DOCUMENT RESUME

ED 033 426 CG 004 631

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TITLE Monitored Play Therapy: Conceptual and Methodological Issues.
INSTITUTION American Psychological Association, Washington, D.C.; Georgia State Coll., Atlanta. Child Development Lab.
Pub Date 2 Sep 69
Note 14p.; Paper presented at the American Psychological Association convention, Washington, D. C., August 31-September 4, 1969

EDRS Price EDRS Price MF-$0.25 HC-$0.80
Descriptors *Aggression, Behavior Change, Behavior Development, *Behavior Patterns, *Children, *Constructed Response, Data Analysis, Data Collection, Males, *Play Therapy, Psychotherapy

Abstract

There are many unanswered questions about play therapy. Monitored play therapy is an attempt to discover answers to these questions. The main emphasis is on quantitative recording and analysis of the process and outcome of play therapy. However, because of its newness, monitored play therapy also has some weaknesses. The main strong point is the conceptual and physical separation of the stages of play into aggression and construction. The use of separate play rooms for aggression and construction eliminates many problems. However, some of the weaknesses found in this framework are: (1) the equality of stimulus properties of the two rooms, (2) differences in times required to complete games in the two rooms, (3) the importance of a skill factor in playing games, (4) little opportunity to manipulate aggressive materials in the clients own way, (5) no opportunity for the destruction of objects, and (6) no creative outlet for aggression. The role and limits of playroom aggression are explained as being within the limits of social acceptability. Monitored versus traditional play therapy is discussed, primarily with respect to the conceptual framework, data, and value of play therapy over no therapy. (KJ)

ED033426

CG 004 631

Monitored play therapy: conceptual and methodological issues[1]

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Interest in play therapy has traditionally focused on the needs of the client rather than the need for research data. The literature reflects this emphasis, and is replete with case histories and subjective accounts which describe a variety of approaches to play therapy. However, it is difficult and, in many cases, impossible to replicate or objectively evaluate the findings of these reports. Only a handful of researchers (e.g., Landisberg and Snyder, 1946; Fleming and Snyder, 1947; Lebo, 1955; Lovaas et al., 1965) have applied experimental methods to study and control the significant aspects and effects of play therapy. Even in these studies, various limitations and methodological weaknesses have frequently obscured the interpretation and generality of their findings. Ginott (1964) pointed out that research has "left unanswered the most important questions about play therapy: What is the process of play therapy? What variables critically affect this process? What are the behavioral changes that follow play therapy? How does the effectiveness of play therapy compare with that of other treatment methods?"

With its emphasis on the quantitative recording and analysis of the process and outcome of play therapy, monitored play-therapy appears to be the most promising avenue available for discovering the answers to these

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[1]Paper read at a symposium on "Current developments in monitored play therapy," presented at the annual meeting of the American Psychological Association, Washington, D.C., September 2, 1969.

[2]The author wishes to thank Dr. Ray Craddick, Georgia State College, for his advice and suggestions.

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critical questions.[3] As a tool that can simultaneously serve the needs of both the clinical practitioner and the researcher, this approach can provide a needed link between these two heretofore isolated areas of interest.

However, monitored play-therapy is still in a preliminary stage of formulation. There are several aspects of it which need further clarification before it can be considered a valid treatment tool. In order to avoid the mistakes ot the past, these weaknesses must be acknowledged and, wherever possible, eliminated. The unresolved problem areas fall into three main categories: (1) the methodology, (2) the role and limits of play room aggression, and (3) the value of monitored play-therapy over other methods of therapy and over the absence of therapy. The first category is unique to the monitored play room; the other categories refer to issues which are applicable to all forms of therapy.

Methodology

The outstanding innovative feature of monitored play-therapy is the conceptual and physical separation of the stages of play room behavior into aggression and construction. Although the use of separate play rooms for aggression and construction eliminates many of the problems of traditional play therapy, it creates several new problems as well. The arrangement of the monitored play laboratory is based on the assumption that after an initial exploratory stage, the toys in the aggressive room will elicit only aggressive behavior and the toys in the constructive room will elicit only constructive

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[3]In working with aggressive older children, Ginott (1961) has developed an activity room with many materials which are similar to those in the monitored play laboratory. It contains, in addition to traditional materials, a variety of penny-arcade machines, such as rifle galleries, table bowling, and boxing machines. However, unlike the monitored play laboratory, these machines were not designed to provide objective data for analyzing the process of therapy.

behavior. Yet, there is no evidence that this assumption is correct. In fact, the selection of toys for the respective play rooms was based more on clinical inference than on systematic observation. Lebo (1958) found that such inferences may be unwarranted. He discovered that some toys which have been accorded high theoretical value by therapists actually have negligible empirical value. For example, the toy telephone, a staple item in many playrooms, was found to contribute little to encouraging the child to express himself verbally.

