CHAPTER II

REVIEW OF THE LITERATURE

In this chapter the literature was reviewed under the following topics: play therapy, theoretical approaches to play therapy (including child-centered, Adlerian, cognitive-behavioral, and Jungian), play media, elementary school counseling, and play therapy in elementary schools.

Play Therapy

Play is a natural means of communication for children. Play flows from children spontaneously and naturally with no inherent goals or purpose (Axline, 1947; Garvey, 1977). Play simply flows from children and they easily devote their full attention to the play. Although Schaefer and O'Connor (1983) maintained that there is no single, comprehensive definition of play, certain attributes are agreed upon. The characteristics of play are that it is pleasurable, intrinsically motivated, and noninstrumental. The benefits of play are evident (Axline, 1947; Gil, 1991; Hellendoorn, Van-der-Kooj, & Sutton-Smith, 1994; Schaefer & O'Connor, 1983). Both the cognitive and affective elements of play allow children to learn about themselves and to express emotion (Cattanach, 1992; Landreth, 1982; Van Hoorn, Nourot, Scales, & Alward, 1993).

Play has been used as a therapeutic approach for almost as long as there

has been psychotherapy with children. In 1919, Hug-Hellmuth (Landreth, 1982) first advocated the use of play to treat children; he was soon followed by Klein, Freud, and Levy (Gil, 1991; Schaefer & Cangelosi, 1993; Schaefer & O'Connor, 1983). Play therapy is distinguished from other therapies used with children by its use of play to identify and treat concerns. Because play is a natural way for children to express themselves, play therapy seems an appropriate way to utilize this affinity (Axline, 1947; Schaefer & O'Connor, 1983). Because of their developmental or emotional inabilities, children can communicate through toys during play in ways that they cannot through language (Brady & Friedrich, 1982; Cattanach, 1992; O'Connor, 1991). Play therapy facilitates the expression of emotions in a safe environment and enables children to deal with distressing situations.

While different theoretical approaches convey their own definitions of play therapy, all play therapies are distinguished from other methods of counseling children by their use of toys as a medium. Play therapists select familiar toys and props, such as dolls, puppets, clay, crayons, telephones, cars, and masks, which facilitate exploration and expression (Gil, 1991; Kottman & Johnson, 1993; Landreth, 1993). Often sand and water trays, accompanied by small figures, are used as another means to facilitate expression in the playroom (Allan & Brown, 1993; Oaklander, 1978; Schaefer & Cangelosi, 1993). Play therapists select toys with intentionality according to their rationale (Kottman, 1995; Landreth, 1991).

All toys are not viewed as facilitative to the goals of play therapy.

Play Therapy for Different Issues

Play therapy is an appropriate intervention for children with a broad range of issues. "Play therapy has been demonstrated to be effective with children of all diagnostic categories except the completely autistic and out-of-contact schizophrenic" (Landreth, 1991, p. 42). In contrast to studies of child psychotherapy and play in general, play therapy research is scarce (Hellendoorn et al., 1994). Nonetheless, the research that is available has shown play therapy to be successful with the following issues:

1. Divorce (Faust, 1993; Mendell, 1983),
2. Grief / Loss (Carter, 1987; Landreth, 1991),
3. Illness / Hospitalization (Golden, 1983; Landreth, 1991; Webb, 1995)
4. Aggressive Behavior / Conduct Problems (Allan & Brown, 1993; Allan & Levin, 1993; Axline, 1947; Cattanach, 1992; Fall, 1997; Fall, Balvanz, Johhson, & Nelson, 1999; Gil, 1991; Kottman, 1993; O'Connor, 1993; Singer, 1993; Willock, 1983),
5. Elective Mutism (Barlow, Strother, & Landreth, 1985; Knell, 1993b; Landreth, 1991),
6. Abuse / Trauma (Cattanach, 1992; Gil, 1991; Mann & McDermott, 1983; Marvasti, 1993; Schaefer, 1994; Terr, 1983; White & Allers,

1994),

7. Learning Disabilities (Guerney, 1983; Johnson, McLeod, & Fall, 1997), and
8. Developmental Disabilities (Hellendoorn, 1994; Johnson et al., 1997; Leland, 1983),

Children in the above case studies often demonstrated a wide range of specific behaviors which had a negative effect on the children and their environment. Problematic behaviors were hypothesized to be triggered by circumstances such as unstable home lives, neglect, divorce, abandonment, physical or sexual abuse, trauma, the death of a loved one, chemically abusive parents, and biological diagnoses. In many instances, if one behavior was present, others likely existed simultaneously.

