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Abstract

Twenty-four pre-school children were pre-tested with an orally administered measure of self-concept and randomly assigned to two groups, the Therapy group and the Control group. The Therapy group members were provided with a total of ten 30-minute sessions of individual, non-directive play therapy; the Control group members received an equal number of sessions of individual attention without therapeutic orientation. A post-test of self-concept was performed at the termination of the treatment period. A 2 x 2 x 2 (Treatment Group x Date of Testing x Sex) analysis of variance was performed on the data to determine whether or not a significant pre-post increase in the self-concept scores of the children in the Therapy group occurred as a result of the play therapy experience. Although the mean score increase for the Ss in the Therapy group was notably greater than that of the Ss who received no play therapy, significance at the .05 level was not reached. The author attributes this absence of statistical support to several reasons, the primary factor being the observation that while the majority of the pre-post changes occurred in the hypothesized direction, a few of the changes were so radically discrepant that the impact of the total pattern of change was attenuated in the data analysis.

The Effect of Non-Directive Play Therapy Upon Self-Concept in Young Children

Establishing communication in therapy is frequently a difficult task, and the difficulty increases when one is dealing with a young child who has not yet acquired fluid verbal skills. To facilitate the therapeutic process, it is necessary to find a medium of communication which is both effective and comfortable for the child in that situation; "the therapeutic medium best suited for young children is play" (Ginott, 1961, p.7). Through the manifestations of a child's imagination and spontaneity, one can build a communication bridge which provides both an unobstructed road for his self-expression and a pathway toward learning about the child.

Non-directive play therapy builds this bridge by first allowing the child to be himself. He is fully accepted for who he is, not for who he could or should be (Moustakas, 1953). He is respected as a person who is aware of his own thoughts and feelings, and who is capable of dealing with them successfully. The process also is client-centered in that no questions are asked and neither interpretations nor suggestions are given; it is a growth process which is directed entirely by the child. The participation of the therapist involves providing a sensitive, understanding environment in which the child can feel secure enough to open up and express himself freely. The therapist's task is to listen, to be aware of what the child is experiencing, and to reflect those feelings back to him accurately in order to help him understand what he is experiencing (Axline, 1969).

In this kind of environment, a child's play can generate a total exposure of his "self" so that it is recognized by the child. Only then will he be able to understand himself and direct himself, allowing the therapeutic process to advance.

Play therapy has been offered as a therapeutic process for both

"normal" and "problem" children (Axline, 1969; Moustakas, 1951, 1959; Muro, 1968). It is suggested to be beneficial as a growth experience, in which the attitude of non-directive therapy provides the child with the freedom to explore his world and his emotions within an atmosphere of support and respect. Play therapy also may be considered an experience of catharsis, in that the child is given the opportunity to release all of his repressed emotions and direct them toward the play materials without fear of repercussion (Moustakas, 1953). He can deal directly with what he is feeling, allowing himself to "let go" and express himself wholly.

To rid himself of the uncertainty and the guilt of these hidden emotions should be a positive action for the child. As Axline has stated, "He can bring his self-concept out of the shadow land and into the sun." (1969, p.13). Knowing also that he is still accepted by a significant adult during this process, and that he is, in fact, respected for his ability to deal with his emotions in an adequate manner, it appears correct to suppose that the child does begin to gain confidence in himself and obtain support for his image of himself as a worthwhile person (Axline, 1955).

Some research has centered around social benefits of this hypothesized inner growth. A study by Thombs and Muro (1973) examined improvement in sociometric position as a product of therapy. They asked second graders each to choose five classmates with whom he would like to work on a class project. The students were then assigned scores by receiving five points for being anyone's first choice, continuing to one point for being a fifth choice. Twelve children who had low sociometric scores were provided with 15 half-hour sessions of group counseling with play media. Post-treatment sociometric testing found a significant increase in the scores of this play therapy group over those of a control group of low-scoring children, whose members had no treatment. Although not reaching significance, the score increase of the play therapy group also was greater than that of a similar group of children who received verbal counseling during the treatment period.

Cox (1953), in an early investigation of sociometric status as an

index of behavioral change, also used non-directive play therapy techniques as the treatment intervention. This study's sample consisted of children from an orphanage population, ages 5 to 13 years, who were selected either to participate in ten weeks of play therapy sessions or to receive an equal number of simple rest periods. Initial pre-test data included (1) a quantification of the responses to six TAT cards, (2) sociometric scores, (3) responses to a social adjustment questionnaire, and (4) interview data from the orphanage staff. Subsequent analysis found that (1) and (2) used alone could serve as accurate indicators of total adjustment; these two measures, therefore, were used to determine pre-test scores, and second post-treatment assessment, and a final long-term assessment performed 14 weeks after the termination of treatment.

Results of the second assessment indicated an overall significant difference between groups for both measures. Cox additionally noted an interesting finding related to the age of the subjects. When the data from the sample was separated into individual sub-samples according to the children's ages, it was found that the TAT-based measure delineated more positive change in the younger children than in the older children, and that sociometric status received the greatest enhancement from play therapy experience in the group of older children. Again, at the third test administration, an overall significant difference between groups was found; the major source of this difference was found to lie in the score changes for the older children, however. The implication was that there appeared to be a greater potential in older children for increasing adjustment, especially in the social sphere, as a result of play therapy intervention.

In contrast, McBrien and Nelson (1972) found no support for the efficacy of play therapy as a facilitator of social growth. Their sociometric procedure involved asking each child to nominate three friends with whom he wanted to sit, to play, and to work. The total number of nominations a child received, regardless of place (first, second, or third) or activity, was his score. The twelve children who scored lowest in their first grade classroom were used as subjects, as

were the twelve lowest in a second grade classroom and in a third grade classroom. One-third of each age group was provided with ten 40-minute sessions of therapeutic free play, one-third with equal time in discussion groups which worked with self-disclosure, and one-third with no therapeutic sessions at all. Post-test results found an overall mean score gain of 11.96 points for all groups, but none of the groups' increases reached significance. In addition, the play therapy group's mean increase was the smallest of the three, 10.917 points. Informal teacher interviews provided information to suggest some improvement in attitude and behavior as a result of both therapy procedures, however.

In addition, McBrien and Nelson commented that the age differences among the subjects and the related differences in group processes which they produce were confounding elements in the data. An example was the fact that for first graders a 40-minute session was too long, even a session of free play. This explanation is supported by Lebo's (1952) systematic research on the differences in the play therapy process as a function of differences in the subjects' chronological ages, and his later proposal (Lebo, 1958), based upon this empirical evidence and also upon theoretical evidence from psychoanalytic and learning theories, that the age of the participating child does indeed make a difference in the process of play therapy.

