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Non-Directive Play Therapy: Past, Present and Future

Jeslina Jayanti Raj

Eastern Illinois University

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Non-Directive Play Therapy: Past, Present and Future

BY

Jeslina Jayanti Raj

THESIS

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Non-Directive Play Therapy: Past, Present & Future

Jeslina J. Raj

Eastern Illinois University
Abstract

The paper focuses on the history, research and future directions of non-directive play therapy. According to the history of play therapy, the first person to advocate studying the play of children in order to understand and educate them was Henry Rousseau. The history of play therapy is discussed with further details. Few studies have been done that empirically support the effectiveness of non-directive play therapy and there have been no investigations of therapeutic processes. From a behavioral perspective, it is understood that non-contingent attention in the form of attention, the absence of demands and the environmental richness of the playroom will enhance the relationship between the child and the therapist, which in turn is essential for a therapeutic experience. Play therapy remains in great need of empirically based evaluations. Single case experimental designs, prolonging the treatment phase and incorporating new measures, just to name a few, are examples of suggestions for future directions. These suggestions are discussed in detail.
Dedication

To my mom and brothers for their love, encouragement and guidance. Most importantly, in memory of my father who always taught me to believe in myself.
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History of Play Therapy

Play therapy was developed as a technique for treating children when professionals in the field of mental health recognized that interventions they had designed for adults were not feasible for use with children. The person-centered approach is a technique that is receiving much attention in the field of play therapy. Person-centered play therapy is gaining popularity as an appropriate intervention for mistreated children although research in this field is greatly needed (Ryan & Wilson, 1996).

The first person to advocate studying the play of children in order to understand and educate them was Henry Rousseau (Lebo, 1955, as cited in Landreth, 1982). In Emile (1930), Rousseau expressed his ideas on the aims of childhood training (Lebo, 1955, as cited in Landreth, 1982). He recognized the fact that childhood was a period of growth and that children were not simply adults. Rousseau stressed the importance of play in understanding the child when he recommended that a child's teacher becomes a child himself in order to join the games of his student and thus become a proper companion. Rousseau's references to the play and games of children were more in line with educative or training purposes than in accord
with modern investigative or therapeutic uses of play (Lebo, 1955, as cited in Landreth, 1982).

Carl Rogers (1902-1987), in his search for an alternative form of therapy to address the limitations of psychoanalysis, turned to the humanistic values (West, 1992). He was attracted to the premise that, given a caring environment, individuals have within themselves the capacity to overcome or grow through their inner conflicts. Later, this approach became known as non-directive, client-centered therapy, now termed person-centered therapy (West, 1992). Rogers' philosophy grew out of his work with people in therapeutic and teaching relationships. His philosophy has grown and changed as a result of his life experiences and of his integration of these experiences. Carl Rogers described personality based on the experiences he had as a therapist. According to Rogers, an infant recognizes that experiences are real within the setting of personal experience. The infant accepts what has already been incorporated by self-definition, and rejects whatever that does not fit. The interaction between the child's inner world, the child's personalized filtering system and the environment, allows the child to develop a self-concept that is personally created through understanding of the self in the environment.
When a child experiences an environment that is harsh, conditional, and rejecting, then the child develops a negative self-concept. The child begins to develop defenses that disallow any information that does not fit the defined sense of self (James, 1997). Accepting information that does not fit the established concept of self would create instability. In order to recognize and accept the information, the person has to distort the information so that it will be accepted into the already existing perception of the self. Otherwise, the instability will lead to anxiety. The defenses that disallow the entrance of the inconsistent information are rigidity, distortion, and denial (James, 1997). In the event that the child is not able to balance the perception of self with the environmental implosion, the defenses will not serve as a "safety net." (James, 1997 p.146). When this takes place, confusion occurs and it will eventually lead to conflicting problems.

The defenses will no longer be needed when the individual receives therapy because it is an opportunity to change the perception of self within the environment (James, 1997). At that time, the individual will be able to value self within the environment with increased precision. Rogers stressed that the therapist should be
responsible in providing an environment that contains only components helpful to the person's seeing himself or herself as worthwhile. The therapist views the person with positive regard, complete acceptance, and empathy. Using these components as a mirror, the person will be able to develop a sense of self-worth.

Virginia Axline (1947) made early contributions in the adaptation of the client-centered approach to child therapy (James, 1997). Axline, like Rogers, saw the child as having a mutual relationship with the environment. Axline worked in the United States and was inspired by the profound approach of Carl Roger's active non-directive counseling. Many play therapists became interested in play therapy after reading Virginia Axline's, *Dibs-In Search of Self* (1964), a moving story of how she empowered a disturbed and distant boy to heal himself and to disclose his intellectual gifts through play. According to Axline, a child tends to develop self-perceptions based on the information mirrored by significant others. This is a powerful experience, because both the child and the environment are constantly changing. Axline suggested that the child strives toward growth in order to satisfy basic needs. She explained the basic drive of the individual as that of "complete realization" (James, 1997, p. 147).
Axline described the difference between the adjusted child and the unstable child as being the way in which the child deals with the environment. According to Axline's theory, the adjusted child directs behavior in order to achieve complete self-awareness. However, the maladjusted child has not learned how to achieve self-realization without using "devious methods" (James, 1997, p.147). For example, the maladjusted child would use temper tantrums, crying and whining to achieve realization. The maladjusted child continues to unsuccessfully struggle until the self-perception distorts in order to regain a balance between the unmet needs and the harsh environment (James, 1997). This effort toward regaining balance requires that the child use defenses of rigidity and self-distortion. The maladjusted child perceives the defenses of rigidity and distortion as ways of achieving self-realization. When these defenses no longer protect the sense of self, the child becomes completely disorganized. In order to be restored to a state of balance, the child needs therapy.

Reconstruction of the self will occur when the conditions of the therapeutic environment are established. These conditions consist of allowing children to see themselves as being worthy in an atmosphere of complete acceptance. Axline contended that children have all of the
components necessary for growth and change. In a therapeutic environment, children will utilize these components with the non-directive, accepting therapist. Children will grow when they are in a state of acceptance within the right conditions. The role of the therapist is to assure the children that the conditions of safety are in place. The therapist creates conditions that are different, accepting and therapeutic. The process occurs because the therapist has incorporated a certain set of values and has set the right conditions for therapy to take place.

Children describe their world and express their feelings through their play (McMahon, 1992). When children are in an environment where their language and the content are not restrained, they are able to experience their feelings and to reorganize those feelings. With this understanding of the unique needs of childhood, Axline developed techniques for working with children using the approach of non-directive play therapy. This setting and non-directive conditions provide children with the option of allowing needs to appear so that these needs can be reevaluated in a safe setting. When this occurs, the child corrects distortions, gives up dysfunctional techniques and defenses, and moves to a state of balance (McMahon, 1992).
Axline suggested that the relationship is structured within the framework established by eight basic principles (as discussed in McMahon, 1992). The first principle recognizes that the therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible. This is done by explaining to a child that he or she may play with any of the things in the playroom or use them in any way they wish. The therapist should not suggest anything particular that the child should do. If the child sits in silence, then the therapist would do the same too. The second principle states that the therapist accepts the child exactly as he or she is. Praise and encouragement are as inappropriate as criticism and disapproval, since both imply judgement. If a child paints a beautiful picture, the therapist will not praise it because it is the child’s opinion that matters, not the therapist’s.

