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1993: AXLINE'S EIGHT PRINCIPLES OF PLAY THERAPY REVISITED

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ABSTRACT: *Axline's book Play Therapy, published in 1947, serves as a model in instructional techniques for many students wishing to learn basic skills utilizing play therapy as an assessment and treatment tool. Her insight, examples, and direction give guidance and substance to future clinicians who want greater knowledge and skill in working with troubled children. The authors examined Axline's eight basic principles of non-directive play therapy and student responses to learning these principles in play therapy classes. It was concluded that Axline's book, Play Therapy, remains a classic text and a foremost resource in the field. Coupling it with experiential learning is an invaluable basis for teaching play therapy.*

Axline's book Play Therapy (1947) is one of the most widely used and best known resources in the field. The authors of this paper have observed that Axline's text is the most meaningful when read and studied in conjunction with direct experience in play therapy. Axline's explanations and illustrations of the eight basic principles of non-directive play therapy have particular relevance in teaching/training play therapists. The authors re-examine these eight important principles as profound guidelines.

All students referred to in this article were pursuing an undergraduate degree in Psychology or Human Development. Each student anticipated more advanced formal training in play therapy

beyond this first introduction to the discipline. Each student was assigned a play therapy client and was observed and assisted directly by the instructor, a licensed clinical psychologist. Client sessions were typically 30-50 minutes in duration. The instructor made periodic observations through a one-way mirror or by recording sessions on video tape. When these two options were not feasible, the instructor sat in on student sessions.

Clients were mildly troubled children ranging in age from five to ten years and were selected from a referral base by the instructor as appropriate for the course. The referral base was school personnel and/or parents, who were interviewed by the instructor. As a licensed clinical psychologist, the instructor also reviewed each child's case, selected those with mild adjustment disorders (e.g. divorced parents, new school transition, etc.), and excluded those with severe disorders such as psychotic tendencies, severe conduct disorders, schizophrenic tendencies and severe eating disorders. The referred children were mostly Caucasian, middle class, and approximately equally divided according to sex.

Typically, students demonstrated initial cognitive understanding of each of Axline's eight principles. Students reported that putting the principles into practice was a very difficult task, and that it was not until being directly involved in working with a child or children for at least ten weeks that they felt a sense of confidence in approximately implementing and realizing the therapeutic significance of Axline's principles.

Several techniques were used to facilitate student mastery of play therapy. Instructor feedback was provided on an individual basis through positive, constructive critiques of student logs and of direct or videotape observations of student play therapy sessions. Required student logs focused on self reflections and on the content and process of their therapeutic sessions. In feedback sessions, the instructor attempted to build confidence and insight through a focus on individual student strengths. One-on-one appointments proved valuable in that students reported feeling comfortable and open to explore personal blocks and feelings of frustration.

As the semester progressed and students gained direct experience, weekly small (3-4 student) group discussions were held to explore in-depth understanding of play therapy principles and how

these principles are put into practice. These discussions, in which videotapes of play therapy sessions were sometimes reviewed, were helpful in allowing students expressions of very personal feelings and frustrations and in understanding that they were not alone in their reactions to learning play therapy. Students reported that open exchange of ideas and feelings facilitated their learning from each other. Notably beneficial from a teaching and learning perspective were sessions in which students role-played their play therapy experiences. Students were encouraged to assume the role of their client, so that additional insight was gained from the child's perspective. Role playing sessions used psychodrama techniques to act out client interactions. Students were also encouraged to practice identification of personal feelings and reactions, especially those derived from children's non-verbal cues.

Although the following examines each of Axline's principles separately, it is important to note that in actual play therapy experience these principles typically blend together in an interactive manner as part of therapeutic interchange with the child.

