child. Finally, the cognitive-behavioral play

therapist uses praise and interpretations to help the child acquire new skills and behaviors, along

with gaining an understanding (Knell, 1993).

Some behavioral techniques underlying classical conditioning, operant conditioning, and social learning that can be implemented in cognitive-behavioral play therapy include: systematic desensitization; contingency management including positive reinforcement, shaping, stimulus fading, extinction, and time-out; and self-monitoring. There are also a variety of cognitive techniques that can be used in cognitive-behavioral play therapy sessions, including: recording dysfunctional thoughts; cognitive change strategies; coping self-statements; bibliotherapy; and problem-solving (Knell, 1994). Children should be viewed on the basis of what they can do rather than what they cannot do. Therefore, any beliefs that young children lack the cognitive skills needed to engage in cognitive interventions should be eliminated. However, the play therapist must make sure that there is a match between the developmental level of the child and the level of the complexity of the intervention chosen.

Behavioral Techniques

Behavioral techniques are an integral part of cognitive-behavioral play therapy. Depending on the child and his or her situation, various techniques can be applied to help the child overcome the dominant problems. Described below are the most commonly used behavioral techniques. Each behavioral technique has its own body of research support, however none are cited in this paper due to the uncertainties of behavioral techniques specifically applied to children with aggressive behaviors.

Systematic Desensitization. In systematic desensitization, replacing a maladaptive response with an adaptive one can reduce a child's anxiety or fear (Knell, 1995). The goal is to break the association between a particular stimulus and the anxiety or fear response that it usually elicits. Play therapy provides an ideal condition for breaking the association between a stimulus and its maladaptive response. The child brings difficult events into play. The play

changes as the child acts and reenacts the situation. As the child plays out a situation in order to

gain mastery over it, the play may resemble a desensitization paradigm.

Positive Reinforcement. Positive reinforcement is present if its immediate and consistent

application over time increases the frequency and/or duration of a desired response (Varley,

1984). Both material reinforcers (e.g., tokens, points, money) and social reinforcers (e.g., praise,

attention, affection, recognition, approval) have been found to be effective ways of accelerating

nonaggressive behaviors. Combining material and social rewards increases the reinforcing

properties of social events. Many children with aggressive behavior can be courteous and polite,

willing to verbalize their needs, and able to delay gratification in certain situations. However,

they rarely exhibit such positive social behaviors with parents, peers, teachers, or counselors.

Since these children have appropriate social behavior in one setting, it is probable that contingent

positive reinforcement can spread these appropriate social actions to other situations.

The play therapist's praise or other reinforcement of the child communicates to the child

which of his or her behaviors are appropriate. The therapist conveys a message to the child and

consequently may influence the child's behavior. By encouraging the child to explore certain

topics rather than others, the therapist may be reinforcing a particular direction for therapy

(Knell, 1995). If there is a particular problem that is the focus of treatment, then the therapist

may use praise as the child exhibits mastery over the problem. However, merely reinforcing a

child for exhibiting specific behaviors does not necessarily deal comprehensively with the

behavior. In order to use positive reinforcement, the behavior that the therapist wishes to

encourage must already occur.

A study conducted by Walters and Brown (1963) demonstrated that it is possible to shape

aggressive responses by training boys to strike a Bobo doll. Two of the groups were reinforced

with marbles, one a continuous reinforcement schedule and one on a fixed ratio schedule. A third

group received no reinforcement. Half of each group showed feelings of frustration after

training. During the experimental period, each child was paired with another child who had not

been trained to hit the doll. Pairs competed in physical contact games and aggressive responses

were recorded. There were no differences in rates of aggression between the frustrated and

nonfrustrated subjects. Subjects trained on the fixed ratio schedule exhibited significantly more

aggression than the other groups.

Shaping. Shaping is a process where desired complex behaviors are broken down into

smaller component parts (Knell, 1994). The child is reinforced for emitting each component and

linking them together in an integrated, complex response pattern. Under the supervision of the

therapist, verbal instruction, demonstrations, and rehearsals teach desired behaviors. In the

situation where the behaviors are desired, the therapist prompts the new behavior by a mutually

understood signal and reinforces it as soon as it happens. As the child acquires the component

behaviors, he or she is gradually required to link more of the behaviors together in the direction

of the final goal to attain the same reinforcement. More behavior requirements are faded in while

the frequency of reinforcement is faded out.