The third principle states that the therapist should establish feelings of tolerance in the relationship so that the child feels free to express his or her feelings completely. For instance, the child should be allowed to beat up the mother doll or bury the baby in the sand or lie down on the floor and drink from a nursing bottle without shame or guilt.
The next principle suggests that the therapist should be alert to recognize the feelings the child is expressing in order for the therapist to reflect those feelings back to him or her in such a manner that the child gains some insight into his behavior. For example, Oscar looked around the room and said “I’ll bust up everything in here!” Axline responded, “You're feeling tough now”. She warns against falling into the trap of responding to the contents if his words by saying “You can play with the toys any way you want to but you can’t bust them up” (McMahon, 1992 p. 29). This following principle states that the therapist should maintain a deep respect for the child’s ability to solve his or her own problems if opportunities arise. It is the child’s responsibility to make choices and to initiate changes.

The sixth principle recognizes that the therapist should not attempt to direct the child’s actions or conversations in any manner. The child leads the way and the therapist follows. If the child needs help during play, the therapist gives only limited amount of help at the time. The next principle indicates that the therapist should not attempt to hurry the therapy along. It is a gradual process and this should be recognized by the therapist. The last principle states that the therapist
should prompt the child to be aware of his or her responsibility in the relationship and establish only those limitations that are necessary to anchor the therapy to the world of reality. For example, Axline (1964) told Dibs he had only three more minutes before it was time to go home. Based on Axline’s principles, non-directive play therapy can be effective in bringing about feelings of which the child is unaware into consciousness where they can be dealt with (McMahon, 1992).

From the beginning, the therapist works toward developing a relationship with children that will be different from any other relationship they have experienced (James, 1997). Axline stressed that this relationship has no room for shame, bribery, or compliments. The therapist continuously recognizes the child’s feelings and reflects those feelings back to the child in a way that adds to the child’s sense of identity. The therapist accepts the child exactly as he or she is. She used the technique of reflective listening, based on the counseling principles of empathy, warmth, acceptance and genuineness. Acceptance of children at their own rate of growth is necessary for a successful therapeutic experience.

As children develop they must be able to differentiate types of reflections from others. The person most able to
provide this clear reflection is the therapist. Then acceptance of the child is critical, otherwise the child will again realize that a significant other is not authentic. The therapist shows children acceptance by allowing them to move at an individually defined rate of speed. The therapist allows children to make personal choices in the playroom. Axline indicated that "the therapy hour is the child's hour" (James, 1997, p.148). This implies that the therapist follows the child's plan in a non-directive manner. Axline does indicate that the use of limits are necessary so that the relationship can develop in an authentic way. For example, Axline did not allow the child to attack the therapist (this would cause the child emotional harm because it would damage the therapeutic relationship).

Axline made a distinction between reflection and interpretation (James, 1997). Interpretation, according to Axline, implies explaining the symbolism that children express in play. For example, children might summon up a lion in their play because they have seen one on television, in a book or at the safari park. The play might be seen as a straightforward expression of their interest in the lion, or their wish to communicate with someone about the lion. In this case, the lion is probably
a sign. But if through the lion, children want to express something of their own aggressive, strong nature or if they are angry with a parent and want to 'gobble him or her up', then the lion might be symbolic (Wilson, Kendrick & Ryan, 1992, p. 54).

Reflection of toy play is done so that the child will know that the play has been understood. Reflection helps the client to better recognize their feelings and is in a strict sense non-interpretive. In other words, Axline defines reflection as the "mirroring of feeling and affect" (Wilson, Kendrick & Ryan, 1992, p. 23). Children gain insight because the therapist uses clear words to describe feelings. When this occurs, children can experience feelings in a different way. Thus, new perceptions about themselves develop because these feelings have been approved by a significant other. When the feelings are placed in a context of safety and reality, they are no longer scattered. They are clear, and children have the ability to recreate perceptions so that those perceptions reflect reality. Children have a natural tendency for growth that will surface when they are allowed to use meaningful language and play in a therapeutic relationship, on a self-directed time line. "Reflection of feelings is more commonly used, and clever interpretations are not the
order of the day, the reception of the play often being sufficient” (West, 1992, p.128). Axline’s suggestions remains as the basis for non-directive play therapy.

Approaches to therapeutic play

Directive

Axline made a major distinction between non-directive and other play therapy methods: “Play therapy may be directive in form that is, the therapist may assume responsibility for guidance and interpretation, or it may be non-directive; the therapist may leave responsibility and direction to the child” (cited in Schaefer & O’Connor, 1983, p. 21). There are many different approaches to play therapy such as release therapy, relationship therapy and psychoanalytic play therapy. All of these different approaches are used by play therapists, depending on their choice of orientation, although client-centered play therapy is currently much more preferred (Ryan & Wilson, 1996).

In the 1930s, David Levy developed another form of play therapy called release therapy (Landreth, 1991). Release therapy is a structured play therapy approach for children who had experienced a specific stressful situation (cited in Landreth, 1991). His theory specifies that the major role of the therapist is to be a ‘shifter’ of scenes
to recreate through selected toys the experience which brought about the child's anxiety reaction (Landreth, 1991 p. 30). The child is permitted to engage in free play to gain familiarity with the room and the therapist. Then the therapist uses play materials to introduce the stress producing situation when the therapist feels it is appropriate. The reenactment of the traumatic event allows the child to release the pain and tension it caused. At other times, the child may be allowed to select her own free play. "In this process of 'playing out' or reenacting the experience, the child is in control of the play and thus moves out of the passive role of having been 'done to' and into an active role of being the 'doer'" (Landreth, 1991 p. 30). As the child plays, the therapist reflects the verbal and nonverbal feelings expressed.

The emergence of the work of Jesse Taft and Frederick Allen, referred to as relationship therapy, constituted another significant development in play therapy (cited in Landreth, 1991). The philosophical basis for relationship play therapy evolved from the work of Otto Rank (cited in Landreth, 1991). He stressed that the growth of a relationship between the therapist and client as being very crucial with a consistent focus on the present, the here and now.
In relationship play therapy, the primary emphasis is placed on the healing power of the emotional relationship between the therapist and the child. No effort is made to explain or interpret past experiences. It differed from non-directive play therapy in that it placed major emphasis on present experiences and situation. It emphasized present feelings and reactions, so there was no need to question the client as to his or her earlier experiences. Present feelings and reactions are the primary focus of attention and this approach reportedly led to considerable reduction in the length of therapy as compared to non-directive play therapy.