Most observers of children at play would agree that toys tend to have "behavior-propelling qualities" (Ginott, 1960) of their own--qualities which determine the type of behavior associated with them. In fact, there is some evidence that dart throwing (Walton and Kidd, 1966), guns (Berkowitz and LePage, 1967), and war games (Feshbach, 1955) have aggressive cue properties. However, extrapolation from these results seems unwarranted in light of Lebo's finding (1958) that all toys within the same generic category (e.g., guns) do not share the same response-eliciting probabilities. Lebo discovered that specific types of guns differed in terms of their expressive value for children.

Further research is necessary to test the assumptions underlying the selection of toys for the two rooms. There are a great variety of studies which could be designed to yield data about the response probabilities of the toys in the aggressive and constructive rooms. For instance, a child could be presented with a random selection of toys and asked to select the ones he would play with if he were angry; then he could be asked to select those he would play with if he were happy. Another investigation might utilize blind independent raters' observations of the type of behavior associated with specific toys. Still another study might focus on the

differences between the types of toys children select after being subjected to a frustrating situation and those they select after being subjected to a pleasant situation.

Another problem created by the unique aspects of monitored play-therapy is the implicit assumption that the stimulus properties of the two rooms are equivalent and vary only in regard to aggressiveness and constructiveness. Yet, there are at least two additional sources of inequality between the two rooms which may account for the results obtained. First, the rooms may not be equally attractive to the child. There are more toys and a greater variety of types of toys in the constructive room than in the aggressive room. In addition, the constructive room has a work table and chairs. It seems reasonable that a child would find more things to do and a greater variety of stimuli in the constructive room, and thus find it more attractive. In the results previously reported (Brown, 1969), subjects shifted their attention from the aggressive room to the constructive room during the course of thereapy. This shift might be attributed to the child's decreased aggressiveness (an emotional change). On the other hand, this shift might represent a faster satiation of interest in the aggressive room materials (an intellectual change).

A second source of inequality is the difference in time required to complete the games in the two rooms. Many of the aggressive room activities--e.g., the guns, darts, boxing, and nail pounding--have no set duration and may be completed in a very short time. Because of their more complex nature, many of the constructive room activities take longer to complete--e.g., the mold making set, the erector set, the nine-inning baseball game, and the ten-frame bowling game. It is possible that a child may spend more

time in the constructive room by virtue of the fact that the materials in that room demand more time to work with. This observer noted one instance in the constructive room when a child persisted for about 15 to 20 minutes in building a mechanical toy even though he appeared to have lost interest in the activity much earlier. If time spent in the playrooms were the only measure used to chart the progress of therapy, the results might be misleading. Time records should always be considered in conjunction with the therapist's notes which contain a frequency count of the child's activities; i.e., the number of activities observed during each session.

Another weakness in design is the possibility that skill is an important factor in the aggressive room games. Accuracy is necessary to play the gun and dart games successfully. Since the attempt to improve one's abilities could be considered an aspect of constructive play, this factor should be minimized in the aggressive room activities. Even after the exploratory phase has supposedly ended, a subject may persist in an activity in the interest of improving his skill rather than for the purpose of releasing his aggressive feelings. With the gun games, for instance, a subject's accuracy might influence the number of shots he makes. Since most of the gun games register a score at the completion of a game, the number of shots relative to the number of correct responses could be computed; or the time on a gun relative to the score on that gun could be computed. The resulting ratios might indicate whether or not skill is a significant factor. Also, a gun with no target might be introduced to allow for the random expression of aggression idependent of precision and skill.