Stimulus fading. Stimulus fading is a technique where the discriminative stimulus

(usually the therapist) is gradually faded (Knell, 1995). Sometimes children exhibit specific

behaviors with certain people or in certain situations. The therapist may be required to follow the

child to the situation or person to observe the behaviors and spend time with the child during that

circumstance. The presence of the therapist may aid the child in using positive behaviors learned

in therapy.

Extinction. Extinction is the gradual reduction of a conditioned response that occurs due to lack of reinforcement (Darley, Glucksberg, & Kinchla, 1991). Consequences do not follow the behavior, and as a result, there is a gradual decline in the frequency and intensity of the aggressive behavior. Since extinction does not teach new behaviors it is best used in conjunction with positive reinforcement procedures that strengthen the desired behavior (Knell, 1995). Extinction has limited usefulness with children with aggressive behavior because of the inflammatory quality of the aggression chain, and the dangers of ignoring early reaction signs. It is most useful with children with aggressive behavior in secure residential settings when a specific reinforcer can be identified that maintains the aggressive acts. Since children with aggressive behavior use avoidance tactics, intervention can be focused on the avoidance process.

Aggression is frequently reinforced by social events. Extinction can be helpful by reinforcing staff and peers for ignoring outbursts. Extinction is a very useful strategy for dealing with temper tantrums and aggressive demands or threats since the child is not given something he wants after an inappropriate tantrum.

Time-Out. Time-out is one of the most widely used mild punishment procedures for children with aggressive behavior. Time-out involves the immediate removal of the individual for a brief time from a situation to bring about complete termination of positive reinforcement. The child must be removed from whatever is reinforcing the behavior in the immediate environment to a less desirable environment (Knell, 1995).

Time-out is normally applied before minor aggressive incidents (intense arguing or threats) escalate into major events (fist fighting). It usually occurs in a small, secure room devoid of stimulation and activities. The child is not attended to by staff and peers, and is not allowed access to books, magazines, food, toys, and the like. Release from time-out occurs when the

child has remained quiet and controlled for a predetermined time period. There are usually no other penalties, but is used quickly every time the behavior of concern occurs. Therefore time-out is based on the conception that aggression is a chain of interrelated responses, ranging in severity from back talk to assault, that are maintained by social and concrete reinforcers. When intervention occurs early in the chain, the aggressive spiral is interrupted and external reinforcement is depreciated (Knell, 1995). It is important to note that time-out is best used in conjunction with positive reinforcement and skill remediation programs that encourage the development of nonaggressive ways of meeting needs. However, time-out should be used sparingly since it is depriving the child time with their therapist.

  <u>Self-monitoring.</u> Self-monitoring is a child's observations and recording of information about certain aspects of their behavior. Self-monitoring can serve several purposes. It may be the only means of obtaining information from the natural environment, along with subjective reactions to events. It can also serve as a baseline for later comparisons, and it is useful throughout therapy. Hypotheses can be tested using self-monitoring, which may be more accurate than recalled data. Finally, it serves as a point for discussion in therapy by providing structured information about the child's experiences (Knell, 1995).

<u>Cognitive Techniques</u>

  Cognitive techniques are an integral part of cognitive-behavioral play therapy. Depending on the child and his or her situation, various techniques can be applied to help the child overcome the dominant problems. Listed below are the most commonly used cognitive techniques. Each cognitive technique has its own body of research support, however none are cited in this paper due to the uncertainties of cognitive techniques specifically applied to children with aggressive behaviors.

Recording dysfunctional thoughts. Children are often asked to self-monitor their thoughts by using such methods as writing in a log book or talking into a tape recorder. Most often self-monitoring is done through a Daily Record of Dysfunctional Thought. On this thought sheet, the child monitors stimuli, emotional responses, and cognitions. The use of this thought sheet is very limited for children. This type of recording is conceptually complex and requires a level of writing not evident until later childhood. However, parents may be helpful in reminding their child to record simple thoughts of prearranged times or after particular incidents. For preschoolers, this recording is more often a monitoring that is done by parents of the child rather than by the children themselves. Therefore, such monitoring is a recording of dysfunctional statements made by the child rather than dysfunctional thoughts (Knell, 1995).

