Play Therapy Training in a Residential School for Children with Emotional and Behavioural Problems

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Introduction

The role of special schools in general has been under consideration since the advent of the Warnock Report (Warnock, 1978). A more specific consideration is the role of special schools (often residential) for children with emotional and/or behavioural problems. Although placement within the terms of the 1981 Education Act is formally to meet the child's 'special needs' forces are at work to meet the needs of mainstream schools, social services and families. This conflict of interest is, of course, paralleled by the treatment/ sentence ambiguity of 'Special Hospitals'.

This hidden agenda can create priorities which leave what used to be termed 'malad' schools with an implicit function as a 'baby-sitting' service. While the formal philosophy is curative often, in the past, such schools have not been able to establish effective therapeutic processes (Topping, 1983).

Many schools seem to have attempted to establish an improved educational framework. While this is extremely important in terms of ideals like normalisation, it is in itself not a very good argument in terms of a status of separation and specialisation. One philosophy which has been adopted for helping disturbed school children at varying levels of rigour is behaviourism. (Topping, 1983). In my experience, often this is in most evidence in terms of institutional privilege and sanction rather than an attempt to tailor treatment to specific individual problems. Perhaps the priorities of the institutional milieu set the therapeutic agenda. Staff rotas; the division between education and care staff; the need to keep children managed; and the not insignificant

requirement of maintaining the physical structure and establishing ergonomically effective routines, all jostle with the idiosyncratic needs of individual children.

While at an informal level there may not be institutional or systems demand for a curative approach, this conflicts with often a formal declaration that this is a goal which should be striven for. Indeed, claims for efficacy, especially in relation to parents, are often in terms of the specialist help that is available.

These strong forces which both encourage and at the same time discourage the development of therapeutic options, obviously need to be considered when an outside agent seeks to facilitate development. It is obviously important that these should be judged and consistent liaison utilised to overcome any problems occurring. A strong personal contact between the institution and the innovator I believe is essential. Furthermore, it must be an appropriate time for the institution to take on a new development. More specifically, this development must fit within the evolving school policy and recognise existing staff priorities.

The School

The school was a small, mixed sex residential school for children within broadly the primary and middle school age range. It was located in a semi-rural setting approximately a third of a mile from two large northern villages.

Previously, as far as I could gather, the school had excelled in activity-based ventures. It had a well-developed woodwork and pottery facility and a tradition of a full range of extra-mural outings. Also, there had been a paired reading project (Topping et al., 1985). However, with the exception of the latter, most developments did not include the involvement of outside agencies.

When I newly arrived in the authority, the school was allocated to me as a responsibility on a short-term basis (pending further staffing developments). At my arrival, the school's Headmaster and his wife, who was head of care, were on long-

term sick leave pending early retirement. Although they still lived on site, I had no formal contact with them for the duration of my involvement with the school.

The former deputy was acting head and there was an acting head of care. While both eventually attained full permanency, there was an understandable degree of uncertainty in the long interregnum. The acting head teacher was a strong-minded resourceful woman who was, in my opinion, an expert at crisis management. The uncertainty, I feel, created a vacuum. I was keen to assist in harnessing the energy of the school to evolve positively.

In the initial stages of employment, I commuted sixty-six miles to work. On some occasions, because of tiredness or out-of-hours commitments, I would frequently lodge at the school. This gave me a familiarity as I got to know staff and pupils on a more informal basis.

As I saw it, there was a need to focus my involvement with the school. The energy and general anxiety, together with some specific uncertainty about the role of the psychologist, needed to be framed to some positive end. My perception was that they had been used to utilising psychologists in the role of a bureau professional. Gatekeeping reports and attendance at reviews. And yet they thought there could be more.

In addition to a caseload, I was given responsibility for project development within the Authority. I considered that a project would help focus staff's concern; and give a more functional role to the psychologist. I felt a therapeutic project would be useful in that it represented a direct resource for the children; was a very appropriate activity for a psychologist; and also, was a publicizable feature relevant to the formal requirement of the institution. This latter feature I thought was particularly important because there was considered to be a 'surplus' of residential provision in the authority for children with emotional or behavioural problems. At the point before the project was initiated, numbers of children in the school were low in comparison to the school's maximum establishment.

Play as a Therapeutic Medium

The earliest forms of psychotherapy developed in this century were talk therapies. Devised with adults in mind, Freudian, Jungian and Adlerian therapeutic techniques are not easily available to the developmentally young. Anna Freud (1965) gives a whole list of reasons why children cannot easily free associate, the standard technique of Freudian psychoanalysis. Play is perhaps a more natural and accessible medium for initial expression.

Many different schools of analysis have utilised play as a therapy for children. Anna Freud saw play as a means to an end in encouraging the verbalisation so important in Freudian analysis (Fries, 1937). Melanie Klein, by contrast, treated play as direct primary data reflecting the child's subconscious. She and her supporters were thus quicker to make direct interpretations and intervene more directly in the therapeutic situation (Klein, 1932).

As well as differences in therapeutic philosophies, there have been variations in techniques. Play therapy can either take place in the play room with the therapist as a participant, or more restricted contexts, using specific materials may be utilised.

"The Handbook of Play Therapy" (Shaefer & O'Conor, 1983) provides an interesting compendium of techniques.

The Lowenfeld World Technique

Margaret Lowenfeld represented a third, less theoretically disposed, force in British child psychotherapy. Although at a practical level evidence of her influence is to be found in nearly every UK Child Guidance Clinic, she wrote very little apart from a rather psychometric biased book by Bowyer (1970). It was not until her death that details of the technique were formally published (Lowenfeld, 1979).