Returning to the original subject of investigation, the relevance of the studies cited to this research lies in the relationship between social experience and a child's image of himself. Cruickshank and Paul (1971) emphasize the point that a child's self-concept does not arise nor does it grow in isolation. His self-concept is an accumulation of images presented to him by interactions with others.

"Popularity" or sociometric position is a visible phenomenon among young children, and the assertions of Cruickshank and Paul are applicable: "Competency" is a salient experience in a social situation and is extremely important to the development of a positive self-concept. A child sees himself as holding a high position among his peers and his image of himself increases as a consequence.

Therefore it seems a plausible suggestion that the augmentation of sociometric position would exist coincident with an augmented self-concept level.

A rather unsophisticated piece of research by Fleming and Snyder (1947) was considered by Lebo (1953) to be a kind of prototype in studies of this contention. These researchers investigated both social and personal changes resulting from twelve group sessions of non-directive play therapy. Three measures were utilized for pre- and post-testing, one of which was the Rogers Test of Personality Adjustment (1931). The population from which they drew their subjects was a group of children's home residents; three girls, ages 8 to 11 years, who had received the "highest" negative rankings on the combined psycho-sociometric measures composed one therapy group, and four boys who also ranked "highest" in that population made up a second therapy group. Scores of a remaining group of 23 children served as control data for this study.

Reviewing the data concerning the Rogers Test, a significant increase in adjustment for the girls in the treatment group was observed, especially on the test's Personal Adjustment index, and no increase was observed in the scores of the ten girls serving as controls. This result was suggested to demonstrate the fact that play therapy may be considered an effective technique for enhancing personal adjustment, i.e., self-concept. For the male group, however, no significant improvement in adjustment was observed; the therapeutic process in this case was believed to be confounded by the sex of the therapist and the great diversity in the degree of maladjustment in the four boys.

Less abstract is the relationship between positive verbalization and self-concept. One notable study reported the number of positive statements which children participating in two conditions of play therapy made about themselves (Siegel, 1972). Sixteen learning disabled children in grades two, three, and four were provided with 16 sessions of play therapy. The four subjects with highest levels of

therapist-offered "accurate empathy, unconditional positive regard, and genuineness" and the four subjects who received the lowest levels of the same three conditions were measured for the number of positive statements made about themselves in the third, eighth, twelfth, and sixteenth sessions. There were no initial differences, but by the eighth session the "High" children were making a significantly greater number of positive statements than were the "Low" children. This amount decreased a small degree in the twelfth session; by the final session the "High" children were again making significantly more positive statements about themselves, and also more insightful statements, than were the "Low" children. The import of this research is that a positive self-image does result from play therapy experience, and that the degree of warmth and respect given to the child will produce an effect upon the amount of this beneficial change.

Siegel (1971) had gathered data earlier which demonstrated improved psychological functioning as a result of play therapy sessions. The purpose of this research was to examine the effectiveness of a variety of types of treatments within a population of learning disabled children, grades two through five. The intervention category with which we are concerned contained: 1. play therapy, 2. parent counseling, 3. both, and 4. neither. Several evaluations were made, and hypothesized factors were analyzed; three primary factors were chosen as the dependent variables. Although significant improvement on all three factors was obtained in the three therapy groups, the result which is important here is that the factor "Interaction between Child and Parent Adjustment" was found to be significantly greater when play therapy, parent counseling, or both interventions were utilized than when neither of the two were used. We may isolate from this study the fact that the play therapy process produced a significantly greater degree of improvement in the children's psychological adjustment than was found in the control group. As Moustakas (1955) has theorized, play therapy appears to offer an interpersonal

relationship within which a disturbed child may progress along the same stages of emotional development that an adjusted child had experienced in his family relationship during the first five or six years of his life. He has the opportunity to work through his initial "diffuse, negative feelings" and proceed toward the "clear, separate, usually realistic positive and negative feelings" which characterize the adjusted child.

Finally, suggesting a parallel function of improvement in self-concept does not seem unreasonable. The process of play therapy, by providing the freedom and security in which a child can explore his self-directed and other-directed feelings, also provides the opportunity for strengthening both self-concept and the ability to deal with others.

Emotional adjustment also is mentioned in a study by Bills (1950), which primarily investigated reading skill improvement in retarded children as a result of non-directive play therapy. He used three Ph.D. students who had had several years of experience in dealing with psychological problems as judges of emotional adjustment. At the termination of the treatment period all three of these judges evaluated the growth in the adjustment of the eight participating subjects and independently agreed that five of the eight children had gained in adjustment. Although the three judges were not in agreement concerning the remaining three children, none of them were judged by all three not to have had some gain.

The effects of play therapy upon a population of retarded children also were examined by Newcomer and Morrison (1974). They divided a sample of twelve institutionalized mentally retarded children, ages 5 to 11, into three experimental groups. In the first group, the children were provided with 30 sessions of individual play therapy; the second group participated in 30 sessions of group play therapy; the last group, the control, was given no therapy at all.

In this study, the Denver Developmental Screening Test (Frankenburg & Dodds, 1970) was utilized, specifically the Personal-Social section and

Language Development section. The result that is important here was that significant increases in the social functioning scores and the intellectual functioning scores were obtained in both therapy groups, whereas no change occurred in the control group. No support was provided for the additional hypothesis that results would differ for the two types of play therapy utilized.

Changes in types and levels of functioning were investigated by Seeman, Barry, and Ellinwood (1964) in order to provide data on the efficacy of play therapy. They based their analysis upon an interpersonal assessment of these changes, using a "reputation test" (Tuddenham, 1952) and a behavior rating scale completed by the children's teachers. The reputation test was constructed with a format such that each child's score was based upon his peers' perceptions of personality characteristics, measured through the use of responses to item-pairs, one of each pair being considered indicative of good adjustment and the other indicative of unfavorable adjustment. Sixteen second and third grade children from an upper-middle class city school, who obtained the lowest adjustment scores of their classmates, were chosen as the subjects in this study. Half of these children received weekly sessions of individual play therapy and the other half of the group had no treatment. Post-testing was performed seven months later, at the end of the school year; a follow-up test also was administered one year after the second testing date. Results from the reputation test indicated more positive score change in the experimental group, compared to the controls, with significant differences occurring in the pre-test vs. follow-up interval and the post-test vs. follow-up interval.