Allan and Taft stressed regarding children as persons of inner strength with the capacity to alter their behavior constructively. Therefore, children are given freedom to choose to play or not to play and to direct their own activity. The hypothesis was that children gradually come to realize that they are separate persons with their own strivings and that they can exist in a relationship with other persons with their own qualities. In this approach the child has to assume responsibility in the growth process. The therapist concentrates on those difficulties which concern the child rather than on those concerning the therapist.
Psychoanalytic play therapy is currently used comparatively rarely with children but historically it is significant in that the work of Sigmund Freud, Melanie Klein and Anna Freud (McMahon, 1992). Before starting therapy with children, Anna Freud aimed to create a loving and caring relationship with the child so that the child would like her and feel dependent on her. Play was one of the main ways of achieving this. Also by observing play she was better able to understand the child’s problem. Unlike Melanie Klein who thought that all play was symbolic, Anna Freud believed that it could be a re-playing of real events or even pure exploration. For instance, a child who looks in her therapist’s handbag is not necessarily looking to see if her mother’s womb is holding another baby. After the initial assessment, Anna Freud used play methods less than free association, asking children to see pictures, tell stories, draw or describe their dreams.

Anna Freud perceived playing in therapy as a means of permitting children to express conscious feelings and thoughts and to act out unconscious conflicts and fantasies. Interpretation to the child of the symbolism of the play might follow, but only if it was suggested by a good deal of material. The positive tie created earlier
helped the child 'face up to the often very painful revelation of repressed material' (McMahon, 1992 p. 33). Anna Freud's analytic work was often with latency age children, those who had developed strong psychological defenses and therefore resistances to therapy. She always kept sight of the child's real world and worked only slowly down from reality and conscious feelings towards deeper levels of the child's unconscious. She did not think a quick, deep interpretation could be lastingly therapeutic.

In sharp contrast to Anna Freud, Melanie Klein made profound explanations to children of the unconscious meanings of their play from the start (McMahon, 1992). According to Axline and Klein, interpretations should be given very sparingly. If the child strongly rejected her interpretations she felt that this indicated that it was correct. "When a child accepted an interpretation, its anxiety and guilt would lessen, enabling the symbolic exploration of feelings, free of the fear of damaging real people" (McMahon, 1992 p.33). Her interpretations often involved sexual meanings, which she did not hesitate to offer to the child. It is perhaps this, which led many people to reject her ideas (McMahon, 1992). Klein's most significant contributions have been her explanation of the origin of the child's emotions, tracing them back to
infancy and her specific use of play in therapy. Children’s play is the equivalent of free association in adult psychoanalysis, revealing unconscious anxieties and fantasies.

**Non-Directive (Child-Centered Play Therapy)**

Inspired by the founders of play therapy, Garry Landreth began his work with children by following the theory of personality described by Carl Rogers and used many of the approaches described by Virginia Axline. Landreth’s work on non-directive play therapy is an elaboration of Axline’s theory, although Janet West (1992) states that Landreth’s work should be recognized as separate and apart from Axline’s model. Landreth has revised and extended Axline’s eight basic principles. The principles are similar to Axline’s concepts. Landreth’s philosophy of child-centered play therapy is representative of the inborn human capacity of a child to aim toward growth and maturity and an attitude of deep and enduring belief in the child’s ability to be competent in self-directing (Landreth, 1991). It is believed that the human organism moves forward naturally through developmental stages of growth in a progressive manner toward greater maturity. This tendency is innate and is not externally encouraged or taught. “Children are naturally curious,
delight in mastery and accomplishment, and energetically live life in their continual pursuit of discovery of their world and themselves in relation to the world" (Landreth, 1991 p. 60). According to Landreth, children have a built-in tendency to move in subtle directedness toward adaptation, mental health, developmental growth, independence, autonomy of personhood, and what can be generally described as self-actualization.

The basic character or nature of children’s lives is activity. A child’s approach to living is an on-going process. This can perhaps best be seen in a close observation of their play which is active and forward moving, toward enhancing self-satisfaction in the activity of living life. This inherent push toward discovery, development, and growth is readily observable in the developmental stages of infants and young children. Children experiencing difficulty or frustration in attempts to accomplish a physical developmental task will use their own unique coping skills to master the task with effort, determination and vitality (Landreth, 1991).

According to Garry Landreth (1991), the child has the capacity to solve his or her own problems and to take notice that mature behavior is more rewarding than immature behavior. Play is the singular central activity of
childhood, occurring at all times and in all places. Children do not need to be taught how to play, nor must they be made to play. Play is spontaneous, enjoyable, voluntary and non-goal directed. The child is able to act out his or her feelings without any hesitation or guilt. When play is self-initiated and spontaneous, it permits a child to express more fully and more directly than they do verbally because they are more comfortable with play. Playing out their experiences and feelings is the most natural, powerful and self-healing process in which children can engage. When a child plays and expresses freely without direction, he or she is expressing a period of independent thought and action.

The child-centered philosophy as described by Garry Landreth, is just that, "an encompassing philosophy for living one's life in relationships with children" (Landreth, 1991, p.55). Children are the only ones who can provide information about themselves. Children are given the opportunity to be themselves, in the process of playing out feelings, emotions and experiences and they are quite apt in appropriately directing their own growth. The child-centered therapist focuses on developing the kind of relationship which promotes inner emotional growth and children's belief in themselves. Child-centered therapy is
a feeling, a theory, and a way of reality. Every child holds a personal perceptual view of self and the world that is reality for the child. This view of the self is the basis for individual functioning in whatever daily occurrences that the child experiences (Landreth, 1991).

“This view of self and the limitless potentialities within each child are the basis for the theory of personality structure on which the child-centered approach to play therapy is based” (Landreth, 1991 p. 56).

The child-centered theory of personality structure is based on three central concepts: (1) the person, (2) the phenomenal field and (3) the self (Rogers, 1951, cited in Landreth, 1991). The person is all that a child is: thoughts, behaviors, feelings, and physical being. "The phenomenal field refers to everything the child experiences whether or not at a conscious level, internal as well as external, and forms the basis of internal reference for viewing life" (Landreth, 1991, p.57). Whatever the child perceives to be occurring is reality for the child. The self is all of those perceptions the child has of self.

A basic proposition borrowed from Rogers is that every child “exists in a continually changing world of experience of which he is the center” (cited in Landreth, 1991, p.57). As the child reacts to this changing world of experience,
the child does so as an orderly whole so that a change in any one part results in changes in other parts. Therefore, the child, as a total system, strives toward perfecting the self because a continuous powerful intra-personal interaction occurs. As this active process takes place, the child becomes a more “assertively functioning person, moving toward betterment, independence, maturity, and embellishment of self as a person” (Landreth, 1991, p.60).