In addition to the research weaknesses mentioned above, the design of the monitored playroom has several therapeutic weaknesses. First, there is little opportunity for the child to manipulate or restructure the aggressive

materials in a way that is directly symbolic of his conflicts outside the play room. With the possible exception of the machine gun game with cowboy targets and the plastic soldiers, the aggressive room games may be too objective and inflexible to permit the child to endow the materials with conceptual and functional content that is both meaningful to him and easily interpretable by the therapist. Several possibilities for symbolic targets (e.g., photographs and drawings) in dart and gun games have been suggested by Kidd and Walton (1966) and Nichols (1961). Many of these procedures could be incorporated in the monitored play laboratory with little inconvenience and expense. For example, several types of targets could be offered to the subject such as pictures of adults and children of both sexes. The subject could then select the type of target at which he wishes to shoot. The type of choice made would give the therapist valuable insights about the nature of the subject's conflicts.

A second therapeutic weakness is the absence of opportunities for the destruction of objects. Buss (1961) and others (e.g., Stone, 1956) have suggested that destructiveness is a significant aspect of children's aggressiveness. The introduction of a balloon-breaking game (perhaps with human faces painted on the balloons) would be an inexpensive solution to this problem.

A third limitation is the absence of an outlet for the creative expression of aggression; i.e., the origination of aggressive productions. For example, there are no materials in the aggressive room for the child to express his anger by drawing pictures or writing stories in which significant persons are murdured. Such activities would not be appropriate in the constructive room by virtue of their predominately aggressive nature. These activities

represent a mature level of sublimation of aggressive feelings, and should be made available to the child.

An additional problem is related to the handling of creative productions which originate in the constructive room. If a child starts to play aggressively with construction room materials, L'Abate recommends that the therapist tell the child that such behavior is appropriate only in the aggressive room. The therapist then can suggest that the child take the materials in question into the aggression room if he wishes to continue playing aggressively with them. Does such a procedure stifle the spontaneous expression of the child's feelings? If a child builds a tower with blocks in the construction room and then decides to kick it down, how does he move it into the aggression room to kick it down without destroying it in the process of moving it into the other room? These and other questions require careful consideration.

The Role and Limits of Playroom Aggression

Every therapist who works with children--whether within the framework of monitored play-therapy or within a more traditional framework--must deal with the issue of how and when aggression is to be expressed in the therapy setting. There seems to be general agreement concerning the therapeutic value of (1) recognizing and accepting the patient's aggressive feelings, and (2) encouraging the discharge of tension through acting out of intrapsychic conflict. Yet, with few exceptions, (e.g., Rosenthal, 1956, Schiffer, 1952), most therapists (Ginott and Lebo, 1961; Hammer and Kaplan, 1967) impose some limits on aggressive acting out in order to protect the permanent playroom equipment and the body and clothing of the therapist and child from injury and damage. Within these broadly defined limits, therapists

differ in their definitions of "damage" or "injury."

Several writers (Ginott, 1964; Bixler, 1964) have cautioned against allowing the child to attack the therapist in any physical sense, and Ginott goes so far as to declare that the therapist should maintain a "nonplaying relationship" with the child. He asserts that "therapy is retarded when the therapist participates with the child in play activities, either as a 'parent' or 'playmate'" (Ginott, 1964). Taking a more moderate stand, Ross (1964) contends that "depending on the manifest needs of the child, the therapist should either take a passive, observing role or an active, participating one."

In monitored play therapy, L'Abate, (1968) suggests that aggression be expressed within socially acceptable limits. As a consequence, the aggression room games encourage the controlled, indirect expression of the child's hostile feelings. The child is free to act out these feelings in a sublimated manner without fear of injury to or retaliation from the actual target of his feelings. He may shoot a gun at an inanimate target, throw darts at a dart board, hammer nails into a wooden board, or hit a punching bag. In addition, the child is given the opportunity to play aggressive games with a human antagonist, the therapist. For example, the child may engage the therapist as an opponent in one of the war games in the shelves or in a boxing game.

The advisability of allowing the child to hit the therapist (albeit with boxing gloves) is one of the most controversial issues raised by L'Abate's conception of playroom aggression. He believes that boxing is commonly accepted in our society as a means of sublimating aggression and, therefore, is appropriate behavior for the playroom.

It is obvious that there can be no definitive prescriptions for procedures

to be followed by all therapists in all playrooms with all types of children. Play therapy should be a flexible technique, responsive to the social and psychological needs of the child insofar as it does not interfere with the therapist's ability to remain accepting of the child. A therapist, working with a timid child who needs to express his hostility more openly, may find that boxing with him has therapeutic benefits. However, the therapist who participates in such an activity should be cognizant of the dangers of the situation. The therapeutic relationship may be on tenuous ground if the child is allowed to manipulate the therapist in a manner which may frighten the child and/or erode the image of the therapist as an accepting, non-punitive adult.