In addition, the authors presented the changes in aggression scores taken from the teachers' ratings. They emphasized that perceived aggression was reduced for each of the therapy subjects, while this reduction was not observed in the control group. The data was suggested to show that the permissive play therapy environment was, in fact, a suitable and beneficial atmosphere even for aggressive

children who are frequently believed to improve only in a controlled environment.

Significant benefits in the sphere of social functioning and in total adjustment as a result of individual play therapy also were reported in a study by Dorfman (1958). For her subjects, she used 17 public school children, ages 9 to 12, who were judged to be maladjusted. In the elaborate design, these children served as their own controls by having their adjustment scores determined both before and after a 13-week no-therapy "wait period" and then again after a period of play therapy sessions. An important instrument used in this research again was the Rogers Test of Personality Adjustment. Data analysis found no significant changes in the subjects' scores to have occurred during the no-therapy period, while both the Social Maladjustment index and the Total Score demonstrated significant score increments following the therapy period. Compared with an independent group of children who were to serve as controls for total time of involvement in the study, the experimental subjects again displayed a significantly greater score change on the Social Maladjustment index, and a trend toward significance in the changes in Total Score.

Using a modified form of the Sentence Completion Test, which is outlined in the study, a significant adjustment decrement was discovered during the no-therapy period, while a significant improvement in adjustment was again exhibited in the post-therapy data. In addition, the improvement was found to be significantly greater in the experimental subjects than that observed in the independent controls.

Here is more evidence for increased effectiveness in dealing with the environment as a result of the play therapy experience; and the suggestion is repeated that a child's self-concept does similarly increase parallel to the social effectiveness.

In a study by Herd (1969), 26 children between the ages of 6 and 11 who were described as behavior problems, were divided into three treatment groups and pre-tested for several variables, including "mature and desirable behavior patterns", "personality adjustment",

"interpersonal relationships", and "adequate use of intellectual capacities". One group was provided with ten sessions of individual play therapy, the second group had placebo play sessions, and the control group was given no treatment. While little statistical significance was found in the post-test increases, interviews and casual conversations with parents and teachers, unsolicited letters, therapists' observations, and statements from the children themselves provided evidence that the play therapy sessions were more successful in producing positive behavior changes than were either the plain play sessions or the control situation.

Thus we have seen positive changes as a result of play therapy demonstrated in several different populations of exceptional children. The experience has provided psychological and social growth for many of the children, and it is suggested that this growth will, in turn, affect each child's self-concept in a positive manner (Axline, 1969).

Browne (1971) began empirical investigation of self-concept changes in a study which compared the effects of three group counseling approaches: verbal counseling groups, play media counseling groups, and classroom meetings. Her sample was chosen from a population of third grade children who initially were rated low in self-concept by the Thomas Self-Concept Values Test (1967). Post-treatment testing found significantly more positive score change on the Self-Referent dimension in the group of children who had received counseling through the use of play media than in the group of children participating in class meetings, and significantly more positive score change on the Peer-Referent dimension in the play media group than in a control group which received no treatment. Browne suggested that play media counseling is a "superior method" in effecting a score change.

Further empirical support for the belief that play therapy is an effective technique for the enhancement of self-concept was provided by Wall's (1973) research with learning disabled children. She randomly assigned six- to thirteen-year-old students, from each of four self-contained classes, either to an experimental group which received

24 therapeutic self-directive play sessions or to a control group which received no treatment. Pre- and post-testing were performed with the Self-Concept and Motivational Inventory (SCAMIN) (Farrah, Milchus, & Reitz, 1968), and data analysis was conducted by using appropriate t tests. These analyses demonstrated a significant positive change in the self-concepts of some of the children in the experimental groups, and no significant positive change in any control group. Wall concluded that additional support had been provided for the hypothesized benefits resulting from a play therapy approach with educationally handicapped children.

Because even the so-called "adjusted" or "normal" child experiences fears, frustrations, and other disturbing affect, he also can benefit from the opportunity for emotional release and for an accepting relationship afforded by the therapy sessions. Moustakas (1955) has expressed his idea that all children, whether disturbed or not, experience the same types of feelings, with the differences occurring in the intensity and frequency of those feelings. Consequently, the atmosphere of play therapy should be as beneficial for the normal child and his adjustment as it has been shown to be for the exceptional child. The hypothesis of this study, therefore, is that a significant increase will be observed in the self-concept scores of normal children participating in individual play therapy sessions, and that this pre-post increase will be significantly greater than any increase which may occur in a control group.

Method

Subjects. Twelve females and twelve males from the River Road Church Nursery School, Richmond, Virginia, were used as the Ss in this study. These children are from basically homogeneous socio-economic backgrounds, coming from middle and upper-middle class families. All of the children are from two-parent homes. The children's ages at the time of pre-testing ranged from four years, three months to five years, four months. None has been diagnosed as having any significant emotional or intellectual impairment; consequently, the children are

considered normal for the purposes of this study.

Apparatus. The Self-Esteem Inventory (Coopersmith, 1967) was used to obtain the self-concept scores of the Ss. However, in order to make this measure more appropriate for the pre-school children used in this study, many of the items first were modified a small degree by simplifying the vocabulary and/or rewording the items to make them more concrete. For example,

14. I'm proud of my schoolwork.
    (I can draw pretty pictures, and work nicely with the games here at school.)
22. I give in very easily.
    (I give in very easily if somebody takes a toy from me.)
38. I have a low opinion of myself.
    (I don't think I'm a good girl/boy.)

Also see Appendix I for a copy of the instrument.

Because pilot work had led the author to question the validity of the SEI when administered to children of pre-school age, a clarifying investigation was performed. To help establish the validity of the self-concept scores, subjective teacher ratings of each child's level of self-concept were collected. The rating forms asked the teacher to assign a score of one through ten to each child according to the image which she believed the child had of himself, a score of ten indicating the highest self-concept level; the two teachers at the nursery school who had the most contact with each of the children provided the ratings for that child. Inter-rater reliability was found to be adequate for these subjective ratings (.61).

The teacher ratings and the SEI scores were then correlated to determine whether or not the self-concept scores obtained on the objective measure were parallel representations of the children's "observed" levels of self-concept, according to the teachers who knew the children well. The coefficient of correlation was found to be high enough to accept the validity of the scores ($r = .74$).

The play materials included a doll family, a doll house, and a

few pieces of furniture to scale, a nursing bottle, clay, drawing paper, crayons, a toy gun, toy cowboys and indians, toy cars, a few puppets, two soft baby dolls, a telephone, a set of building blocks, puzzles, maps, and an inflatable punching toy. This toy selection was based upon the minimum assortment suggested by Axline (1969), supplemented by creative toys for the enhancement of self-concept which were suggested by Muro (1968).