As experienced in the unique phenomenal field, the child’s behavior is goal-oriented in attempts to satisfy personal needs which for that child constitutes reality. Personal needs, then, influence the child’s perception of reality. Therefore, the child’s perception of reality is what must be understood if the child and his or her behavior are to be understood. Thus, the therapist avoids judging the child’s behavior and works hard to try to understand the internal frame of reference of the child. The child’s phenomenal world is the point of focus and must be understood if a person-to-person (child and therapist) relationship contact is to be made.

"The constantly changing interaction of the person of the child - thoughts, behaviors, feelings, and physical being - with the experiential environment is such that the child’s perspective, attitude, and thought is constantly
changing" (Landreth, 1991, p.57). This has great significance for the therapist who may only see the child once a week. The child this week is in some ways different and the therapist must catch up so to speak. Events that were reacted to one way last week may be reacted to differently this week as the child's inner world of reality changes. This constantly changing communication within the child seems to explain the enormous flexibility within children and the generating effect on hope.

Life is a continual process of personal influential experiences. Children are constantly experiencing an internal reconstruction of thoughts, feelings, and attitudes (Landreth, 1991). Therefore, past experiences are not experienced with the same degree of intensity or impact day after day. Thus, the therapist has no need to take the child back to past experiences as would Levy because the child has grown since those former events. As a result, they no longer have the same impact they formerly had. Therefore, the therapist allows the child to lead, to take the current playroom experience to where the child needs to be.

The third central concept of the child-centered theory of personality structure is the self. As the child communicates with significant others in the surroundings
and from the total phenomenal field, the child, as an infant, progressively begins to distinguish a fragment of these experiences as the self. The self grows and changes as a result of continuing interaction with the phenomenal field.

Research on Non-directive Play Therapy

Client-centered researchers were considerably more active when the approach was first introduced than they have been in recent years. The earliest report on outcome appeared at almost the same moment as Axline's book in 1947.

The following experiment by Bills (1950a) was designed to test the hypothesis that significant improvements occur in the reading ability of slow learners when these children have been given a non-directive play therapy experience. The subjects (18 children) were third-graders who had been previously classified as slow learners. They were assigned to the third grade class because of an inability to learn at a normal rate and not because of intellectual or emotional factors. The study was done over ninety days in three periods of thirty school days each. The first of these periods was the control period, the second the therapy period and the third was considered as a period for noting lasting or cumulative effects of the therapy. Three
types of test were used in measuring the gains of this group and the rest of the class during the three periods of the study. On the first day of the control period all of the children (therapy and control group) were tested with the oral and silent reading tests. During the next two weeks they were tested with an intelligence test. At the end of the control period all of the children in the therapy and control group were retested with the oral and silent reading tests, and these tests were given again at the end of the therapy and third periods.

Oral and silent reading tests gave a reading grade score and a reading age equivalent for each child and the intelligence test gave a mental age. Any discrepancy between mental age and reading age was taken as a measure of reading retardation. The four children who showed the greatest discrepancy were chosen as part of the therapy group and these children had very high intelligence quotients. The other four children were selected from the group with discrepancies and approximately average intelligence quotients. These eight children made up the therapy group and the rest of the children in the class may be thought of as a comparison group.

During the therapy (second) period, the eight children of the therapy group were given a play experience of a non-
directive therapeutic nature following the principles established by Rogers, Axline and others. For the first three weeks of this period the children met in individual sessions with the experimenter and during the last three weeks each child attended an individual session and one group meeting each week. Each session lasted forty-five minutes. All of the children in the class were retested at the end of this period with the oral and silent reading tests. Nothing was done with the children during the third period. At the end of this time all of the children were tested for the fourth time with the oral and silent reading tests. According to Bills, he concluded that when the eight slow learners received a non-directive play therapy experience, they showed significant gains in their reading ability. It is possible that these children were able to learn at a more rapid rate when they had received the play therapy experience or the gains which the children showed in reading skill resulted from information which the child already possessed but was unable to utilize with maximum effectiveness. There were no significant gains for the rest of the children in the class.

Bills (1950b) repeated the same study with well-adjusted retarded readers and found no improvement in their reading ability (cited in Schaefer & O'Connor, 1983). He
concluded that the gains in reading in the first study were related to improvement in personality adjustment and that when personality problems are at the root of reading problems, client-centered play therapy is effective, otherwise it may not be. According to Bills, this comparison study is very important because it makes clear that the gains in Bills' first study (1950a) were due specifically to the child-centered therapy rather than nonspecific factors, for example, attention, suggestion, teacher effectiveness, and experimenter demand. With these early successes, the client-centered play therapists knew that they had a "viable" treatment, the first step in evaluation.

In criticism to these studies, Bills (1950a) did not randomly assign children to the treatment and control group, therefore the characteristics of the subjects in the groups were not balanced or averaged out. It must be emphasized that the therapy and control groups were not matched and that statistical comparison of the two groups was therefore not possible. Due to the inadequacy in using control groups, the conclusions and results for these studies were not clear. The design of this study (1950a) does not permit a conclusion on the effect of maladjustment on the reading ability of a child, but results do suggest
directions for future research. Future investigation might well take the form of an inquiry into the effects of play therapy on the reading level of children who show adequate emotional adjustment.

Dorfman's central hypothesis for this study is that personality changes occur during a therapy period which do not occur in the same child during a no-therapy period, and which do not occur in control cases (Dorfman, 1958). The subjects were from a public elementary school. The therapy group consists of 17 children whose teachers believed them to be maladjusted. The controls were not therapy candidates but were matched for age, sex and test scores. Three personality tests were given: one objective (Rogers test of personality adjustment), one nonverbal projective (Machover human figure drawing test) and one verbal projective (sentence completion test). All 17 cases were seen individually at school. Therapy was conducted within the framework of the client-centered approach following principles by Axline and Dorfman. Sessions were held weekly and the children were told that they must come 10 times after which they could stop if they wished. No tests were given by the therapist. For the therapy group, pre-wait and pretherapy Roger's tests were given in class by teachers. The Rogers Test is a standardized objective test
yielding five indices of maladjustment: total score, personal inferiority, social maladjustment, family maladjustment and daydreaming. The Rogers Test was given by a graduate psychology student to small groups partly composed of classmates considered well-adjusted by their teachers. In this way, the researchers tried to avoid singling out the therapy children for special attention other than therapy. Posttherapy tests were given individually by the same psychology student who had administered the pre-wait and pretherapy Rogers Tests. Follow-up tests were given in small groups to therapy cases and others by a new psychometrist. For the control cases, projective tests were given in class by teachers and the Rogers Test was given in small groups by the same psychometrist who tested the experimental group.

The results stated that on the Rogers Test, certain therapy improvements (total score and social maladjustment) were noted as being reliably greater than those of the pretherapy period and of the control group. While the process of change did not continue in the follow-up period, the gains of therapy were maintained.