Play is typically used with young children because it provides a language that does not require verbal communication. Although there is a modicum of play therapy research with adolescents and even adults, it is primarily used with children between the ages of 3 and 10 (Kottman & Johnson, 1993). The available research with older populations is not applicable to this study.

Play Therapy Survey Research

During the last fifteen years, there has been tremendous growth in the play therapy profession (Phillips & Landreth, 1995). Before this expansion, survey research was limited. Kranz, Kottman, and Lund (1998) summarized the

previous survey research as being "dated" and noted that "current application of [play therapy] findings [was] limited by small samples, foci that were either too narrow or too broad and incompatibility of data gathering procedures" (p. 73). Since the recent growth in the play therapy profession, two surveys have illustrated current play therapy practices (Kranz et al., 1998; Phillips & Landreth, 1995).

Phillips and Landreth (1995) surveyed 1166 attendees of the Association for Play Therapy 's annual and summer conferences. Participants were questioned about demographic concerns, professional development, practice issues, and clinical issues. The researchers found sex differences in training and professional identity of individuals who practiced play therapy. The majority of participants of both sexes had not received graduate level training in play therapy, but had attended workshops. Most respondents were not receiving supervision for the play therapy. Respondents were spending less than half of their time doing play therapy. Actual play therapy sessions held by the respondents were likely to be with individual children, once per week, for 11 to 20 weeks.

Phillips and Landreth (1995) described the typical play therapist as a female between the ages of thirty-one and fifty who was relatively new to the profession. She had a Master's degree but received her play therapy training in workshops. She worked in a private practice or an agency setting. The authors

suggested that a vital need existed for graduate level training in play therapy. They believed felt that a stronger child development background would be an asset to participants.

Regarding actual practice, Phillips and Landreth (1995) found "considerable agreement in [the] sample regarding the everyday conduct of play therapy" (p. 24). They had mixed reaction to this consensus, regarding it as both a strength and a weakness of the profession. It was a strength that the consensus indicated a growing coherent profession. They viewed the agreement as a weakness if it resulted from the influence of other factors, such as managed care restraints, rather than actual practitioner agreement. The authors also expressed concerns that the field might lack diversity without varied practices such as the use of different theories . Despite the potential deficit, the authors concluded that it was not a cause for concern and they stressed the overall encouragement of the survey's results.

Kranz, Kottman, and Lund (1998) surveyed 81 attendees of the Association for Play Therapy's annual conference. The aim of their survey was to gather opinions of play therapists' practice and training. The authors found demographic results similar to the Phillips and Landreth (1995) study. The majority of play therapists were Caucasian females between the ages of 30 and 49. More practitioners conducted child-centered play therapy than those based on other theoretical foundations. Kranz et al. (1998) also found that play

therapists received the majority of their training from workshops rather than structured university course work.

Kranz et al. (1998) summarized the results of their survey with recommendations for demographic concerns, professional trends, training and practice priorities, and practice issues. They concurred with Phillips and Landreth (1995) that more male and ethnic play therapists were needed. Kranz et al. hypothesized that the abundance of child-centered play therapists resulted from more exposure to child-centered play therapy in play therapy resources and training. They suggested that a qualitative inquiry concerning why the respondents' chose a particular theory might provide more insight into their findings. The authors also found it critical that new play therapy training opportunities be developed through universities and agencies. Planned structured programs would offer participants a coherent framework that they were unable to obtain from scattered workshops. Finally, Kranz et al. summarized concerns play therapists have about issues related to their practices, including communication with other professionals and parents about play therapy.

Theoretical Approaches to Play Therapy

While play is a natural way for children to express themselves, play therapy is based on a specific theoretical orientation which utilizes play as a method for communication. Because of their developmental or emotional

inabilities, children communicate through toys during play in ways that they cannot through language. Play therapy necessitates an understanding and utilization of an organized theoretical framework rather than random use of toys or games within a classroom or with a talk-based therapy. While a myriad of approaches to play therapy have evolved (Kottman & Schaefer, 1993), the following are some of those approaches which are more likely to be used in the schools.