Cognitive change strategies. Helping children with changing cognitions dictates that the child will need assistance from adults in generating alternative explanations, testing them, and altering them. To challenge one's beliefs, it is necessary to distance oneself from the beliefs. Play allows the child to reenact problem situations and gain mastery over events and circumstances. The play therapist can assist in this mastery by providing the experiments in the play situations, and by assisting the child in looking at the evidence, exploring the alternatives, and examining the consequences (Knell, 1995). The therapist may structure some of the play with the child to reflect alternative scenarios so that the child will experience different reactions and consequences for the same situation.

Coping self-statements. The way a child interprets events, not the events per se, affects the child's ability to cope. When one believes negative self-thoughts, maladaptive reactions may follow. These negative experiences may prompt continued negative self-statements, which may lead to poor decision-making. Depending on the age of the child, different types of coping self-

statements may be used. With older children and adolescents, Meichenbaum's stress inoculation training can be used. This technique helps the child develop positive coping statements such as "I can meet this challenge" or "I handled it pretty well" (Knell, 1995). Children in the preoperational stage of cognitive development may benefit most from learning simple statements about themselves, often in the form of self-affirmation. For example, statements such as "I can sit," or "Good sitting" contain a component of self-reward and are verbally simple.

Parents can model positive self-statements. Young children love hearing praise for accomplishments. Praise such as "Good boy," "Good girl, you picked up the toys," or applauding are often effective (Knell, 1995). It is vital for parents to understand that children will not internalize positive feelings unless taught the value of their actions. Specific labeling with positive feedback for their behavior is often effective.

Bibliotherapy. Bibliotherapy is being used increasingly as an adjunct to therapy even though it is not a technical cognitive intervention (Knell, 1995). Children's books use a storytelling approach to teach certain concepts and how to use these in one's life. Children's literature often teaches morals. More recently there has been a proliferation of stories about children with specific problems or those dealing with traumatic events (divorce, death, moving). In these stories a message is conveyed indirectly, with the hope that the reader will learn something through the characters in the book. The story models ways of coping with life events.

Problem-solving. Cognitive-behavioral methods can be incorporated into a problem-solving approach. To include cognitive techniques, the therapist must teach the child problem-solving strategies that focus on self-improvement and self-monitoring. The child must be taught self-reinforcement, self-instruction, self-evaluation, and self-control. This allows the child personal control of the success of their therapy. The therapist must also incorporate behavioral

techniques. These can include reinforcement and punishment. For example, the therapist gives the child a sticker every time positive behaviors are displayed. By utilizing both techniques, the child gains some self-control but is still guided by the therapist.

<u>Research</u>

Cognitive-behavioral play therapy has yet to be subjected to systematic empirical study (Knell, 1994). Methods of study might account for a positive outcome. Play therapy is a particularly difficult process to subject to empirical study. Systematic research must occur, particularly with regard to process and outcome issues. The integration of cognitive-behavioral techniques into play interventions offers a promising direction due to the specificity of treatment goals.

<div align="center">Person-Centered Approaches to Play Therapy</div>

Carl Rogers is the originator of person-centered theory. Therapy is based upon the central hypothesis of the child's capacity for growth and self-direction (Dorfman, 1951). The therapist attempts to test the validity of the hypothesis under varying conditions. The theory is based on the belief that each child lives in a continually changing world of experience of which he or she is the center. This private world is called the experiential field (Perry, 1993). This field includes all that the child experiences, whether or not the child actually perceives the experience. The child reacts to the experiential field as it is perceived. This perceptual field is considered reality to the child. The child will respond to the experiential field as an organized whole. Characteristics of the child's behavior will tend toward total, organized, goal-directed responses. When an avenue of meeting the child's perceived need is blocked, the child will develop another avenue. A change in any part of their life can produce a change in another part.

The child has one basic need. That is to actualize, maintain, and enhance his- or herself (Perry, 1993). The transition toward self-actualization includes a move in the direction of greater independence, autonomy, self-regulation, self-government, self-responsibility, and socialization. This move will not be easy since the child must endure the struggle and pain they encounter through their growth and enhancement.