Principle 1. "The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible" (Axline, p. 73). Most students reported little hesitancy in initiating contact with the child or parent(s) and with encouraging the child to enter the playroom. However, once in the playroom a number reported feeling awkward and uncertain. Not only were these uncomfortable feelings typically not anticipated, this difficulty in transition from classroom to playroom appeared to relate to the student's sense of comfort in assuming a new responsibility: that of a beginning play therapist. For many, the new role was both confusing and difficult to separate from their other roles, i.e., student, mother, father, employee. These students were often role locked. Constructive criticism and positive support for their struggle proved helpful in their ability to switch roles. Student therapists learned that development of a new role takes considerable time and practice.

Most students found that developing a genuinely warm and friendly relationship with a troubled child was not always easy, particularly where that child was perceived by the therapist as being initially resistant to the therapeutic relationship. This resistance was often reported as the child not talking or including the therapist in play

activity. The novice therapist's interpretation of this resistance, along with a strong need to be liked by the child, often blocked acceptance of the child on his or her own terms. In fact, a significant number of students reported that it was initially easier to relate with a child whose personality characteristics matched their own. When faced with this dilemma of acceptance, students typically reported two approaches to resolving their discomfort. First was a tendency to over verbalize. The second approach was to withdraw and opt for noninvolvement with the child. In either approach, the student became overly concerned about their own feelings rather than concentrating on the child's needs.

Another difficulty was a tendency to make value judgments based on the behavior and/or statements of the child. The therapist often provided the child with clues for approved behavior rather than allowing the child to react spontaneously and with self-direction. Not until well into the semester did student therapists become more comfortable with the initial principle and show less need to want to "fix" the child. As students were able to relax more during encounters with the child and become less self-critical about how they "should" be in their role as therapist, establishment of rapport became more natural and easy.

Principle 2. "The therapist accepts the child exactly as he is" (Axline, p.73). A complete acceptance of the child appeared to be one of the most difficult principles for students to incorporate. into their therapeutic repetoire. Many times student therapists reported feeling that the behaviors displayed by the child were unacceptable, which resulted in a lack of genuine acceptance of the child. Most students appeared most relaxed and self-assured with a child who fit closely into their own value system. They also appeared to be most comfortable in reinforcing positive behaviors. The therapist's urgency of pushing the child to do the "right thing" often led to client disequilibrium and therapist uneasiness.

Some students reported becoming immobilized in attempts to accept the child completely, fearing that any action on their part would interfere with the child's self-determination. This sense of immobilization created feelings of detachment from the child, and prevented students from responding as they would naturally. The following were reported as posing the most difficulty in the ability to accept the child totally: silence or withdrawal on the part of the child,

detachment from the therapist in which the therapist was not included in the child's play activities, and very aggressive and/or hostile behaviors. When these particular behaviors were manifested over long periods of time, student therapists reported disengagement from the child, a loss of interest in the process, and a sense of general futility about personal effectiveness. In a few instances, beginning therapists overwhelmed the child by their sheer exuberance in wanting to establish a relationship. Many students expressed some confusion in being able to discriminate between acceptance of the child and acceptance of the child's behavior. As the play therapy students matured, they realized that attaching conditions of worth to the child's behavior only limited their therapeutic effectiveness. Learning to see and accept the child as a unique self helped free the therapist from using past frameworks of reference to stereotype the child and limit their progress. Labeling "fixed" the child to move only within the confines of the therapist's frame of reference. Granting the child freedom to be, released the child to the therapeutic process at his or her own pace and direction.

Principle 3. "The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely" (Axline p. 73). Students often verbalized an attitude of permissiveness to the child, yet when observed by the instructor or other students, they frequently manifested a lack of congruence between their verbal and nonverbal expressions. Some students allowed the child a wide range of self expression, whereas others appeared very constricted in what they thought were appropriate or inappropriate behaviors. For this later group, messiness and rambunctiousness were reported as two of the most difficult behaviors to permit. Students were often faced with a dilemma about limits that had to be set; e.g., to prevent deliberate destruction of toys or aggression toward the therapist. Many students reported that they were unable to maintain a consistent approach toward permissiveness. This lack of consistency often caused the child to receive a "mixed message" which then caused the child to experience feelings of confusion.