This is another study without random assignment and non-equivalent control groups (matched based on sex, age and test scores but not on maladjustment), therefore the
results are unconvincing. As for the graduate psychology student who administered the tests, it was not indicated if the student was blind as to the experimental conditions. It was not mentioned in the literature if the teachers who administered the test received training for this purpose.

A study done by Phillips and Landreth (1998) examined 1166 play therapists' responses to six clinical issues in play therapy. According to Phillips and Landreth this is the largest and most comprehensive survey done in the play therapy (PT) field. Subjects in this research were solicited from four different sources: (a) participants in the 1991 Annual Conference of the Association for Play Therapy (APT), (b) the 1991 University of North Texas Annual Summer Play Therapy training Conference, (c) the entire 1991 membership of the Association for Play Therapy as well as (d) the entire 1991 non-student membership of Division 12, Section 1 (child clinical psychology) of the American Psychological Association. Across all four data sources, the mean return rate was 33%. The survey was comprised of 26 structured-response and open-ended items. Play therapist’s identified (1) the percentages of their PT clients in specific age ranges (0-2, 3-5, 6-8, 9-11, 12-14, 15+ years); the specific ages of their (2) youngest and (3) oldest clients; as well as the percentages of (4) female
and male clients. Play therapists also identified from specific lists (5) the criteria they used for determining whether a child ought to receive play therapy; as well as (6) the disorders most responsive to play therapy. Success in play therapy was measured by play therapist's estimates of (7) percentages of children completely, mostly, little or not at all successfully treated at agreed-upon termination. Play therapists then provided (8) judgements regarding the "five factors that most determine the likelihood of successful play therapy" from a list of specific factors.

The results showed that play therapists, on average, considered play therapy mostly or completely successful with 80% of the children who ended treatment. However, these were subjective accounts, with the therapist rating his or her client on success without any direct measures. Therefore, the ratings of success may be positively biased because therapists who use the therapeutic technique of play therapy believe it works, and their beliefs may have been reflected in their accounts of the outcome of therapy.

This study and the previous studies were essentially a compendium, a conglomeration of case studies or AB design studies. Even though case studies and AB design studies yield rich and interesting data, the deficiency of precise
measures and/or the lack of experimental control for the target behaviors call for the use of a more empirical evaluation. However, few actual studies have been done that empirically support the effectiveness of non-directive play therapy.

Seeman, Barry and Ellinwood (1964) studied children who were aggressive and withdrawn. 150 children from grades two and three were administered the Tuddenham Reputation Test and teachers completed a teacher rating scale for each child. The Tuddenham Reputation Test and the teacher rating scale allow classification into categories of high adjustment, aggression, and withdrawal. All scores were converted to standard scores and subjects in this study consisted of the sixteen children with the lowest scores in adjustment. The sixteen children were randomly designated into the experimental (8 children) and control groups (8 children). Girls and boys were equally represented in the groups as well as aggressive and withdrawn children. The subjects in the experimental group participated in a median length of 37 non-directive play therapy sessions. The teacher rating scale and the reputation tests were administered on three occasions: once before therapy, once at the end of the school year and finally one-year after the second testing. By the time of
follow-up testing, the classes had been reorganized and were taught by different teachers, so that this testing period would be considered the most removed from the experiment.

The children in the experimental group showed significant improvement when compared to the control group on the posttest and follow-up. By follow-up, it was found that children in the control group had aggression scores, which were higher than the average child in the class. All children in the experimental group had lower aggression scores than the average child in the class. It is clear from the results that children who are involved in a therapy experience are perceived by others as significantly less maladjusted after therapy.

Some of the limitations for this study are that there is no clear explanations as to how non-directive play therapy was used. It is mentioned that each child had to receive play therapy sessions but it is never mentioned as to the content of each session. The use of the Tuddenham Reputation Test and the teacher rating scale were not adequately supported or described. The authors mentioned that these scales are easily explained and match the theory of therapeutic outcome predictions. However, the authors
did not mention anything further regarding the reliability and validity of these measures.

A more recent study by Trostle (1988) in Puerto Rico investigated play therapy designed to elicit greater social acceptance in young bilingual Puerto Rican children and to increase their self-control and fantasy expression levels. Bilingual Puerto Rican children were chosen because Puerto Rican boys frequently encounter social, language syntax and other adjustment problems upon entering a new school environment. Twenty-four normally developed bilingual children were randomly assigned to the experimental group and were equally divided among 6 playgroups. The treatment groups received play therapy, once each week, for 10 consecutive weeks. Children in this group participated in play sessions influenced by the non-directive, child-centered principles. The child-centered play therapist provided the children in the experimental groups with non-directional toys including; crayons and paper; modeling clay; blocks; puppets; masks; plastic “families”; and a punching figure. The therapist told the children, upon entering the playroom, that they could do “just about anything they wanted in this special play room.” On the other hand, the control group received all pre- and posttests but did not participate in the child-centered
play sessions. Instead, they took part in unstructured free play sessions with their classmates. The therapist used five behavioral "tools" during each of the child-centered play sessions: recognition of the child's feelings and developmental stages, structuring the play environment, reflective responding, limits and consequences.

The Kendall and Wilcox Self-Control Rating Scale (1972) is an observation based questionnaire. It was used to rate the children's behavior both before and after the study was conducted. The teacher independently of the experimenter rated each child on a seven point bipolar Likert-type scale. Prior to the onset of the study, the teachers were asked to rate each child on the 33 questionnaire items by simply circling the numbers which most closely corresponded to general behaviors observed in the child since the school year began in September. The same procedures were followed at the conclusion of the study. High scores indicated lower degrees of self-control and low scores indicated higher degrees of self-control.

The Play Observation Scale (1981) is a measure of behaviors corresponding to Piaget's stages of maturity reflected in the areas of movement, simple language, make-believe and reality. A total of 17 play behavior categories are listed on a grid scale. The observers, who
received no information regarding the children's experimental or control group assignments, systematically tallied each of the child's play behaviors every 10 seconds onto one of the 17 categories. The observers rated each child for 10 consecutive minutes. High total numbers of tallies in the Fantasy play and Reality based play areas indicated a higher level of developmental maturity for the child.

The results on the post-tests clearly indicated that children in the group play sessions showed significant improvements on self-control and on the higher developmental level play behaviors of make-believe and reality when compared with those in the control group. Boys in the experimental group became more accepting of others (as measured by the sociogram post-test) than boys or girls in the control group. Girls in the treatment group did not score higher on acceptance measures.

A noted strength of this study is the involvement of an extended assessment period compared to the typically brief laboratory experiment or the descriptive accounts that characterizes many client-centered investigations. However, since this study was conducted in Puerto Rico, there might have been cultural and environmental
differences which could have affected the outcome of the study and limit its generalizations.