The child's behavior is a goal-directed attempt to satisfy his or her needs as experienced in the field he or she perceives. Emotions accompany and often facilitate the child's goal-directed behavior. The therapist is best able to understand the child's behavior based on the internal frame of reference of the child. With the help of the therapist, gradually a part of the perceptual field will become part of the child's self. The therapist uses the self in a restricted sense of awareness of being for the child. As a result, the child will be able to differentiate between me, I, and myself from their environment (Perry, 1993).

The therapist attempts to provide a relationship of warmth and understanding where the child feels safe enough to relax his defenses long enough to see how it feels to operate without them (Moustakas, 1955). However, the therapist does not provide leadership to the child. The therapist accepts the child exactly as he or she is at the moment and does not try to mold him or her into some socially approved form (Dorfman, 1951; Moustakas, 1955). In order for therapy to be successful, the therapist must perceive the world as the child sees it; perceive the child as him- or herself as seen by themselves; to lay aside all perceptions from the external frame of reference while doing so; and to communicate something of this empathic understanding to the child (Rogers, 1951).

Person-centered play therapy places an emphasis on the therapeutic relationship. The basis of this therapy is the notion that individuals are basically motivated to reach their highest

potential. In the person-centered approach, personality change is considered to begin within the individual, and thus the desire for change comes from the child rather than the therapist. The therapist merely creates conditions that are favorable to change.

Axline (1947) developed a play therapy approach based on the theories of Rogers. Axline (1947) developed eight principles for person-centered play therapists that are crucial to follow. They are: (a) develop a warm, friendly relationship with the client, in which rapport is established quickly; (b) accept the child as he or she is; (c) establish a feeling of permissiveness for the child to freely express feelings; (d) recognize the child's feelings and reflect those feelings back to the child so they gain insight; (e) maintain respect for the child's ability to solve problems; (f) do not direct the child in any way; (g) do not hurry the therapeutic process; and (h) establish only necessary limitations so the child is aware of his or her responsibility in the relationship (Axline, 1947).

From a person-centered point of view, play is a way that children learn what no one can teach them. In play, children are dealing in a sensory-motor way with concrete objects, which are symbols for something else the child has experienced directly or indirectly. Play is the child's inner world because it is their symbolic language of self-expression. It provides a means through which conflicts can be resolved and feelings can be communicated. Play is to the child what verbalization is to adults. Therefore, play therapy is defined as an interpersonal relationship between a child and a therapist, trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child to fully express and explore self (feelings, thoughts, experiences, and behaviors) through play (Landreth, 1991).

In play therapy, children are given an opportunity to learn about themselves in relation to the therapist. The therapist will behave in ways that he or she intends will convey to the child the

security and opportunity to explore not only the room and toys but also the experience and relationship. Play therapy is an experience in self-exploration, self-in-relation-to-others, self-expansion, and self-expression (Axline, 1982). It is an experience of social and emotional learning for the child. Therefore, the child's learning is both acting and reacting. By allowing children to manipulate their world without the threat of severe loss or punishment, play therapists can help them work out their emotional problems and learn about the world around them. Social play gives the child the opportunity to develop ideas of their own identity, interact with others, and learn various social roles along with the importance of rule-bound behavior.

Play is a medium for expressing feelings, exploring relationships, describing experiences, disclosing wishes, and achieving self-fulfillment. It is the natural and comfortable medium of expression for children because they seldom discuss their feelings; they demonstrate or show their feelings by acting them out. Ginott stated, "the child's play is his talk and the toys are his words" (Landreth, 1983, p. 201). Since play is something children have always known, they are more likely to express themselves honestly while in that medium. Until children reach a level of facility and sophistication with verbal communication that allows them to express themselves fully and effectively to others, the use of play is necessary if significant communication is to take place between the child and therapist.

Person-centered play therapy assists in the development of children by helping them learn to know and accept themselves. It also assists in accomplishing the broader school objective of learning about the world by helping children get ready to profit from the learning experiences provided by teachers (Landreth, 1991). The potential learning experiences available are directly related to the degree of climate of safety within which the children feel fully accepted and safe enough to risk being and expressing their emotional beings.