Procedure. All 24 children had the SEI administered to them orally and individually by independent examiners as a pre-test of self-concept.

Six females and six males were randomly selected to constitute the therapy group. Each of them participated in ten 30-minute sessions of individual, non-directive play therapy, one session per week, as defined by Axline (1969). See Appendix II for example session.

The control group, the remaining twelve children, received ten sessions of individual attention in the form of a story-telling period, one session per week.

All 24 children participated in their sessions under the guidance of the same person, the E.

At the termination of the ten-week treatment period, the SEI was administered in a similar manner as a post-test of self-concept.

Results

Although an increase in many of the Ss' self-concept scores was observed, support for the hypothesis of this study was not provided by the data analysis; the change failed to reach statistical significance.

The SEI scores for each of the Ss are shown in Table 1., arranged according to treatment group and sex.

Insert Table 1. about here

A trend toward positive change can be observed in the data; in each of the treatment groups and for both sexes, pre-post increases have appeared for many of the Ss.

To demonstrate this more clearly, Table 2. presents a rank ordering

of the Ss' score changes for each of the treatment groups.

Insert Table 2. about here

With the exception of a few tangential scores, the changes in the therapy group can be observed primarily to be in a positive direction and of greater magnitude than the score changes calculated for the control group, a mean increase of 10.5 points compared with a control mean increase of 3.5 points.

A 2 x 2 x 2 (Treatment Group x Date of Testing x Sex) analysis of variance with repeated measures on one factor was performed to determine the significance of this data. The analysis demonstrated no significance in the overall score increase, $F(1, 47) = 2.86$, $p > .05$, indicating that this increase could have been obtained by chance. Interactions also failed to reach significance; neither the type of treatment nor the sex variable was found to produce a significant difference in the observed score changes of the Ss, respectively, $F(1, 47) = .71$ and $F(1, 47) = 1.76$, $p > .05$.

Discussion

The results of the statistical analysis suggest that the play therapy experience does not produce a significant increase in a child's self-concept. One may assume, therefore, that the positive score changes observed in the data are not of a magnitude sufficient to support a description of play therapy as a catalyst in the growth of self-concept, nor to present it as having an effect greater than that of spontaneous change.

This weak effect may have occurred because true growth in play therapy simply does not exist or is, at most, negligible. Other research, such as McBrien and Nelson's (1972) study and Herd's (1969) data, have produced similar negative results; considering the few good, empirical studies on the outcome of play therapy which have been conducted, these instances of non-support should not be taken lightly. Substantial positive results are not great in number; consequently,

several negative outcomes can become an important percentage.

Speculating, future research may find that play therapy is fun for the children involved, but that it actually does little more than provide situational release for many of them. A child may see himself as being free and accepted in the playroom, but may think of his state of being as a contrivance he experiences only in that situation. He may enjoy the sessions but close them off cognitively, as not related to the real world, thereby not permitting the therapeutic benefit to generalize to that child's total self-concept. Or, perhaps in-depth research will disclose that play therapy is effective only with specific types or ages of children, precluding widespread positive results. The point to be made is that the simplest explanation of an invalid hypothesis cannot be discarded, for a variety of potential reasons.

One must also consider, however, the suggestion that the hypothesis of the efficacy of non-directive play therapy actually could be valid, but the data not strong enough to produce statistical significance.

For example, the author's sample may be too small, so that even a notable increase in the children's self-concept scores may be mathematically attenuated by the statistical procedure. Another difficulty may result from the developmental ages of the subjects in this sample. Because self-concept is more clearly defined in older children, the population referred to in much of the theory and the supportive experimentation, the growth process stimulated in play therapy sessions may not be totally applicable to a child of four or five years of age. In the process of development and maturation, preschool children may not yet have reached a stage in which the insight and responses to it have restorative powers simply becuase the children have not yet reached the base point of development at which play therapy begins. A preschool child may appreciate the freedom and the catharsis, but may not yet have attained the developmental level at which these cognitions can act as a springboard to higher-level functioning.

A second point to consider in discussing the ages of the subjects

involved pertains not to the children themselves, but to the instrument used to measure their self-concepts. The modified form of the SEI utilized in this study has not been formally validated; we have neither the certainty that the situations presented by the instrument's items tap into self-concept of preschool-age children, nor the assurance that the children are responding to the items because of those same images upon which Coopersmith (1967) based his test interpretation. The import of this conjecture is that this instrument may not have been measuring changes in self-concept at all.

A third possible cause of the lack of statistical significance in support of a valid hypothesis concerns the duration and frequency of the play therapy sessions themselves, and the length of the treatment period used in this study. Future research may find that play therapy is, indeed, effective as an augmenter of self-concept if the "carry-over" time between sessions is short or if the sessions continue regularly for a minimum of six months. The possibility of this appears to provide a plausible reason for the failure of this study, but one can only put the blame for an inadequate design upon the current limitation of knowledge of the various aspects of the process of play therapy.

Assuming a positive stand, while an absence of statistical significance is the definitive test, the author believes examination of the raw data also to be important in delineating sources of the statistical disconfirmation and in finding possible starting points for positive effects.

Viewing the score changes of the control subjects, one can see the relative absence of a systematic effect. Although the mean score change was in a positive direction, one can see that this was a result of extreme scatter, with some extra weight on the positive side, rather than a result of a small and consistent positive effect. Score changes ranged from indications of an undermining of self-concept through no observable change to an appreciable enhancement of self-concept. The story-telling experience, therefore, is suggested not to produce a

uniform response in the children used in this sample.

Inspection of the raw data of the therapy group, however, discloses a definite positive trend in nine of the twelve subjects, ranging from an increase of eight points to an increase of 34 points. One can see, also, that those nine numbers seem to cluster around a median score change of 19 points, certainly a marked increase. The two scores which manifest a feasible negative change in self-concept are not considered by the author to be important contraindications for the benefits of non-directive play therapy; neither represents a decrement of more than four positive responses out of the fifty scorable items on the SEI.

The change in the twelfth score of the treatment group displays a child whose self-concept has dropped 36 points in the therapy interval, from a pre-test level within the upper third of the sample. Certainly, the possibility of poor response to the therapeutic environment exists, as does a minor initial confusion in a child's view of himself and his world as a result of the permissive attitude of therapy. The author believes, however, that little in the non-directive play therapy procedure is capable of seriously harming a child's image of himself; perhaps the most negative occurrance in a therapy session would be to have a child become aware of "ugly" feelings he can project, but the supportive attitude of the therapist is always present to counteract conclusions of "I feel bad things, so I am bad." The author therefore suspects that outside influences were at work either during that same ten-week period or on the day of post-testing, producing the marked drop in the self-concept level of that single child.