Child-Centered Play Therapy

Child-centered play therapy is based on Rogers' person-centered philosophy (Axline, 1947). The theory is characterized by congruence, unconditional positive regard and empathy (Corsini & Wedding, 1995). Rogers' person-centered therapy is characterized by non-directiveness (Rychlak, 1981). Axline paralleled Rogers' theory in her creation of child-centered play therapy (Axline, 1947; Gil, 1991; Landreth, 1991). Axline (1947) presented eight basic principles which the therapist must follow:

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist accepts the child exactly as he is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.

4. The therapist is alert to recognize the feelings that the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behavior.
5. The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.
6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.
7. The therapist does not attempt to hurry the child along. Therapy is a gradual process and is recognized as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship.

The child-centered play therapist provides a non-directive atmosphere by allowing the child to make the decisions and structure the play. The therapist's attention is non-judgmental and is focused on the child's words, actions and feelings. The child is able to explore emotions in the therapeutic surroundings. The therapist reflects and responds to the child's emotions to facilitate change. Child-centered play therapy does not require assorted techniques for various problems. Rather than focusing on a specific problem, child-centered play

therapy follows the child's intrinsic drive to heal and grow (Landreth, 1987; Landreth, 1991). The child is able to grow at an individual pace while playing in a trusting environment (Axline, 1947; 1964).

In child-centered play therapy, the therapist reflects the child's actions and feelings. The therapist does not question the child, but may respond if the child questions the therapist. The therapist allows the child to direct him or her and may participate in the play if invited (Axline, 1947; Landreth, 1993). If the therapist is invited to join the play, he or she participates as directed by the child. The child is "the boss" in the child-centered playroom and may do what he or she pleases within the time allotted for each individual session. The therapist sets limits when appropriate and enforceable in order to keep the child safe (Landreth, 1991; Moustakas, 1959). The playroom environment established by the therapist creates a safe place in which the child is allowed to be in control, become empowered, and work through his or her painful or unpleasant emotions. The experience of control in the playroom furthers the expression of individual self-control outside the playroom (Leland, 1983).

Adlerian Play Therapy

Adlerian play therapy is based on Adler's Individual Psychology (Kottman, 1994; 1995; Kottman & Schaefer, 1993) and maintains the same assumptions of human behavior, including purposeful, goal oriented behavior, a desire to belong, a sense of connectedness to other humans, and a subjective reality (Rychlak,

1981).

The Adlerian play therapist has multiple aims. Kottman outlines four stages in Adlerian play therapy (Kottman, 1994; Kottman & Johnson, 1993). Initially, building an egalitarian relationship between the child and therapist is vital. This cooperative relationship is perceived as an equal partnership by both child and therapist in order to develop a shared bond and trust (Kottman, 1995). The child and therapist share responsibility and the child is never forced to do anything.

During the second stage of play therapy, the therapist investigates the child's life-style. Kottman (1995) defined a child's life-style as "the way the child views himself or herself, the world and others and the repertoire of behaviors based on these views" (p. 10).As a result of perceptions of early events, a child sets up a life-style which is faulty. Because this life-style is faulty, the child is misdirected. The Adlerian play therapist must challenge these misdirected goals. Children have four goals; attention, power, revenge, and proving inadequacy. According to Adlerian psychology, the therapist strives to develop an understanding of the life-style and goals of the child.

An Adlerian play therapist forms hypotheses about the child's behavior during the third stage of play therapy. The therapist aids the child in gaining insight into his or her life-style and the resulting faulty goals and mistaken beliefs. Play is used to get at the life-style and to determine these faulty hypotheses.

Finally, the Adlerian play therapist helps the child to develop the courage to consider alternative methods of coping by reeducating and encouraging the child (Kottman, 1994; Kottman & Johnson, 1993).