Children learn to be more open in expressing their feelings. Once their feelings have been openly expressed and accepted they lose their intensity and can more easily be controlled. Over time, as children learn to responsibly control their feelings, they are no longer controlled by those feelings (Landreth, 1991). The therapist believes in children's ability to be resourceful and so resists doing anything that would deprive children of the opportunity to discover their own strength.

As the therapist allows the child to struggle to do things for him- or herself, the child learns to assume responsibility for self and discover what it feels like to have responsibility. When children are allowed to figure out things, to derive solutions to problems, and to complete tasks, their creative resources are developed and released (Landreth, 1993). Then children will tackle their own problems and experience the satisfaction of doing things all by themselves. Through this process, the child learns to be creative and resourceful in confronting problems that were formerly overwhelming.

Unlike most other adults in the child's life, the play therapist does not make choices or decisions for the child or try to control him or her by either direct or subtle means. Any limits on children's behavior in the playroom are verbalized in such a way that children are allowed to control their own behavior (Moustakas, 1955). Since control is not externally applied, children learn self-control and self-direction and subsequently they are allowed to make their own decisions. Also, the therapist avoids making even simple choices for the child, knowing that children learn to make choices and to be responsible for their choices by being allowed to experience the process of making choices (Landreth, 1991).

As children experience being accepted just as they are with no conditional expectations from the therapist, they gradually begin to accept themselves as being worthwhile (Landreth,

1993). Acceptance is first felt by children and then becomes known to them. As they experience being accepted for who they are, children gradually learn, at a feeling level, to accept themselves. This increased level of self-acceptance is a major contributor to the development of a positive self-concept and self-efficacy.

<u>Stages of Person-Centered Play Therapy</u>

Guerney (1983) outlined play therapy in the form of sessions. The first session must be conducted carefully since the perceptions and impressions formed will have considerable effect on the course of the therapeutic events. It is critical that the therapist conveys to the child an atmosphere that will be warm, friendly, supportive, and accepting. The therapist must be empathetic, and show a comfortable physical proximity through words, smiles, tone of voice, and relaxed body posture. Simple, short explanations of what the play sessions are all about is required. The majority of the structuring takes place in the first session. It is imperative that the therapist notifies the child that they are allowed to "do almost anything." This phrase is necessary because it prepares the child for limits that might need to be set later (Guerney, 1983).

It is also important for the therapist to notify the child of their stance during the playtime. The therapist should tell the child that he or she will play with the child if the child desires. Without being impatient, the therapist must provide enough structure to help the hesitant or confused child to make use of his or her time (Guerney, 1983). If necessary, the therapist can sit down and mold some clay or arrange toy animals while offering warm smiles to the child until the child feels free to join in or start his or her own activities. Overall, the therapist's job will be to understand the child and his or her problems.

In early sessions, the child will explore the realities of the playtime, the therapist as a person, and him- or herself in relation to this different social environment (Guerney, 1983). At

this time limits are tested and aggressive behaviors may emerge. The therapist should not infer

that hesitations mean that the child needs adult direction to play, but rather that the child is

lacking the resources to initiate play alone. The child must learn that the adult will not judge or

criticize in order for them to become free to use their own latent resources. During this early

period it is also necessary for the therapist to actively structure his or her own identity for the

child. If the child plays silently, the therapist should remain attentive and interested and comment

on the process.

During midsessions, children will build a relationship of trust and relaxation with an adult

that has little to do with the control and power issues of the earlier phases. At this time

personality reorganization and a growing acceptance of the self begins to emerge (Guerney,

1983). The accepting, noncritical attitudes of the therapist have made an effect. Aggression tends

to level off and is followed by a greater expression of regressive behaviors. These are expressed

in the form of babytalk, playing baby, or feeding or nurturing dolls, animals, or the play

therapist. These behaviors display the independence-dependence issue.

Later sessions are more reality oriented. While some role-playing, puppet play, and other

fantasy play continues, more reality elements are included (Guerney, 1983). Aggression will

drop to a low level but will not disappear completely. At this point, aggression is generally

circumscribed and related to recent events. Tolerance of frustration for the "here and now" of the

play increases and the child will be able to laugh or be casual about losing. Social behaviors will

prevail over antisocial behaviors.