Returning to consideration of the wide range of score changes obtained for the control group, in the same light, it appears somewhat unlikely that a 24-point drop and a 40-point drop could be produced by a situation in which a child is sought out weekly for the privilege of having a story read to him. Perhaps the only two negative possibilities which occur to the author are that a child may prefer to remain with his friends rather than to be removed, and that

the child may realize that he is merely being taken for story-telling rather than for the privilege of playing with a group of new toys.

The first suggestion's relationship to this study's dependent variable is minimal. Participating in a less-preferred activity may cause disappointment or anger, but the child is able to recognize the external source of the unpleasant decision. Logically, a child's concept of himself should not be markedly affected by this decision or its resulting situation. The second suggestion admittedly does have some connection to self-concept level, however. It is feasible that a child would feel "second-rate" if his peers were being chosen for a more attractive activity. Supposing this to be true, the author questions the potency of this discovery for a child whose original self-concept was judged to be in a strong position of 82 or 90 points on the SEI. Again, outside sources are believed to have contributed to this decrement.

Finally, the observed 30-point and 48-point increases in two of the control group's subjects appear to diverge considerably from the general picture of the data. The important question here involves the probability of a child's self-concept to increase to that degree simply from the individual, non-therapeutic attention. Subjective speculation produces the conclusion that in a child whose self-concept is extremely low initially, any positive experience could provide a boost; this appears to be the case for one of the children, whose pre-test score was at 30 points. In this explanation, however, the salient fact is the exceptionality of that case; in view of the hypothesis of this study, the scores of that subject could be disregarded.

The second marked increase in the self-concept of a control subject appears to offer no immediate explanation. One may conjecture that the individual attention also was sufficient to affect this subject significantly, although her initial self-concept was not unusually low; alternatively the suggestion is plausible that external factors may have influenced her affective state on either of the two test dates, or during the treatment interval.

Although extraneous variables certainly could have confounded all of the test results, the configuration of the data indicates to the author the appropriateness of informally excluding only the single, extreme decrement in the therapy group and the four suspect score changes in the control group, confining the discussion to the scores which present a cohesive form.

This new picture of the data, however, is not meant to alter the description presented earlier; no systematic, positive effect is observed in the control group's score changes, while a strong increase can be seen in the therapy group's scores. The author's subsequent opinion, therefore, is that the play therapy experience most likely does produce an increase in self-concept greater than that produced by attention alone.

Implications and Applications

The results of this study may serve to define and direct future utilization of non-directive play therapy. Specifically, it is a quantified demonstration of the theoretical growth process achieved in play therapy; the data has demonstrated that, for a population of normal preschool children, the technique has possible potential for becoming supported as an efficacious method of producing an augmentation of self-concept.

In a ten-week period of weekly sessions, a child appears to receive sufficient feedback and stimulation to catalyze a hypothesized growth process. He experiences a basic freedom, the freedom to be himself, which is too frequently absent from his daily life. He can do and say what he wishes, and guide the entire world of the playroom, without the constraints of "oughts" and "shoulds". He becomes able to see the person he is.

This experience of insight apparently generates the growth process. It provides a fundament for growth in self-concept because it exposes the self. Through the freedom and security of the play therapy experience, the child begins to uncover and discover the person he is and the things he enjoys.

Insight alone, no matter how powerful the revelations, cannot produce the entirety of the therapeutic effect; in isolation, a child's perception of himself has no guideposts with which he can measure his thoughts and his behavior and assess them positively or negatively. Feedback is necessary, and this provides the returning curve of the spiral process of growth in play therapy.

The therapist's key function is to supply feedback for the child's expressions, adding to this insight; more importantly, however, it is to demonstrate acceptance of all the child has expressed.

In play therapy, the child should never feel that his thoughts and actions are inappropriate; the therapeutic relationship is constructed in order to assure him that he is sufficiently responsible to decide what is appropriate for himself. The singularity of the play therapy situation is that predetermined ideas of the proper use of the toys and of proper conversation are absent. All of the child's behavior is acceptable.

This is not to say, however, that the child's behavior is continually lauded. The absence of praise in the therapist's feedback is equally important if the child is to know his true self is accepted. He is not to be told that he is correct in his thoughts and actions, because this is as much a violation of the therapeutic atmosphere as is disapproval. Again, indicating correctness implies predetermined ideas of appropriate behavior, and removes the controls from the child.

Acceptance alone supplies the guideposts in the play therapy process; consequently, the feedback tells the child he has worth as a person.

The theoretical spiral process suggested by the author therefore begins with the reflection of the child's feelings as a part of this feedback, which assists in the definition and clarification of his true identity through his own verbal and behavioral expression. The child then finds that his real self is exposed and is fully accepted by a significant adult. He becomes more able to observe and to accept himself; and he responds with a higher-level concept of the self he observes.

The need for a controlled process of this type obviously results from the unfortunate fact that children frequently cannot obtain empathy and acceptance in their usual environment. Even well-adjusted children may experience situational difficulties, and this study has suggested the possibility that the supportive atmosphere of play therapy can help these normal children work through situational, negative feelings and grow toward a higher-level self-concept.

An important function of this data, therefore, is to serve as one more bit of evidence in an area that is deficient in empirical research. Information concerning non-directive play therapy has progressed not far beyond the theoretical and information-gathering stage; although the few studies cited earlier are valuable attempts at gathering statistical evidence for the efficacy of the play therapy process, they are essentially the first attempts. Psychologists and educators are only beginning to glean the empirical findings upon which full-scale implementation of the play therapeutic technique should be based.

This paucity of statistical support is clearest in the research specifically involving self-concept and the process of play therapy. Knowledge of this area of investigation appears especially important when one considers that an elevated self-concept has been suggested as a prerequisite for adequate emotional functioning and for academic success. The frequently observed problem of low self-concept in otherwise well-adjusted children who are not functioning well in academics and in the socialization skills should provide the impetus for growing interest in the etiology and augmentation of low self-concept levels in young children.

Only when a sufficient amount of statistical evidence is gathered will one be able to state if non-directive play therapy has the characteristics necessary to be utilized immediately, needs to be modified or supplemented and tested again, or does not show enough potential to justify its implementation.