In India, Dogra and Veeraraghavan (1994) studied the effectiveness of play therapy and parental counseling on children with "aggressive conduct disorder", a term coined by the authors. They compared two groups of children, the experimental group and the control group. Each child was randomly assigned to the experimental or control group. The experimental group underwent a psychological intervention program for a duration of 8 weeks, consisting of play therapy and parental counseling. The control group did not undergo any intervention, although they were required to go to the hospital for the entire 8-week period. Each child in the experimental group had to receive individual play therapy for two sessions per week for a period of two months. Children were able to express their feelings freely through sand play, painting and drawing.

In the first session, all the children were administered the Pareek and Rosenzweig Picture-Frustration test (1959). This scale is administered to understand the child's level of tolerance when faced with a difficult obstacle. The Child Behavior Rating scale by Cassel (1981) was administered to the children's parents. This scale is
administered to understand the child’s behavior in various areas of maladaptive behavior and also to recognize the parents’ and teacher’s relationship with the child. At the end of the 8-week period, all of the children were again tested with the Picture-Frustration study and the parents were again administered the Child Behavior Rating Scale. The results suggested that psychological intervention was successful in bringing about a reduction in “aggressive conduct disorder” for the experimental group, as compared to the control group.

There are three limitations to this study. Parental counseling was linked with individual non-directive play therapy, but the use of parental counseling helped parents understand their child better and it is uncertain as to why both of these were combined. Another limitation is that since non-directive play therapy and parental counseling were done simultaneously, it is unclear whether it was the non-directive play therapy, the parental counseling or the two combined that led to the improvement of the children. Since this study was conducted in India, there might have been some cultural and environmental differences, which could have affected the outcome of the study. However, the fact that it was done in a non-western culture is a clear advance for play therapy research. Another strength is
that this is the first research done on aggressive conduct disorder in relation to play therapy.

As reported in *Play Therapy: A Comprehensive Guide* (1997) by James O’Dessie, Cowden (1992) studied the effects of client-centered group play therapy on self-concept. Cowden attempted to show that group play therapy would increase the self-concept in seven children using eight sessions of play therapy group. Her findings were statistically inconclusive, however, she indicated that the progress based on clinical notes indicated a progression toward increased self-concept.

**Strengths and limitations of Non-directive Play Therapy research**

Most studies are based on group centered play therapy or individual therapy combined with parental counseling. There are not that many studies that specifically examines individual play therapy, the most common form of play therapy, as a means to decrease inappropriate behavior. Given the popularity of play therapy, it is puzzling to find out that there are so few experimental studies showing its effectiveness. Most of the studies that exist utilize group designs. Group designs are time consuming and costly. It is time consuming and costly because each child in a particular study has to receive play therapy sessions...
and usually group studies have a large number of participants. Researchers in the field of play therapy need to carry out more empirical evaluations to establish the reliability and validity of non-directive play therapy. The current literature has not employed methodologically sound measures of treatment effectiveness. It is not clear under what conditions this popular mode of treatment for children works. Empirical evaluation of this treatment mode remains weak and no studies have been carried out on the mechanisms of change in non-directive play therapy.

A noted strength is that play therapy research is being conducted in Non-western cultures (e.g., India and Puerto Rico) which suggest that it might be effective because some cross-cultural studies suggest good generalization to non-western culture.

**Why might Non-directive Play Therapy work**

Although a few limited studies have explored whether non-directive play therapy works, even fewer studies have explored the therapeutic processes underlying its possible effectiveness. Moreso than any other play therapies, client-centered play therapy grants the individual freedom to be himself or herself without facing evaluation or pressure to change. Axline (1947) describes the process as “an opportunity that is offered to the child to experience
growth under the most favorable conditions," that is, by 
playing out feelings as he or she brings them to the 
surface, faces them, learns to control them or abandons 
them (cited in Schaefer & O'Connor, 1983). The child "
begins to realize the power within himself to be an 
individual in his own right, to think for himself, to make 
his own decisions, to become psychologically more mature, 
and by so doing, to realize selfhood" (as cited in Schaefer 
& O'Connor, 1983 p.16). This is purportedly the underlying 
factor for the effectiveness of non-directive play therapy. 
Many therapists agree that the relationship between the 
child and the therapist is very crucial and this may 
determine the effectiveness of play therapy. From a 
behavioral perspective, it may be that non-contingent 
reinforcement in the form of attention and the absence of 
demands that are incorporated into the therapeutic 
relationship that make non-directive play therapy 
effective. The environmental richness of the playroom 
could be one of the other determining factors for the 
effectiveness of non-directive play therapy.

The first component, which might be essential in 
establishing a therapeutic relationship, is the use of non-
contingent reinforcement (NCR) in the form of attention. 
In a non-contingent reinforcement procedure, the reinforcer
is delivered on a fixed time or a variable time schedule. In the case of non-directive play therapy, in which the therapist's attention is in effect delivered non-contingently, this allows the therapist to provide a warm, safe and caring environment, which in turn tells the child that he or she is acknowledged. Research on NCR with regard to non-developmentally disabled populations is almost nonexistent. Several studies with developmentally disabled individuals demonstrate the impact of NCR on behavior.

Hagopian, Fisher and Legacy (1994) studied the effects of non-contingent reinforcement on attention-maintained destructive behavior in identical quadruplets. The subjects were 5-year-old identical quadruplets diagnosed with mental retardation and pervasive developmental disorder who displayed destructive behavior that was maintained by social attention. Three conditions—social attention, toy play and demand were used. During social attention, the client was given toys and instructed to play while the therapist looked at a magazine. During demand, the therapist presented demands using sequential verbal, gestural, and physical prompts every 10s. During toy play, the therapist interacted with and praised the client approximately once every 30s following 5s of no target
responses. Each session was 10 minutes in length. During the dense-schedule condition, the therapist delivered attention on a fixed time 10-seconds schedule. Six 10-seconds intervals of attention were delivered each minute. The lean-schedule condition was identical to the dense-schedule condition except that one 10-seconds social interaction was delivered on an fixed time 5-minutes schedule. Overall, the rates of destructive behavior were clearly lower under the dense schedule than in both baseline conditions when compared to the lean schedule for all 4 clients. These findings suggest that NCR, using the reinforcer responsible for behavior maintenance, can be an effective treatment for destructive behavior maintained by social attention in children with developmental disabilities.

One potential limitation of NCR is that response-independent reinforcement may be delivered immediately following a maladaptive target response and provide random reinforcement. Such effects were not evident in the current investigation. One potential explanation is that reinforcement was initially delivered on a dense schedule in which the rate of reinforcement exceeded the rate of maladaptive behavior. Thus, the clients received
reinforcement more often in the absence of destructive behavior than in its presence.