During a play session, an Adlerian play therapist recognizes the goals of a child and states them back to the child. The play therapist may direct the child to what they need to be doing. Ultimately the therapist connects playroom behavior to the real world in order to reeducate the child. In the playroom, the child is encouraged to brainstorm, adopt, and practice new behaviors for use outside the playroom (Kottman, 1993). Adlerians believe that everyone has feelings of inferiority. Children may feel overwhelmed by parents, friends, or teachers. Play therapy provides an opportunity to deal with emotional struggles rather than internalizing them. Kottman (1995) also encouraged continual consultation with parents and teachers throughtout the process of Adlerian play therapy.

Cognitive Behavioral Play Therapy

Derived from behavioral and cognitive theories, cognitive behavioral play therapy addresses children's involvement and thinking (Knell, 1993a; 1993b). The theory asserts that behavior and emotions are mediated by cognitions, but not the reverse.

A cognitive behavioral play therapist attempts to discover the reinforcements, consequences, and cognitions which shape a child's undesirable

behaviors. Subsequently the therapist can help the child to learn acceptable behaviors (Knell, 1993b). The therapist utilizes numerous behavioral and cognitive interventions to achieve these goals. An example of a cognitive intervention would be a therapist identifying and correcting irrational beliefs of a child. For instance a therapist might tell a young child who says she is hurt (because she has been hurt in the past) that she is okay now. An example of a behavioral intervention would be modeling or role playing. A therapist might use puppets as a model for the child during a play session. Play is the medium for the therapist to introduce new skills and behaviors as well as to observe the child (Knell, 1994) .

Cognitive behavioral play therapy involves the child throughout the play. The play is structured and the therapist is directive, with an agenda for the specific problem. The relationship with the therapist is also a primary therapeutic factor (Knell, 1994). Initially the cognitive behavioral play therapist determines a match between the child and the type of play and play media. During the play sessions, as children are taught to cope, their defective logic is corrected (Knell, 1993b). The child acquires new behaviors which have been reinforced in the play.

Jungian Play Therapy

The ideas of Jung have been applied to child counseling in Jungian play therapy (Allan & Berry, 1987; Allan & Brown, 1993; Allan & Levin, 1993;

Vinturella & James, 1987). Children play out themes related to their own life struggles between good and bad feelings. The Jungian play therapist facilitates ego development as the child gains control over these struggles (Allan & Brown, 1993). Jungian play therapy is similar to child-centered play therapy in the belief that children know how to heal themselves and naturally direct the play to meettheir needs.

The relationship between the Jungian play therapist and the child is a key factor in successful therapy. The relationship stimulates unconscious free expression in the child's play and games and allows unconscious feelings and experiences to come into consciousness (Allan & Levin, 1993). The Jungian play therapist's role is to understand the struggles of the child and reflect appropriately on the child's feelings. The therapist acknowledges both transference and countertransference. Jungian play therapists use an assortment of play media. Sand play is a commonly used form of Jungian play therapy which includes the use of a sand tray and symbolic miniature objects (Allan & Berry, 1987; Vinturella & James, 1987) .

In the process of Jungian play therapy, a child evolves through three stages: chaos, struggle and resolution (Allan & Brown, 1993; Allan & Levin, 1993) During the first stage, the play therapist witnesses the "dramas" in the play, provides limits, redirects activities, and comments on action. Next the play therapist verbalizes the child's struggles as the child's play fluctuates between

expression of good and bad feelings. It is during this middle stage that the therapist uncovers unconscious material and the child develops control over the confusion between the good and bad feelings. During the final stage of Jungian play therapy, the child has a new understanding and acceptance of what has happened to him or her. The therapist continues to link play to issues in the child's life (Allan & Levin, 1993).

Play Media

A fully equipped playroom is not essential for successful play therapy (Fall, 1994a; Landreth, 1991). The selection of specific play media which allow children to express themselves is more important than the quantity of items. Each play therapist adopts a particular rationale: it is vital that the play therapists' choice of play materials is consistent with this theoretical underpinning (Landreth, 1991; O'Connor, 1991). Landreth (1991) documented general characteristics of toys and materials used in play therapy. These characteristics included the ability to facilitate emotional expression (both verbal and non-verbal), to be appealing to the child, to provide experiences for children to feel successful, and to be durable. Play media assist the therapist in developing a positive therapeutic relationship with the child. Play media allow the child to reenact real life events and struggles as well as releasing feelings about them (Kottman, 1995; Landreth, 1991).