We are dealing with a procedure which requires time, effort, and expense. While a significant increase in a child's self-concept is certainly worth the price, it would be unwise to utilize the procedure

ubiquitously without first demonstrating that the same therapeutic result could not be obtained from a more simple and less costly process such as simple sessions of individual attention. So this study does appear to assist in making that decision through the demonstration of a possible effect from the play therapy experience, one which may be greater than that produced by attention alone.

The author feels justified in offering this data in support of the body of evidence which calls for increasing utilization of the technique in homes and schools, in addition to its use in professional counseling situations.

For example, non-directive play therapy techniques recently have been suggested by Ohlson (1974) for use in parent-child counseling. The benefits of self-expression for the child could be provided by any trained therapist, but a learning experience might be provided for the parents as well, if these techniques are used in the home. The true listening attitude serves to open the parents to their child and his problems and to help them become aware of what he is really feeling; and the same attitude demonstrates to the child that his parents are attempting to understand, and that they do care.

Moore (1971) has proposed therapeutic play sessions in the schools for "those disturbed primary school children whose maladjustment does not seem severe enough to warrant special placement or intensive psychotherapy" (p. 19). She feels that providing access to meaningful communication with a caring adult is a positive move that educators can make. These "borderline" children will then have the opportunity to receive acceptance and experience growth before they have reached that "border" and all the pain it represents.

Communication and expression are also believed by Nelson (1966) to be the major purposes of play therapy when used with normal children who are seeing a school counselor. The counselor is not to analyze and question, according to Nelson, but to use whatever media she can to facilitate communication; and play is considered the best pathway. Nelson (1967) later restates this philosophy of "whatever

works best" (p. 145), and additionally mentions the "need for good hard statistical data" in order to determine what counseling techniques are, in fact, most effective.

One could also foresee play therapy as a planned activity in the weekly schedules of child care centers and nursery schools in an early program of "preventative mental hygiene for normal children" (Moustakas, 1959, p. 49). Through programs such as these, the author might expect two results. First, young children could be taught to explore and express the feelings they are experiencing, and to deal with those feelings in a healthy manner. This does not mean unbridled release would be encouraged, however. There is no need to fear that this play therapy experience would reinforce unrestrained expression of anger or other uncontrolled behaviors which are socially inappropriate. As Seeman, et al. (1964) have discovered, even an atmosphere which accepts aggressive behavior can provide for its reduction in daily life. In addition, as Axline (1969) explains in her description of the value of limitations in a clinical therapy situation,

> The therapist is helping the child to face the problem of adjustment to a realistic world. He will be stopped outside the clinic when he attempts to display such destructive behavior... it seems as though it would be more of a help to the child to let him face the limitations that human relationships will force upon him than to let him give free rein to destructive actions. (p. 130).

And again,

> The child is given the opportunity to get rid of his tensions, to clear the air, so to speak, of his troublesome feelings, and by so doing he gains an understanding of himself that enables him to control himself. (p. 131)

The second result the author might expect, apart from this teaching

function, is the pure catharsis of regular play therapy sessions. A child who is experiencing regular "release times" will not have the opportunity to store up damaging emotions, nor will he learn to do so. He will, instead, never need to feel the pain nor the confusion of repressed and misunderstood emotions; they will be expressed, worked through, and forgotten.

Nickerson (1973, 1974) also has suggested the utilization of play therapy outside the clinical setting for both a preventative function and a method of promoting maximal adjustment in all types of children. In her theoretical paper (Nickerson, 1974), she additionally supports the school as the best setting for play therapy; her reasons center around the fact that many of the problems of children who are called "normal" involve specific school-related difficulties which are detectable in tasks important to school functioning, and which require communication among school personnel. Therefore, if extended empirical evidence indicates success with play therapy, its place in the schools should be given priority.

In summary, this study is helping to conduct the belief that non-directive play therapy is a technique which may be utilized for the enhancement of effective functioning in any population of children, and is simple enough and meaningful enough to be practiced wherever it is needed, in the clinic, in the home, and in the school.

Therapist's Observations

In the role of therapist, the author observed several interesting processes and behaviors which are worth mentioning, although parenthetical to the specific research effort of this thesis.

One category of comments deals with what is happening within the therapist, primarily as a product of the non-directive attitude. The first insight encountered was that adults rarely relate to children with real effort at communication; spontaneous greetings and responses usually appear to have the adult in mind, not the child, and perception of the child's affective state is frequently not an end in itself. "How are you?" is primarily a rhetorical question, as it is

in many adult-adult interactions. "You're a nice-looking boy" may please the nearby parent, but does it really tell a child anything meaningful? "I have a little girl at home just like you" and "I'll bet you're four years old" only serve to pull the attention to the adult. Perhaps "You certainly look happy today!" would be a more effective message, and "Are you out shopping?" would give the child a greater opportunity to communicate.

A second observation is that adults are rarely non-directive when decisions are to be made or a conflict settled. Even the understanding parent who takes time to explain why a situation must be the way it is, expresses the foregone conclusion that it will be the way the parent wants. Beginning with an acknowledgement of the child's position may help, as in "I see that you're unhappy about having to stay home today." The next pitfall to be avoided, however, is to add "...but that's the way things are." Why not stop with a reflection of the child's feelings and allow him to talk it out? Certainly the "wasted time" will have some positive consequence, if only to assure him that an adult does consider his feelings.

Two conclusions project from this discussion. First, the suggestion is that the attitude of non-directive therapy can be and should be incorporated into all our interactions as a kind of daily therapy; secondly, the author believes that this non-therapeutic response attitude adults have modeled and assimilated becomes a covert nuisance to a novice non-directive therapist.

Consider a child who has just completed a puzzle and, smiling, holds it up for recognition. An acceptable non-directive response would be "I see you've finished that puzzle", which unfortunately would be natural to all of us. This response, however, emphasizes the action itself; it focuses on the ability to perform, rather than on how the child feels about his performance. "Legal", but poor quality responses of this type were mistakes made by this author until the misguided emphasis was perceived. "You look really happy about doing that puzzle" communicates more to the child of an awareness of

self; the unstated element of being "OK" only because one can achieve is diminished.

Another of the therapist's difficulties with a non-directive attitude involved the situation in which a child wants an answer. Suppose he builds a house with blocks, commenting, "That's a pretty house." The therapist's response might be "You really think that's a good-looking house", the child would respond "Yes", and the interchange could continue. Occasionally, however, the child is looking for real agreement, and is totally frustrated by a noncommittal response which seems to him to mean "All I can say is that you think it's pretty, but..." The author's suggestion is that one must be aware of this kind of situation, in order not to jeopardize both the therapeutic relationship and the child's self-concept.