Research

Person-centered play therapy has a more extensive body of research than psychoanalytic

or cognitive-behavioral. Studies have been conducted, that have used person-centered play

therapy on children who display aggressive behaviors, along with other problems or diagnoses. In particular, problems include negative labeling, maladjusted behaviors, and disturbed young children. These studies will be described and analyzed.

Johnson, McLead, and Fall (1997) conducted a descriptive study concerning the effects of person-centered play therapy on labeled children. They purported that most counseling interventions for children were directive strategies designed to reduce the incidence of unacceptable behavior. They stated that directive strategies did not address the secondary problems of unsuccessful communication of thoughts and feelings and lack of control over self and the environment. Consideration of these problems with directive strategies suggested that labeled children would benefit from an environment where self-expression was encouraged: relationships characterized by acceptance rather than by disapproval and judgement and a sense of control and a belief in their abilities to cope effectively with the world fostered (Johnson, McLead, & Fall, 1997). This is the type of environment that person-centered play therapy establishes.

The purpose of the study was to determine if six weekly 30-minute sessions of person-centered play therapy effectively addressed the secondary problems of labeled children in the schools. Six children ranging from 5 to 9-years-old were selected based upon their labels. Labels included attention-deficit/hyperactivity disorder, unpredictable behavior in the classroom, mentally disabled with severe deficits in receptive and expressive communication, autism, significant delays in all areas of development, cerebral palsy, and obsessive-compulsive disorder.

Results were based on the researcher's analyses of the play therapy. No statistical measurements were included in the study as evidence of the effectiveness of person-centered play therapy used with children with aggressive behaviors. Results showed that person-centered

play therapy facilitated the labeled children's expression of feelings and increased their skills in coping with the issues in their lives (Johnson, McLead, & Fall, 1997). The feelings and thoughts the children expressed were unconditionally accepted which provided them opportunities to express feelings, experience control, and develop coping skills.

Person-centered play therapy offered these children a safe and nonverbal means of communication. This experience of control paved the way for the expression of greater self-control outside of the therapy setting and fostered children's beliefs in their abilities to cope effectively with the world. Ginsberg remarked, "Children who experience acceptance and nonjudgement are able to grow, develop, and feel good about themselves. This can only foster great mastery and coping in the real world and their real lives" (1984, p. 324). Labels can affect adults' perceptions of children, cause children to be less accepted by peers, and contribute to the messages they receive of disapproval and unworthiness. These environmental messages in turn can cause labeled children to feel both unaccepted and unacceptable. Person-centered play therapy, along with supportive adults and other children, provides labeled children with the acceptance they need.

Elliot and Pumfrey (1972) examined the effects of person-centered play therapy on maladjusted boys. The Bristol Social-Adjustment Guide (BSAG) was administered to 28 boys. Sixteen boys who obtained the highest number of adverse pointers on the BSAG were selected for the experiment and randomly assigned to either a control or an experimental group. Eight were assigned to receive person-centered play therapy for nine weekly one-hour sessions and eight were assigned to the control group to remain in their regular classes. Neither group received special help with their reading other than that normally given by their classroom

teachers, which is a weakness of the study. To accurately measure reading attainment, the researchers needed to assign an experimental group to obtain help in their reading skills.

The hypotheses tested were that improvement in social adjustment would occur following play therapy, and that person-centered play therapy would not improve reading attainment in the absence of any specific instruction. Using t-tests of significance of mean differences, there were no significant differences between the experimental and control groups in improvements of social adjustment, or in reading attainment. Sessions of person-centered play therapy did not result in significant improvement in the experimental group (Elliot and Pumfrey, 1979). Rank order of improvement in adjustment after therapy was significantly related to intelligence and neuroticism. One year later, eleven of the sixteen boys had improved in social adjustment. This demonstrates a long-term improvement in social adjustment, along with the abilities of children to continue to improve after therapy has terminated.