A second study (Derby, Fisher & Piazza, 1996) examined the effects of contingent and non-contingent attention on self-injury and self-restraint. According to this study, self-restraint and self-injurious behavior (SIB) can be considered to be members of the same functional response class in that both are maintained by the same environmental contingencies. Therefore, a single treatment should be effective for both responses. In this study, the effects of providing attention both non-contingent and contingent upon either SIB or self-restraint was examined. The subject was a 12-year-old female with tuberous sclerosis, a genetic disorder that causes benign tumors on various organs, and profound mental retardation. Sessions lasting 10 minutes were conducted and observers recorded the frequency of attempted SIB and the duration of self-restraint. The effects of noncontingent attention (NCR) and attention applied contingent upon either SIB or self-restraint were evaluated using a reversal design. Sessions were conducted both in the morning (four per day) and afternoon (three per day). Results indicate that SIB and self-restraint were maintained by the same contingency, attention. Attention provided contingent upon SIB resulted
in increases in SIB, while self-restraint remained low. Attention provided contingent upon self-restraint resulted in increases in both SIB and self-restraint. Non-contingent attention resulted in near zero levels of SIB and self-restraint. They concluded that non-contingent reinforcement is a potentially effective treatment.

Fisher, Ninness, Piazza and DeSchryver (1996) examined the reinforcing effects of verbal attention. The participant was a 4-year-old boy with autism, oppositional defiant disorder and moderate mental retardation. All sessions lasted 10 minutes. A functional analysis revealed that the participant exhibited destructive behavior that was maintained by attention in the form of verbal prompts. In a second analysis, contingent verbal prompts (e.g., "Don't hit me") produced higher rates of the behavior than contingent statements that were unrelated to the target response (e.g., "It is sunny today"). In this second analysis the participant was given free access to toys while the therapist sat in a chair and read a magazine. Whenever a destructive behavior occurred, the therapist remained in a chair and presented brief verbal attention that referred to the target response (e.g., "Don't hit me") or its effect (e.g., "That hurts"). The unrelated verbal statements condition was similar to the verbal reprimands
condition except that the verbal statements presented contingent upon destructive behavior did not refer to the behavior or its effects (e.g., "It's sunny today"). The results suggest that some forms of attention were more reinforcing than others. A treatment based on these analyses reduced the behavior to near zero levels.

A second component, which may be important to non-directive play therapy, is the absence of demands. Landreth (1991) stated that it is crucial for the therapist to constitute a feeling of permissiveness and to facilitate decision making by the child. The therapist has to establish leniency or permissiveness during the therapy session, which makes it easy for the child to show the depth of his or her feelings. Demands should not be placed on a child because this does not allow the child to be in control of his actions. Most of the studies are done on developmentally disabled children but studies on developmentally normal children are almost nonexistent. A few studies illuminate the possible impact of demands on behavior.

Mace, Browder and Lin (1987) studied the effect of demand conditions associated with stereotypic mouthing behavior in a 6-year old-boy who was diagnosed as "brain damaged", severely emotionally disturbed and had a
medication-controlled seizure disorder. Stereotypic mouthing behavior was assessed during high (table games) versus low response (snack preparation) activities, and familiar (spreading peanut butter on crackers) versus novel activities (peeling a hard-boiled egg) and lastly avoidance of table game activities versus partial avoidance of table game activities conditions. Results showed that stereotypy occurred at a much higher rate during difficult activities (i.e. those that were novel or required a greater number of responses) than during familiar activities. Mace described that for some individuals, one function of stereotypy may be to escape or avoid demand situations.

In another study conducted, three subjects with SIB also suffering from developmental disabilities were exposed to four conditions: demand, attention, alone and play (Pace, Iwata, Cowry, Andree & McIntyre, 1993). During the demand condition, an experimenter presented academic tasks to the subject in a discrete trial format approximately once every 30 seconds, delivered praise contingent on correct responses, and implemented a 30 seconds time-out from the task contingent on the occurrence of SIB. During the attention condition, an experimenter instructed the subject to play with toys that were in the room and proceeded to do paperwork. Contingent on the occurrence of
SIB, the experimenter delivered a verbal reprimand, expressed concern and briefly interrupted the SIB. The alone condition consisted of the subject being alone in an empty room with a chair. Play was a control for the other conditions mentioned. In the play condition, the subjects were allowed to play with any toy that they desired without any demands or disruption. This was carried out whenever the experimenter instructed the subject to play and provided praise every 30s contingent on the absence of SIB and ignored occurrences of SIB. Results indicated that subjects engaged in high levels of SIB whenever demands were given, and very low levels during the other conditions. Accordingly, instructional demands can be problematic to some individuals suffering from developmental disabilities.

The last possible effective component of non-directive play therapy, unrelated to the child therapist relationship is the environmental enrichment of the play therapy setting. According to Landreth (1991), from a non-directive play therapy perspective, it is important to have a variety of toys available for the child so that the child has the opportunity to choose the mode of communication with which he or she is able to express his or her feelings. The play therapy room has to be rich with a
variety of toys, which allows the child to be more expressive. The child should have the opportunity to choose the toy, in order for the child to be able to express his or her feelings and thoughts. Research on the environmental enrichment of the play therapy setting with regard to normal children is almost nonexistent. A few studies demonstrate the effect of an enriched environment on behavior.

Horner (1980) studied the effects of an environmental "enrichment" program on the behavior of institutionalized profoundly retarded children. The participants were five profoundly retarded female residents (9 to 14 years of age) of one living unit of a large state institution for the mentally retarded. The physical setting for the enriched environment consisted of a large number of toys and objects that were placed in a playroom. The five conditions, which measured adaptive and maladaptive behaviors, were: (1) baseline, (2) enriched environment, (3) enriched environment plus differential reinforcement, (4) enriched environment plus non-contingent reinforcement and (5) follow up. The four categories of adaptive and maladaptive behavior were adult directed behavior, child directed behavior, self-directed behavior and object-directed behavior. The first phase consisted of recording four
categories of behavior in the "austere" conditions present before any attempt was made to modify the environment of the living unit. These measurements served as a baseline against which to later determine the effects of the second phase. The second phase involved determining the effects on the four categories of behavior produced by "enriching" the environment with a large number of toys and objects. The third phase was a return to the "austere" conditions of the first phase. The toys and objects were removed from the playroom. The fourth phase was a return to the "enriched" environment of the second phase. The toys and objects were returned to the playroom. Results indicated that there was a substantial reduction in maladaptive self-directed behavior in the enriched environment condition. The variety of toys and objects coupled with differential reinforcement of behavior involving manipulation of those toys and objects resulted in additional reduction of maladaptive behavior and an increase in adaptive behavior. Horner concluded that when the environment is enriched with toys, maladaptive behaviors decrease.

Lindauer, DeLeon and Fisher (1999) studied the effects of an enriched environment on both rates of SIB and negative affect (e.g., frowning, crying, and whining). The participant was a 23-year-old woman suffering from mental
retardation and mood disorder. All sessions lasted for 10 minutes. During the fun time program, preferred stimuli, identified via a preference assessment were determined for the enriched environment. The enriched environment contained 12 items (e.g. a tape player, a box, a slinky and stacking clowns). Results showed that SIB and signs of negative affect were highly correlated and that the enriched environment reduced both effectively.