An additional comment concerns early termination of a therapy session. The author, of course, held the belief that the sessions were therapeutic and should continue the full 30 minutes. However, one must respect the child's awareness of his needs, and allow him to determine the end of the session just as he determines its course. If he feels finished after 20 minutes, the therapist must forget the "shoulds" and allow him the freedom to leave. As Moustakas (1959) believes, this also is a part of the attitude of non-directive therapy.

The play therapy approach was found to provide unexpected assistance in preserving a child's self-concept when he was faced with a task too difficult for him, such as a difficult puzzle. The communication of an awareness of his feelings and an acceptance of his response to the task appeared to provide the child with the ability to acknowledge his poor performance without denial, embarrassment, or long-term frustration and anger. The author especially supports non-directive feedback as an efficacious method of working through a situation of this nature.

Axline (1969) notes the importance of preserving the confidence of the play sessions with each child. For the purpose of planning for widespread implementation in school systems, the author noted a

minor problem with the method of removing children from one class in a back-to-back sequence. Because the children were aware of each other's play time, many of them asked with which toys others had played, whether or not they chose the same activities as others had chosen, etc. The author was somewhat disconcerted by the insistence which a few of the children displayed in asking about the toy selection or the conversational topics pursued by their "best friends"; nevertheless, it was felt that passing on even the most seemingly innocuous information would be a violation of trust.

A final observation involving the therapist's internal perceptions concerns times when a child acts out an entire situation, but provides no clues as to the meaning of the scene. The non-directive approach can only extract from a situation as much as the child chooses to express, and sometimes this is not enough to clarify the meaning for the therapist. In view of the technique's basic attitude, however, the child's understanding of the associations and his catharsis must be the important products; the non-directive therapist shouldn't need to uncover and analyze the antecedents of the behavior for her own gratification. Being kept in the dark is often frustrating, but is sometimes an unavoidable consequence of this therapeutic orientation.

Several points about the therapeutic process and structure itself additionally were noted. The first involves the length of the session. As might have been expected, 30 minutes of solitary play with a limited group of toys appeared to be too long for several of the four- and five-year-olds in this sample. Some of them were observed to be content with one favorite toy for approximately 15-20 minutes and then, having finished the dramatics or project, indicated that they wanted to leave the playroom. Others of the children, throughout the treatment period but especially in the initial sessions, wandered from toy to toy for several minutes and then remarked that they didn't know what to do. The author noted, however, that many of the children quickly became involved in an activity which extended for 15-20 minutes and then moved on to another activity enthusiastically, and

were not able to finish their play because of the session's time limit. The author suggests, therefore, that a 30-minute session does appear to be an appropriate time period for children of preschool age.

The second point regarding this topic concerns the toy selection provided for the study. Although practicality forces many play therapists to be able to pack their "playroom" into a suitcase, the author recognizes the fact that a larger number of available unstructured play materials appears to be advantageous. Consequently, in planning future implementation, a guideline of "as extensive a selection as is possible" should be remembered.

Interestingly, a pattern was observed in most of the children's toy selection. Most of the children spent at least the first session exploring all of the toys. Later in therapy, most children abandoned their least-preferred toys and many eventually ignored all except one or two favorites. However, the author noted a phenomenon which appeared in the entire sample. Those children who had identified a favorite toy spent most of the 30-minute session playing with that toy; by the eighth or ninth session, however, children who had not found a favorite toy or those who had fatigued with a favorite toy returned to the initial behavior of wandering back to each toy in search of something interesting, apparently forgetting that they had previously determined a hierarchy of satisfying play materials, and had discovered the "worthless" toys.

The inclusion of puzzles, which is not suggested by Axline, and the availability of crayons and paper were observed to offer a function not specifically stressed in the theory. These activities, being much less conspicuous than, for example, playing with the dolls or the toy cars, provided an opportunity for what this author calls "withdrawal play" -- activity which can be performed in a small amount of space, makes no sound, and can essentially be "hidden" from the therapist. Doing puzzles and coloring are believed to be good activities for the apprehensive child who doesn't want to jump into

active play from the first, or for the child who is having a bad day and feels a temporary need to withdraw.

These occasional instances of "withdrawal play" form a part of the changing levels of involvement in the process of play therapy observed by the author. The supportive atmosphere of the play therapy situation truly appeared to encourage honest expression of the children's affective states from session to session. A therapist could easily be aware of good days when a child comes in and exhibits positive play behaviors and verbalizations; further, the therapist also could observe signals of a bad day when the child either uses aggressive play for catharsis, or regresses to quiet, restrained play, severing himself from the usual, open interactions with the therapist.

These and other individual differences demonstrated in the play therapy process were interesting to note. There appeared a wide diversity in the ease with which the children adapted to the play therapy situation.

One child had a particularly difficult time in the unstructured atmosphere. He spent his first session sitting on a chair with his back to the therapist, engaging in an extremely ritualistic behavior of lining up the toy cars on his seat, knocking them off one at a time, and lining them up again. He expressed a desire to leave the playroom after approximately 15 minutes of this rigid behavior, and "explained" fluidly about his sore neck, his parents' disapproval of toy guns, and all the other reasons why he should return to his class. This child remained for the entire session on his next visit, but again played only with the cars and in that same manner. Although he eventually reached out to a few more of the toys, he appeared rather restrained in his play throughout the treatment period; interestingly, he became rather free in his verbalization although the restricted activity remained.

Some of the children appeared to follow a natural pattern of adaptation, displaying hesitancy in the first one or two sessions, gradually working toward complete use of the freedom of the situation.

Some of these children were curious about the reasons behind the freedom provided for them; "Why do you let people do anything?" was one question presented to the therapist. Many of the children additionally appeared to need reassurance, and sometimes stopped their play to ask, "Can I really play with anything?" or "I can really just leave this [a toy] here and play with this [another toy] now?" Most of the children were simply elated, however, because of the permissiveness of the situation; "I can do anything I want" and "I don't even have to clean up the mess" were heard frequently.

A few of the children were observed to display almost an instantaneous acclimation to the therapy atmosphere. They ran directly to the toys from the first, playing and verbalizing freely throughout every session.

Only a few instances of deliberate limit-testing were noted. One child in particular appeared to be curious about whether or not minor "assaults" would be permitted. She enjoyed pasting the playdoh on the therapist's hands and bumping the toy cars against her feet, although she never attempted truly aggressive moves. Most of the children were not overtly aggressive, although there were a few who were pleased by the fact that they didn't have to clean up the playroom, and appeared to experience a great deal of pleasure scattering the toys to the four corners of the room.