Moustakas (1955) conducted an experimental study on the frequency and intensity of negative attitudes expressed in person-centered play therapy from well-adjusted and disturbed young children. A group of nine well-adjusted children and a group of nine disturbed children, all four years of age, were selected. Disturbed children were described by their parents and teachers as children with severe problems in their contacts with other children and adults and in their home relationships. Each child was seen in at least four person-centered play therapy sessions by the same therapist.

Of 241 negative attitudes expressed, 10 groups were formed to classify the different types. The 10 groups consisted of: regression in development, diffuse anxiety, orderliness anxiety, hostility toward people, hostility toward home and family, hostility toward parents, hostility toward siblings, hostility toward therapist, diffuse hostility, and cleanliness anxiety

(Moustakas, 1955). T-tests were used to analyze the researcher's findings. Types of negative attitudes expressed by well-adjusted children and disturbed children were similar. For well-adjusted children, the most frequent negative attitude was hostility toward siblings. The most frequent negative attitude for disturbed children was diffuse hostility. Diffuse hostility and hostility toward people in general were expressed frequently in both groups of children (Moustakas, 1955).

Disturbed children expressed a significantly greater percentage of attitudes of diffuse hostility, hostility toward home and family, cleanliness anxiety, orderliness anxiety, and regression in development. Well-adjusted children expressed a significantly greater percentage of attitudes of hostility toward siblings. Differences between the groups in hostility toward parents, people, and therapist, and diffuse anxiety were not significant (Moustakas, 1955). Overall, the disturbed children expressed considerably more intense anxiety and hostility than the well-adjusted children. The disturbed group also showed a greater number of negative attitudes with greater average severity of feeling. This study showed that well-adjusted children do not differ from disturbed children in the kinds of negative attitudes they express. However, they do express them less frequently and less strongly (Moustakas, 1955).

In summary, studies have been conducted on person-centered play therapy with children who display aggressive behaviors. Johnson, McLead, and Fall (1997) conducted a descriptive study on labeled children. They found that person-centered play therapy facilitated the children's expression of feelings and increased their skills in coping with the issues in their lives. Elliot and Pumfrey (1972) conducted an experimental study that looked at the effects of person-centered play therapy on maladjusted boys. Using t-tests to measure effectiveness, no significant improvements were found in social adjustment or reading attainment when the experimental

group was given sessions of person-centered play therapy. Moustakas (1955) conducted an experimental study on the frequency and intensity of negative attitudes expressed in person-centered play therapy from well-adjusted and disturbed young children. T-tests were used to determine the differences in negative attitudes among the two groups. Moustakas (1955) concluded that well-adjusted children do not differ greatly from disturbed children in the kinds of negative attitudes they express.

<div style="text-align:center">Similarities and Differences Among the Play Therapies</div>

Psychoanalytic play therapy, cognitive-behavioral play therapy, and person-centered play therapy have some commonalties that they share (Knell, 1995). First, they all establish a therapeutic relationship by establishing contact with the child, engaging the child in treatment, and engendering the child's trust. Second, they all use play as a form of communication. Play is the treatment modality, as well as a means by which the child and therapist communicate. Third, therapy is demonstrated in a safe place where the child can gain a sense of security and safety. Finally, all therapies obtain clues to understanding the child including how the child views self and others, conflicts and fantasies, and problem-solving approaches.

There are numerous differences that need to be mentioned. The three play therapies differ in how they handle therapeutic direction and goals, play materials and activities, play as being educational, interpretations and connections, and praise. In psychoanalytic play therapy the therapist does not give direction to the client. Rather the client is in control of what direction the play and therapy will take. In cognitive-behavioral play therapy therapeutic goals are established, then the direction of the therapy is based on those goals. Interventions for the child are also based on the therapeutic goals. Person-centered play therapy believes that direction from the therapist

imposes on a child's free expression. The child is allowed to direct the play therapy process so true feelings are expressed that need to be helped.

In psychoanalytic play therapy the therapist is a "participant observer," not a playmate (Knell, 1995). The therapist plays a passive role, and only participates when directly asked by the child. The therapist does not suggest any materials or activities. In cognitive-behavioral play therapy both the child and the therapist select materials and activities. The therapist encourages the child to play independently, however, gives suggestions for materials or activities when needed. In person-centered play therapy play the child always selects materials, activities, and the direction of play. The therapist gives no suggestions or direction, independent selection and play is encouraged.