Often play therapists refer to a "fully equipped playroom" (Allan & Levin,

1993; Landreth, 1991). A few authors have delineated specific categories of toys appropriate for the playroom (Kottman, 1995; Landreth, 1991). Landreth (1991) suggested three categories to provide toy selection guidelines for play therapists. First, real-life toys will allow children to explore and reenact real-life events and conflicts. These toys would include a doll house and family, toy cars, and trucks. Second, aggressive-release toys, such as toy weapons, aggressive animal puppets, or clay, provide the child the opportunity to vent negative emotions. Third, toys for creative expression and emotional release allow children to test their feelings. Toys in this category would include sand, water, and building blocks.

Kottman (1995) suggested five categories of play media for play therapists. Family/nurturing toys are used by the children to explore family relationships. Events that happen with parents and siblings can be recreated with these toys. Children also may address nurturing issues. Examples of family/nurturing toys include a doll house, sets of animal and doll families, puppets, kitchenware, and baby bottles. Scary toys include frightening animal figures and puppets such as snakes, wolves, or bugs. These toys facilitate the expression of fears, both real-life and pretend. Children also are able to protect themselves. Aggressive toys can be used by children to express fear and anger. They can act out these threatening feelings, use the toys to protect themselves, and address problems with power and control. Some examples of aggressive

toys include guns, knives, handcuffs, hammers, and foam boppers. Expressive toys include creative materials such as crayons, paints, scissors, and play dough. They facilitate emotional expression as well as problem solving and creative expression. Finally, pretend/fantasy toys allow children to role play. They can try out new behaviors or pretend to be a different person. Children are able to communicate through the fantasy. Some examples of pretend/fantasy toys include dress-up clothes, disguises, telephones, and a doctor kit. Kottman (1995) points out that a play therapist must not have all the toys in each category, but should have at least some toys representing each category in order to allow the fullest emotional expression from the child.

Elementary School Counseling

School counseling emerged in the early 1900s as a means to help secondary students find a suitable vocation. Individuals with emotional problems were referred to professionals other than a school counselor (Nugent, 1981). Since there were no pressing vocational issues at the elementary school level, elementary counselors were much less common until the 1960s. In 1964 the National Defense Education Act called for the addition of elementary school counseling programs. From then until now, the numbers of elementary school counselors across the nation has grown steadily.

Through the years elementary school counseling has struggled to establish itself as a profession. Homogeneity in practice and preparation is

necessary to constitute a profession. To demonstrate their value to society and uniqueness, all counseling professionals also must establish their worth in relation to other professionals, such as psychologists and social workers (Blocher, 1987). Blocher also illustrated the need for professionals to gain the public's trust. Such trust is achieved from perceived professional competence, self-regulation, and the provision of a service to the public. Professionals regulate themselves by the creation of educational and training standards as well as ethical codes (Nugent, 1981). Professional development is an ongoing process.

Elementary counselors have continually responded to these professional demands as they have established their roles in the schools. The primary function of elementary school counselors has always been developmental, rather than vocational, as they juggle many different roles, such as individual and group counseling, and classroom guidance (Nugent, 1981). Prevention aimed at high risk students also has been an important component (Miller, 1989). Because elementary school counselors must deal with numerous developmental, social, and emotional issues, frequent coordination and consultation with faculty, parents, and the community is also necessary. How much time to spend providing each specific service has been a source of conflict for elementary school counselors for decades (Nugent, 1981). Elementary school counselors persevere in their efforts to come to agreement on this practice homogeneity.

The ongoing controversy over whether elementary school counselors

should be defined as mental health professionals or educators has ramifications for how these counselors should spend their time (Bailey, 1989; Gerler, 1988). Defining elementary counselors as both mental health professionals and educators allows individual counselors to determine their role as they see fit for their institutions. Without a clear professional standard, however, the confusion threatens the professional identity of school counselors.

Historically, elementary school counselors ideally desired to make individual and group counseling and consultation a priority and were able to fulfill this role (Furlong, Atkinson, & Janof, 1979). However, due to pressures such as more difficult populations, counselors were not able to spend their time as they thought it should be spent (Coll & Freeman, 1997; Morse & Russel, 1988). Morse and Russel (1988) reported that elementary counselors were being assigned such duties as substitute teaching and administrative tasks.