More research is needed in this field to outline the effective components of non-directive play therapy. Play therapists from the past and present believe that play therapy is effective but there is little experimental reports to back this notion. The question of "what conditions make non-directive play therapy effective?" is still lingering in the minds of many researchers as answers have yet to be found.

Behavioral studies of Non-directive Play Therapy

A recent series of studies have begun to investigate NDPT from a behavioral perspective using single case methodologies. For example, Wilson (2000) evaluated the effects of NDPT on the inappropriate play of three developmentally normal children with conduct problems and a history of abuse or neglect. Specifically, she examined the effects of attention (contingent vs. non-contingent)
and the play environment (enriched vs. impoverished) using a reversal design. The main goal was to isolate one of the two variables as the primary effective component of NDPT for a particular child. No significant differences were found between the contingent attention and the non-contingent attention conditions. For subjects A & B, inappropriate play increased only when play environment was impoverished but unlike subject A, they did not decrease when the play environment was once again enriched. That is, inappropriate play behavior increased when exposed to a non-enriched environment and decreased when the enriched environment was reinstated.

Although the environmental enrichment was manipulated at levels of enrichment and impoverishment, it is not clear whether the environment was actually at levels of impoverishment during impoverished conditions. “The procedural fidelity data of contingent attention versus non-contingent attention suggested that it may have been difficult for the participants to discriminate between these two contingencies”. If this was the case, it is unlikely that changing the contingency of attention would affect the inappropriate play of the participants.

Bauer (2001) investigated the possible governing mechanisms of inappropriate play behaviors of three
children with a history of abuse and/or neglect. Functional analysis was utilized using contingent attention plus demands, contingent attention and non-contingent attention. For one participant, inappropriate play behavior occurred more frequently in conditions where either contingent attention or contingent attention and demands were present. For the other two participants, results did not reveal any significant differences between conditions.

Referring to her failure to detect an effect for two of her participants, Bauer noted that due to the swift change in experimental conditions, subjects might have had difficulty differentiating between experimental conditions. Demands that were given during the experiment may not have been reflective of the demands the child may have experienced in the natural environment. The lack of a demand plus non-contingent attention condition is important because its non-presence prevents assessing if demands in the absence of contingent attention had an effect for the subject who demonstrated a responsiveness to the conditions.

Sawyer (2001) studied the effectiveness of non-directive play therapy, defined as non-contingent attention, no demands and an enriched environment with
three developmentally normal children with a history of abuse and neglect utilizing an ABAB withdrawal design. Baseline consisted of contingent attention, demands and a non-enriched environment. During the treatment phase, the playroom was enriched. Along with an enriched environment, non-contingent attention and a demand free environment were instituted. For one participant, non-contingent attention, no-demands and an enriched environment was successful in decreasing inappropriate play behaviors. There were no clear results for the other two participants.

This study did not clearly allow for the assessment of processes that could predict treatment response. In other words, this study did not clearly produce notable results to determine the particular condition or conditions that would be therapeutic for the participants. The treatment outcome of non-directive play therapy might have been delayed because the treatment phase ran for a relatively short time, i.e., eight weeks. If the treatment phase had been carried out for a longer period of time, then the results may have been more notable. Furthermore, no formal comparisons were made by other actual play therapist to ensure that non-directive play therapy was consistently provided throughout the study. This is an important oversight because it would have ensured that the actual
method and techniques of NDPT were provided during the treatment phase.

There are some overall limitations for the three behavioral studies mentioned. All of the three studies utilized a parental daily report to indicate whether or not a certain behavior occurred during the course of the day and then the amount of inappropriate behaviors for that day was totaled. As for this daily report, the intensity or the number of times the child behaved in a wrongful manner was not calculated.

**Future directions for behavioral research on NDPT**

Single case experimental designs are in some ways more practical than group design studies for clinical research because they allow the researcher to make instant changes to the experimental design to accommodate to the fluctuations in the dependent variable and also test out assumptions about the causes of these changes. Wilson (2000) was an example of this. Also, the researcher is able to recognize sources of fluctuations in one subject, which in turn gives important information about possible sources of variability in other similar subjects that are in the same treatment. Moreover, compared to group design studies, fewer participants are required in using single case designs thus making them more practical and less
costly. Replicating and extending more non-directive play therapy studies, especially Bauer, Wilson and Sawyer's studies, is a possibility for future advancement in research on NDPT.

One way to extend the studies is to incorporate prolonging the treatment phase, so that the treatment effects can be more clearly detected. It is possible that the previous studies treatment conditions were of insufficient length to detect a treatment effect. Additionally, more conditions can be added to future studies to get a better understanding of non-directive play therapy. Baseline conditions that reflect natural environmental conditions would be a more accurate measure of initial levels of inappropriate play. One way to reflect the natural environmental condition is to carry out the study in the natural environment itself to get the initial levels of inappropriate play. Another alternative would be to set up the play therapy room similar to the natural environment where the problem behavior occurs. Future researchers and play therapists are encouraged to assess play therapy outcomes in additional meaningful ways (e.g., measure negative affect and use more sensitive in-home measures). Measures of frowning, crying and whining could be incorporated as new measures. A sensitive in-home
measure such as setting up a video camera to record the child in the natural environment (child's bedroom or living room), would strengthen the likelihood of detecting generalization.

According to Wilson's and Bauer's studies (2000), the contingencies of attention may not have been detected by the participants. Future functional analysis studies can be carried out in which the experimenter describes to the participant the contingencies to aid discrimination (e.g. different color sweaters during different conditions). However one drawback to this approach is that subsequent behavior might be the product of instructions, rather than contingencies. Researchers may carry out more group studies using multiple baselines. Multiple baseline design across subjects is a procedure where more than one individual is observed simultaneously. Since more than one individual can be observed at the same time, the length of therapy might be considerably shorter. In the previous studies, the demand was only given once and there are no planned consequences for compliance and non-compliance. Demand conditions in these studies may not have been sufficiently aversive to engender escape behavior. Negative reinforcement could be incorporated into the three
behavioral studies by giving the child a demand until the child emits some kind of a response.

Play therapy is widely practiced among many professionals. Although there are studies on non-directive play therapy, it still has not yielded sufficiently methodologically sound measures of treatment effectiveness. A leading play therapist stresses the fact that more "controlled experimental studies and single-case research need to be done to test specific hypotheses about non-directive play therapy" (Ryan, 1999, p.90). Carrying out this type of research will help therapists become more effective and efficient when working with children, which will finally make therapy more beneficial. Currently, case examples are used by many play therapists to back their support of non-directive play therapy. However with successful empirical evidence, more importance may be given to this particular form of therapy.
References