Psychoanalytic play therapy does not use play to educate the child. Education is not the goal of therapy. In cognitive-behavioral play therapy play is used to teach skills and alternative behaviors. The therapist helps the child learn more appropriate skills and behaviors and ways to redirect their inappropriate skills and behaviors. In person-centered play therapy education is not appropriate because it is a form of direction. Rather, therapists must encourage instead of educate.

In psychoanalytic play therapy interpretation is the ultimate tool. Therapists base the therapeutic goals and interventions for the child on the therapist's interpretations of the child's play. In cognitive-behavioral play therapy the therapist introduces interpretations. The therapist brings conflict into verbal expression for the child. In person-centered play therapy the therapist does not make interpretations unless the child introduces them first. The therapist communicates unconditional acceptance, not an interpretation of symbolic play.

In psychoanalytic play therapy praise is considered inappropriate. The therapist remains a passive observer and gives no praise. In cognitive-behavioral play therapy praise is considered crucial. It communicates to the child which behaviors are appropriate and reinforces the child. In person-centered play therapy praise is not and should not be used by the therapist. Praise communicates to the child that the therapist doesn't accept the child, but rather wants the child to be a certain way. Therefore, there are numerous differences between psychoanalytic, cognitive-behavioral, and person-centered play therapies.

CHAPTER THREE
IMPLICATIONS AND RECOMMENDATIONS

Numerous problems exist in attempting to formulate conclusive opinions regarding the efficacy of play therapy based on an examination of the existing literature. First, most studies regarding play therapy were conducted during the 1950s and 1960s. Few studies have been conducted since 1970. The studies, however, can still be utilized to help advance future research attempts. Theories and hypotheses can be built from these past studies. By using this information current research needs to be conducted to demonstrate the effectiveness of play therapy in situations within our changing society.

Overall, more research studies need to be conducted of the various types of play therapy across situations and settings. Professionals can help children reduce aggressive behavior and demonstrate more appropriate behaviors to help them achieve more success and happiness in their lives. Play therapy is one therapeutic technique that may be effective in reducing aggression. However, research must be conducted to determine the effectiveness of play therapy for aggressive behaviors of children. Only then will play therapy surface as an intervention of choice.

Play therapy is a general term for various types of therapeutic play. Information concerning the effectiveness of one approach does not necessarily reflect that of other approaches. Readers must be cautious not to generalize the findings of studies to all types of play therapy. Each study typically represents only one form of play therapy. If one type of play therapy is ineffective for a certain problem, another type of play therapy may be effective. Research needs to be conducted on all play therapy approaches, with various types of presenting problems.

A problem encountered in the research literature was misleading information. Some of the books and journals combined various forms of play therapy but did not indicate this clearly. For example, in a chapter one sentence would be about psychoanalytic play therapy and the next sentence would be about person-centered play therapy. Readers unfamiliar with play therapy must be extremely careful in reviewing materials. Many sources do not clarify the type of play therapy they are studying. If sources do not label clearly the type of play therapy being described or the unfamiliar reader can not easily identify it, discard it. The author may not be a credible source in the area of play therapy. To actually become skilled in the use of play therapy, one must understand differences in assumptions and methods of the various play therapies.

Play therapy can be a valuable method for reaching young children, if used correctly. It is most beneficial when used to help children develop mature and adaptive social skills, establish nonthreatening relationships with children who are difficult to reach, and provide opportunities for mildly disturbed children to model better adjusted peers. Unfortunately, children with aggressive behavior have little capacity for expressive or reflective verbalization, or for dramatic, imaginative play (Willock, 1983). In addition, they tend to feel intensely threatened by the slightest inquiry or observation on the part of the therapist. Therefore, they present several obstacles to the viability of play therapy as a means of helping them.

Methods of study might account for a positive outcome. Play therapy is a particularly difficult process to subject to empirical study. Systematic research must occur, particularly with regard to process and outcome issues. The integration of cognitive-behavioral techniques into play interventions offers a promising direction due to the specificity of treatment goals. Cognitive-behavioral play therapy has yet to be subjected to systematic empirical study (Knell, 1994).

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