Coll and Freeman (1997) studied the role conflict of elementary school counselors. They defined role conflict as "the sense of being pushed and pulled between conflicting messages from various senders" (Coll & Freeman, p. 253). Elementary school counselors were pulled between the American School Counseling Association standards, administrators' requirements, and their own desires. This incongruence could have a deleterious effect on the elementary school counselor and the counseling program.

Coll and Freeman (1997) examined role conflict as perceived by

elementary school counselors and in comparison with middle and secondary school counselors. They surveyed 1,510 counselors who were members of the American School Counseling Association to determine the work conflict of the participants. Coll and Freeman found that elementary school counselors were much more conflicted about their roles than middle and secondary school counselors.

Resource and structural conflict, role overload and incongruence led to the role conflict in the elementary school counselors (Coll & Freeman, 1997). Resource and structural conflict referred to elementary school counselors' feelings that they should be doing things differently, that they did not have necessary resources and that they were required to do unnecessary tasks. Role overload and incongruence referred to conflicting requests from various people and the need to breach policy to do their jobs. The researchers found significant role conflict in all areas, but the most confusion regarded resource and structural conflict (Coll & Freeman, 1997).

Coll and Freeman (1997) made two suggestions for elementary counselors to combat the role conflict. First, elementary counselors had a responsibility to create a public awareness of their work. In this way they could illustrate how their positions contribute to student development and the school as a whole. The authors added that elementary counselors should be wary before committing to obligations outside their role. Second, professional development

should focus on expertise relevant to current counselor demands. Administrators needed to be educated in appropriate roles for elementary school counselors, and superfluous duties, such as scheduling, should be discontinued (Coll & Freeman, 1997). Coll and Freeman also advocated a concentration on the primary roles of the school counselor in order to alleviate role conflict.

As the profession has grown, the vulnerability of elementary school counselors is evident (Coll & Freeman, 1997; Hardesty & Dillard, 1994). Real constraints prevent elementary school counselors from fulfilling what they view as their ideal roles. This leads to confusion over what their actual role should be. This confusion is evident throughout the elementary school counseling literature. One specific source of this confusion concerns the inclusion of play therapy in elementary school counseling programs.

Play Therapy in Elementary Schools

The use of play media to help children express themselves has been a part of elementary school counseling since its inception. Play materials have been a link between verbal adults and non-verbal children (Myrick & Haldin, 1971). Play therapy differs from the random use of play media in the elementary because it is grounded in a coherent body of theory. Muro and Dinkmeyer (1977) warned that "the utilization of play media is not directly akin to play therapy, although some of the techniques and basic philosophy obviously overlap" (p. 219). Many elementary counselors view play therapy as an essential intervention

that allows them to provide appropriate counseling services for the children in their schools.

Elementary schools strive to provide the optimum learning environment for all children. Many children struggle with learning because they are preoccupied with behavioral or emotional difficulties. Elementary school counselors' responsibilities include addressing the needs of these children. They are in a position to help create an environment in schools that minimizes social, emotional, and developmental barriers to learning. Their counseling interventions make a difference in students' learning (Borders & Drury, 1992; Myrick, 1987).

Elementary school counselors use play therapy to address social and emotional issues that hinder student learning. Ultimately play therapy facilitates students' learning experiences. Play therapy is an “adjunct to the learning environment, an experience which assists children in maximizing their opportunities to learn” (Landreth, 1983, p. 201). As children work through their psychological issues and express emotions in play therapy, they are better equipped to learn. Recent surveys have documented the nationwide use of play therapy by elementary school counselors (Kranz, Kottman, & Lund, 1998; Phillips & Landreth, 1995).

Use of Play Therapy in Schools

Several researchers and elementary school counselors have reported success with play therapy in the schools. While the literature in the area of elementary school counseling is most pertinent to this dissertation, the research is very limited. Although minimal, the research sources present elementary counselors using play therapy with a broad array of populations in their school office.