Another observation concerns the children's interactions with the therapist during play. Most of these normal children appeared to be very self-sufficient in their play activity; few needed to call upon someone to "See what I'm doing" or to "Look at this." These children generally asked more challenging questions such as "Do you know what this is going to be?" or "Do you know why I made this door open?" The majority of the verbalizations noted were of a descriptive type: descriptions of their play activity, of their "outside activities", and of themselves.

A few of the children, however, appeared not to enjoy playing with certain materials alone. For example, two of the girls liked

playing with the playdoh but always brought the cans next to the therapist's chair to play, occasionally giving her pieces to mold; one boy preferred doing the puzzles during each of the therapy sessions, but frequently wanted to do a puzzle only if the therapist had one in her lap, also.

Finally, the author noted the content of most of the verbal and play behaviors primarily to be involved with performance, with doing rather than feeling. Much of the spontaneous expression described situations and activities, and feedback surprisingly called out a majority of performance-oriented statements. Not that affective descriptions did not occur; the point is that, in the author's opinion, the children appeared almost more interested in performance than in emotional concerns. Again, perhaps this point returns to the suggestion that "normal" children whose emotional states do not obviously need attention have learned to be a part of a world of adults who ignore real communication of affect.

For further illustration, two examples of the author's therapy encounters are provided in Appendix III, the first side of the accompanying tape.

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Appendix I

Modified Self-Esteem Inventory

	Like Me	Unlike Me
1. I spend a lot of time daydreaming.		
2. I think I know lots of things and can do things right.		
3. I often wish I were somebody else.		
4. I'm a nice girl/boy and I'm easy to like.		
5. My parents and I have a lot of fun together.		
6. I never worry about anything.		
7. I find it scary to do things in front of the other children and have them watch me.		
8. I wish I were younger.		
9. There are lots of things about myself I'd change if I could. (give examples: smarter, nicer, better looking)		
10. I can make up my mind without too much trouble if my parents or teacher gives me a choice of doing two things.		
11. I'm a lot of fun to play with.		
12. I get unhappy and cry alot at home.		
13. I always do good things instead of bad things.		
14. I can draw pretty pictures, and work nicely with the games here at school.		
15. Somebody always has to tell me what to do.		
16. It takes me a long time not to be scared when I'm with anything new.		
17. I'm often sorry for the things I do, and say "I shouldn't do that."		
18. Kids my age like me.		
19. My parents care about my feelings and want me to be happy.		
20. I'm never happy.		
21. The drawing and games I do here are the best I can do.		
22. I give in very easily if somebody takes a toy from me.		
23. I can usually take care of myself.		

	Like Me	Unlike Me
24. I'm pretty happy.		
25. I would rather be with kids younger than me.		
26. My parents make me do things that I really don't know how to do.		
27. I like everybody I know.		
28. I like to be a helper here at school.		
29. I always know why I do things.		
30. It's pretty tough to be me.		
31. Things are all mixed up in my life.		
32. When I have an idea, kids usually do what I say.		
33. Nobody pays much attention to me at home.		
34. I never get scolded (yelled at).		
35. I wish I could do better things here at school.		
36. I can make up my mind and not change it.		
37. I really don't like being a girl/boy.		
38. I don't think I'm a good girl/boy.		
39. I don't like to be with other people.		
40. There are many times when I'd like to run away from home.		
41. I'm never shy (bashful).		
42. I often feel embarrassed by things I do.		
43. I often feel unhappy and want to cry in school.		
44. I'm not as nice looking as most people.		
45. I tell people the things I think and I'm not afraid.		
46. Kids pick on me very often.		
47. My parents know what I like and what makes me sad.		
48. I always tell the truth.		
49. My teacher makes me feel that the things I do here at school aren't very good.		
50. I don't care what happens to me and I don't care if I ever have fun.		
51. I can't do pretty and nice things.		
52. I get unhappy and cry easily when I'm scolded (yelled at).		

	Like Me	Unlike Me
53. Most people are better liked than I am.		
54. I usually feel like my parents are making me do things I can't do and don't want to do.		
55. I can talk to people and have fun and never be shy.		
56. I often feel like I'm not doing good in school.		
57. Things usually don't bother me.		
58. I usually forget when my parents or teachers tell me to do something.		

Appendix II

Axline's Non-Directive Play Therapy

Example Session

We went down to the playroom and Dibs jumped into the sandbox and began to dig a deep hole in the sand. Then he went over to the doll house and got the father doll. "Do you have anything to say?" he demanded of the doll. "Are you sorry for all the mean angry things you said?" He shook the doll, threw it around in the sandbox, hit it with the shovel. "I'm going to make a prison for you with a big lock on the door," he said. "You'll be sorry for all the mean things you did."

He got the blocks and began to line the hole with the blocks, building the prison for the father doll. He worked quickly and efficiently. "Please don't do this to me," he cried out for the father doll. "I'm sorry I ever hurt you. Please give me another chance."

"I will punish you for everything you have ever done!" Dibs cried out. He put the father doll down in the sand and came over to me.

"I used to be afraid of Papa," he said. "He used to be very mean to me."

"You used to be afraid of him?" I said.

"He isn't mean to me any more," Dibs said. "But I am going to punish him anyhow!"

"Even though he isn't mean to you now, you still want to punish him?" I said.

"Yes," Dibs answered. "I'll punish him."

Back to the sandbox he went ....

Dibs walked over to me and drew my arm around his waist. "He is my father," he said. "He takes care of me. But I am punishing him for all the things he did to me that made me sad and unhappy."

"You're punishing him for all the things he used to do that made you so unhappy?" I said.

Dibs walked back to the doll house.

(Axline, 1964, pp. 179-180)

Table 1.

SEI Scores

	Pre-Test	Post-Test
Therapy Group		
Females		
S1	70	92
S2	82	90
S3	74	86
S4	48	82
S5	78	74
S6	78	70
Males		
S7	60	86
S8	68	86
S9	66	86
S10	56	80
S11	58	68
S12	78	42
Control Group		
Females		
S13	60	90
S14	76	86
S15	86	84
S16	74	80
S17	80	78
S18	76	70
Males		
S19	68	68
S20	54	66
S21	52	62
S22	82	58
S23	90	50
S24	42	40

Table 2.

Pre-Test vs. Post-Test Changes in SEI Scores

Therapy Group	Control Group
+34	+48
+26	+30
+24	+12
+22	+10
+20	+10
+18	+ 6
+12	0
+10	- 2
+ 8	- 2
- 4	- 6
- 8	-24
-36	-40
Mean Change +10.5	Mean Change +3.5