For many students, permissiveness was associated with being passive, and their response to these feelings of passivity was inaction. This inaction caused anxiety for the students and compounded their difficulty in reacting spontaneously to the child. The instructor assisted

the students through their discomfort by stressing that active listening and insightful reflecting were not passive enterprises but were unfamiliar modes to most of them which might seem awkward and uncomfortable.

Principle 4. "The therapist is alert to recognize the feelings the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behavior" (Axline p. 73). Initially, a number of students found it easier to respond to the content of a child's statements than to the feelings being expressed. Students tended to intellectualize their responses, or as Axline so aptly stated, to respond in a "wooden" fashion. The ability to adequately demonstrate Principle 4 required a great deal of practice and supervision. Over time, most students learned to accurately recognize feelings of the child, however, insightful reflection often took further training.

Additionally, periods of silence created a dilemma for students because of their feelings of anxiety over what they perceived as a lack of movement in the therapeutic process. Many expressed difficulty in being able to reflect these periods of silence back to the child. Students appeared to interpret the silence as children's attempts to distance themselves from the therapist and as indications of dislike. Silences were often perceived as being longer than the actually elapsed time. During these periods of silence, students became so involved in coping with their anxiety that they began to lose focus on the direction taken in the session and would often report feelings of boredom and disinterest. As self-confidence increased, they were able to view silence as a positive aspect of the counseling session. Then, as their therapeutic skills developed with guidance and practice, the students were able to redirect their focus to the child's feelings and to more effectively reflect those feelings back to the child. Role playing within the class gave students an opportunity to play out difficult issues and situations from their sessions in a supportive environment.

Principle 5. "The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's" (Axline, page 73). There was an initial lack of congruence between student's verbalization of respect for children's abilities and their ability to provide the child with freedom to proceed in decision-making without interference. This incongruence was particularly

evident when the child's decision was in conflict with the student's value system. It was also difficult for students to refrain from intervention when it appeared that the child's choice might lead to discomfort or pain. This sense of protectiveness frequently prevented student therapists from allowing the child to learn that consequences follow decisions.

Principle 6. "The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows" (Axline, p. 73). Due to their impatience for progress to occur, many students had difficulty in proceeding at the child's pace. They reported difficulty in following Axline's non-directive guidelines when it appeared the child's approach appeared circuitous or counterproductive. Additionally, students reported viewing the child's decision-making in a critical or judgmental manner. This dilemma reflected a lack of trust in the child's ability to provide self-direction. The students' ability to successfully implement this principle was helped by their willingness to share personal issues in class discussions. Especially relevant were personal issues that prevented them from allowing the child to lead the way.

Principle 7. "The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist" (Axline, p. 73-74). The impatience of many beginning students appears to arise from an over-eagerness to resolve the child's difficulty, an overestimation of their own helping skills, and/or the pace at which the student therapist was able to effect change. These factors often prevented children from moving at their own pace and, therefore, accepting responsibility for their own behavior. As with Axline's other principles, the student therapists gradually, over the semester, became more skilled in meshing cognitive understanding with the implementation process. In becoming more comfortable with allowing the child to lead, students also became more able to accept the pace at which therapy was occurring.

Principle 8. "The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship" (Axline, P-74). Two approaches to limit-setting were generally observed. In the first, students tended to establish many limits; in the second, too few limits were set. In either situation, it was difficult for beginning

students to establish effective limitations that were reflective of reality and yet were not excessive.

In conclusion, based on student reports and on direct observation of students in the process of learning, the authors feel that Axline's eight principles continue to provide a foundation for professional development of the beginning play therapist as well as for the more experienced in the field. Her insights, examples, and direction not only provide guidance but also substance. Her text, coupled with direct opportunity to place her principles into practice with in-class role playing, and with active discussion of student reactions, can be an invaluable resource for guiding the teaching of play therapy.

REFERENCES

Axline, V. (1947). Play Therapy. Cambridge, Mass.: Houghton Mifflin.