Several case studies have illustrated success with play therapy in an elementary school setting. Kottman and Johnson (1993) discussed the use of Adlerian play therapy in the schools. A fourth-grade boy, who had been referred to the school counselor, exhibited a need to control in his play. He assumed the role of a teacher and told the counselor how to act. The play therapy gave the student a chance to feel some control and role play new behaviors in a safe environment. Combined with the counselor's interpretations and encouragement, the experience led to a change in his behaviors in school and at home. Allen and Brown (1993) discussed a third-grade boy who was demonstrating behavioral difficulties such as fighting. Following fifteen sessions of Jungian play therapy, both his teachers and his mother reported positive changes in his behavior.

Sand play is a form of Jungian play therapy which has been used in the schools (Allan & Berry, 1987; Allan & Brown, 1993; Vinturella & James, 1987). Vinturella and James (1987) described an eight-year-old boy who was referred to

his school counselor for moody, aggressive behavior. The counselor offered a sand tray and numerous miniature figures for the child to construct a scene. The child was able to communicate through scenes he made with the figures. The counselor aided his healing with interpretations and reflections. Allen and Berry (1987) also described sand play with a second-grader in an elementary school. The child's negative behaviors were reduced and his social skills improved after ten sessions of the play therapy.

Play therapy with labeled children has been shown to address secondary problems these children might experience, such as anger, sadness, and helplessness (Johnson et al., 1997). Six male children from ages five to nine received six sessions of child centered play therapy in their elementary schools. The children's labels included attention-deficit/hyperactivity disorder, mentally disabled, autism, cerebral palsy, and obsessive-compulsive disorder. The 36 sessions were transcribed and analyzed using qualitative research procedures. Results showed that the children were able to express feelings through verbalizations and play. The results also showed that the children were able to express feelings of control over the toys, the therapist, and themselves. The play therapy gave the children an opportunity for more effective coping with the issues in their lives (Johnson et al., 1997).

Play therapy in the schools has been shown to raise children's self-efficacy and improve learning behaviors (Fall, 1994b; Fall et al., 1999).

Elementary school counselors conducted six sessions of child-centered play therapy with 31 children. These children were referred with "coping mechanisms which did not facilitate learning behaviors" (Fall et al., 1999, p. 196), such as seeking attention, being easily frustrated, and acting out. The results indicated an increase in self-efficacy in these children. This was beneficial to the children because children with higher self-efficacy are more likely to persist, take risks and make choices rather than limiting their choices and giving up (Bandura, 1986; Fall et al., 1999).

Play therapy with an elementary school counselor can decrease conduct problems. To clarify differences in the play therapy processes of children with conduct problems and children without conduct problems, McLeod (1999) analyzed transcripts from six sessions of child-centered play therapy in the schools (see also Fall, 1997; Fall et al., 1999) . Descriptive empirical research was used to analyze research questions. Qualitative procedures were used to analyze patterns and differences in play therapy process. Quantitative measures were employed to describe changes on the Conners' conduct problem subscale. Results of the study indicated differences in the play process and subsequently improved behaviors of children who scored at the upper end of the subscale.

Play therapy worked successfully in these instances because children are comfortable with play. Play also allowed elementary school counselors to quickly develop a relationship with their children. The play media in the counselor’s office

send a message of safety and acceptance to the child, relieving anxiety and encouraging emotional expression. When the child enters the counselor's play area, the attention from the elementary school counselor, coupled with the facilitative play materials, stimulates the child's natural healing process (Landreth, 1983).

Issues Concerning Play Therapy in Schools

Elementary school counselors have struggled with the issue of whether play therapy is appropriate for the school setting. The blurred lines between counseling and therapy have added to this confusion. Because of the stigma attached to the term "therapy," terms have been used as substitutes to play therapy, such as "play counseling" and "play media" (Hoffman, 1991; Kaczkowski & Patterson, 1975). This has caused confusion because using play media may not be the same as using play therapy if the language and techniques do not have theoretical underpinnings. The use of play media could refer narrowly to specific techniques. Play therapy encompasses an organized language and a range of techniques within a theoretical model.

Many authors believed play therapy was an essential intervention for school counselors. Landreth (1987) stated, "It seems that it is not a question of whether the elementary school counselor should use play therapy, but, instead, how play therapy should be used in the elementary schools (p. 255)". While some elementary school counselors used play therapy throughout their daily

counseling, others would not consider play therapy or even the use of play media as an alternative to their traditional talk-based interventions. The latter often did not believe that play therapy should be in the schools (Golden, 1985). Golden (1985) was adamant that play therapy does not belong in the school setting. He stated that any form of psychotherapy is a long term process and is not suited for the schools.