The ultimate criteria for determining if a particular aggressive act is appropriate in the play therapy setting are: (1) whether the child appears happier or more constructive afterward (Murphy and Krall, 1960), and (2) whether the therapist's acceptance of the child is not diminished. The fulfillment of the first criterion can be determined by a careful analysis of the sequence of events prior to and immediately after an aggressive encounter between the child and therapist. Monitored play therapy is particularly well suited for this type of process analysis. Data from the automatic recorders, tape recordings, and the therapist's notes should furnish reliable information about the effects of a particular type of aggressive behavior.

Research is greatly needed to determine the exact effects of varying degrees of therapist participation. Monitored play techniques can be applied to study the effect of this variable.

Monitored vs. Traditional Play Therapy

In order to prevent misconceptions about the relationship of monitored

play-therapy to other treatment methods and to research, one must have a clear understanding of what this approach is designed to do. First, the monitored play laboratory is not limited to a particular theory of child psychotherapy. It is a tool which can be used for the testing of the stages of aggression and construction according to a variety of theoretical viewpoints. The automated materials do not by themselves perform the therapy; rather, the effects of the therapy are determined by what the therapist does with the materials. Second, the automated materials focus on the non-verbal rather than the verbal aspects of behavior. With this technique, the therapist no longer has to rely only on clinical inferences and hunches based on his interpretation of what the child says. Instead, he can use observable, measurable criteria to assess changes connected with therapy.

As stated earlier, the major distinction between monitored play-therapy and more traditional approaches lies in the separation of play room behavior into aggression and construction. The selection of materials for the two monitored play rooms is made with this distinction in mind. In contrast, the traditional play room often "looks like a junkyard with an astonishing assortment of toys of various vintages, some of them marred and disfigured beyond use. New toys are amassed at random, with the therapist's prediction being the decisive factor in their acquisition. The following'confession' will serve as an illustration: 'I suffer temptations in toy stores...and I have no difficulty in persuading myself that a certain doll is just what I need for a certain four year old who has been getting along just fine without it.'" (from Ginott, 1960, p. 243).

The monitored playroom technique appears to have many advantages over more traditional methods of play therapy. First, it furnishes quantitative

data about the process and outcome of therapy. Second, it permits more controlled variations than have been previously available (e.g., sex of therapist, differential reinforcement contingencies, degree and type of therapist interaction, maturational level of the child, and diagnostic category of his behavior--L'Abate, 1968). Hopefully the controlled manipulation of these factors will reveal the significant variables which affect the therapeutic process. Third, the automatic recording of the child's behavior leaves the therapist free to concentrate on the dynamics of the therapeutic relationship, and, in addition, furnishes him with objective information against which to test and supplement his clinical inferences. Fourth, the controlled monitored play room environment offers more reliable methods for the purpose of gathering longitudinal data or comparing results of many different studies.

Apart from its methodological weaknesses which can be eliminated fairly easily, monitored play therapy appears to have few disadvantages. The most obvious of these is that it focuses on only two dimensions of behavior. However, these are broad and complex dimensions, and probably encompass the most significant aspects of children's behavior, both in and out of the therapy setting. Monitored play-therapy represents an important first step in the controlled observation of aggression and construction. If other categories of behavior are found to be more significant by future studies, they might be incorporated in a similar type of design.

One of the most important contributions that monitored play therapy can make is the determination of the value of play therapy over the absence of therapy. On the basis of present research with traditional methods of therapy with children, it is impossible to determine whether or not the outcomes of therapy are directly related to its specific techniques and

theoretical rationales (Levitt, 1957 and 1963). Perhaps many of the changes presently attributed to therapy would have occurred if the children were given only increased attention. By isolating and comparing the within playroom and outside of playroom behaviors (long-term as well as immediate) associated with different treatment approaches, the relative effectiveness of different methods can be established. Before any type of play therapy can be considered effective, research must show (1) that desirable changes in personality and behavior come about concomitantly with play therapy and (2) that such changes would not have occurred in the absence of therapy" (Ginott, 1964).

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