Campbell (1993) described this controversy with evidence from both sides. Elementary counselors who were opposed to play therapy in the schools believed that it took too much time. Elementary counselors had numerous commitments and responsibilities, often for hundreds of children. Prolonged individual counseling with one child was therefore viewed as unfair to the other children. Additionally, if a child's problems were so severe that they warranted play therapy, the child should be referred to a counseling source outside the school environment. Golden (1985) also noted that many school counselors are not appropriately trained in play therapy interventions.

Campbell (1993) recommended that elementary school counselors must contemplate these factors as they make decisions concerning their personal curriculum. She also presented an argument for play therapy in the schools, citing a response to Golden (Landreth, Strother, & Barlow, 1986). Landreth, Strother, and Barlow argued that play therapy did not have to be too time-consuming. School counselors trained in play therapy managed to successfully

incorporate their skills and knowledge of play therapy into their school counseling curriculums.

Disadvantages to conducting play therapy in the schools also have been reported. Landreth (1983) indicated four reasons to explain why play therapy is not more prevalent in the elementary school setting. First he referred to the short history of play therapy in the United States. Second, elementary school counselors also had not been in the schools for a long time. Third, school administrators were not familiar with play therapy, and fourth, training programs for school counselors often did not offer courses in play therapy. Landreth concluded, “The assumption seems to be that counselors will be able to use verbal exchanges effectively with children. Such an approach shows little understanding of the world of the child" (p. 200).

Elementary school counselors have presented other obstacles which stand in the way of their successful use of play therapy in the schools. Toys cost money and elementary school counselors have limited funds. Additionally elementary school counselors traditionally have had small office spaces which do not provide adequate space to conduct play therapy sessions. Landreth (1983) challenged these issues, claiming inexpensive toys are accessible, for example, from donations and garage sales. Additionally, elementary school counselors need only basic toys. It is not essential to have an extensive toy collection for play therapy to be effective. Fall (1994a) discussed why space issues need not

be a barrier to the successful use of play therapy. She provided examples such as covering a wall with paper for drawing. Fall suggested that even a "closet" with a few essentials is adequate, because the child's free choice is more meaningful than the amount of space in which to play.

Elementary school counselors also have complained about the noise and mess which may accompany a play therapy session. Noise levels which carry beyond counselors' offices may interfere with regular school functioning and school counselors may not have the time to pick up substantial messes numerous times throughout the day. Landreth (1983) suggested the use of limit setting in both of these instances. These limits could be used to meet the needs of the child and the counselor. The counselor could also discuss the noise levels with school personnel if the noises became an issue.

Summary

The increasing use of play therapy throughout the world stems from the simple fact that play is a natural healing process for children. Universally, play is an inherent aspect of childhood. Play has been used as a therapeutic approach since the beginnings of psychotherapy with children.

Play therapy utilizes children's natural affinity for play. Children use toys to communicate and express feelings that they cannot express through language. Play therapy facilitates the expression of emotions and creates a safe environment for children to deal with troubling issues. Play therapy has been

shown to work successfully with children with numerous social and emotional issues.

As play therapy continues to grow on a national and international level, elementary school counselors have been more influenced by the use of play therapy. As the profession of elementary school counseling has grown, there has been confusion concerning the inclusion of play therapy in the schools. This stems from issues such as whether elementary school counselors are mental health professionals or educators. The more elementary school counselors view themselves as educators, the less they appear to view themselves as therapists. Still, many elementary counselors view play therapy as an essential intervention that allows them to provide appropriate counseling services for the children in their schools.

While some elementary school counselors have found play therapy to be a successful intervention, the sparse research regarding play therapy in general, and concerning play therapy in the elementary school setting in particular, has created a barrier to play therapy's success. While research on play therapy has suggested that play therapy is an effective treatment for children with a wide array of problems, the existing research is not comprehensive, and primarily consists of case reports. For play therapy to become a respected approach in the profession, systematic research beyond case studies is required, including research analyses that compare play therapy's effectiveness with other

approaches.