Lowenfeld's apparatus consisted basically of a metal tray approximately 75 x 50 x 7 centimetres, half-filled with sand. Water was present, as well as implements for

use with the sand. Amorphous materials such as plasticine, tubes and wooden blocks were also provided. She placed nearby a cabinet with drawers containing miniature objects of the following kinds:

- Living creatures: ordinary men, women and children; soldiers; entertainers, people of other races; domestic and wild animals.
- Fantasy items: prehistoric monsters; fairy-tale items and science fiction materials.
- Scenery: buildings; fences; gates and bridges.
- Transport of all types.
- Equipment: for houses, roads, playground and hospitals and so on.
- Miscellaneous objects; which could have been anything currently available in the shops.

Lowenfeld introduced the apparatus to the child, explaining that the materials were a form of picture-thinking which aids communication between children and adults. The child was then asked to make something with the materials which the therapist judiciously interpreted.

The author of this paper has had experience of utilising the Lowenfeld technique both during and since his basic training in educational and clinical psychology at the Child Development Research Unit, Nottingham University. Later he applied the technique to children with severe physical and learning difficulties (Jones, 1980).

Traditionally, this technique is associated with a psycho-analytical ethos but at the time I was not totally convinced by these ideas and felt that for disturbed, multiple handicapped children, its efficacy could be more parsimoniously explained as just a mode of self-expression which has the following advantages:

1. It is relatively independent of physical skills. Unlike most artistic therapies, it requires relatively little ability to place objects in sand.

2. Speech is not necessary. The technique is essentially picture-thinking and even sic comprehension of language is not a vital component.

3. The ‘World’ allows for considerable dynamic possibilities. Scaranos can be produced and rearranged at will as a reflection of mental state, without the limitations of permanent representation which paper implies.

4. The ’World’ allows for considerable dynamic possibilities. Scenarios can be produced and rearranged at will as a reflection of mental state, without the limitations of permanent representation which paper implies.

5. Approximate developmental norms exist for the ‘World’ technique, as well as a wealth of literature on the typical productions of individuals with certain psychiatric conditions (Bowyer, 1970). This enables the Lowenfeld materials to be useful in diagnostic work.

6. Unlike other systems of play therapy, with the ‘World’ the child is both a participant yet an outside viewer, so although the fantasies are his production they can be talked about without any need for dramatic asides.

7. The Lowenfeld ‘World’ can be easily recorded using notes, diagrams or photographs. Thus with a series of sessions any developmental changes can be noted by the therapist.

While the above points were conjectured by the author in terms of children with severe learning and physical problems (Jones, 1980), they apply equally well to young emotionally disturbed children who often have difficulties expressing them- selves verbally. In British culture, the open declaration of emotional feelings is generally discouraged. ‘Wounded' children therefore need all the aids available to facilitate an opening to sharing their problems.

Play Therapy and Other Therapeutic Regimes

Many special schools with a varying degree of rigour utilise behaviour modification techniques. Specifically, this is often applied to antisocial attention-seeking behaviour. Aberrant attention-seeking is ignored, and more appropriate behaviour is rewarded. In practise, however, especially in the early stages of the regime, the child's previous behavioural natural history means there is often more ignoring than rewarding. The paradox is that these children badly need attention and they can become very frustrated and more disturbed in the short-term until they learn more appropriate avenues for gaining attention.

At this early stage, therefore, some creative, genuinely non-continent attention can complement any behavioural regime. However, in my experience, children will test the non-contingency of play therapy and precautions need to be taken to ensure in a highly co-ordinated institution that play therapy does not become enmeshed in terms of the rewards and sanctions of a behavioural regime. The two techniques should complement rather than afford problems for each's area of effectiveness.

Play Therapy Training for Primary Carers

Play therapy has traditionally been considered an activity to be undertaken by highly qualified psychological practitioners exercised in some clinical isolation. However, since the therapy's inception, several studies have been undertaken which involve teachers or undergraduate students, e.g. Guemey (1964); Stollock et al (1975); Goldman (1975) and Ginsberg et al (1978). These studies have generally indicated positive findings and have included in some cases parents as therapists (Guemey and Stover, 1971).

Whatever the source of therapists, certain core qualities have been considered to be required to facilitate treatment (e.g. Carkhuff and Bergenson, 1969; Guerney, 1983).

i.e. 1. An openness to the approach.
2. Good quality training and supervision.
3. Personal qualities of non-authoritarian empathy.

4. Ability to become more self-aware.

Of note is 3. Non-judgemental empathy is to some extent at variance with an educational philosophy. Teachers in particular are encouraged to judge their pupils and offer suggestions for performance improvement.

The Organisation of the Project

This initial idea for the project was shared with the Acting Head Teacher. With her characteristic enthusiasm she immediately identified the possibilities for enhancing the skills of her staff and gave it her full backing.

Following these tentative discussions, a presentation on the philosophy and practice of the Lowenfeld World technique was given at a full school staff meeting. My paper (Jones, 1980) together with an unpublished handout written by Nick Lock of the Nottinghamshire Psychological Service (Lock, 1985) was distributed to the staff.

Discussion considered practical issues like the construction of materials together with the purchase of toys; the location of therapy and the influence on the running of the school. There was also a consideration of the personal qualities demanded of staff.

The Head Teacher took an active and spirited role in obtaining the practical materials. A drawered cabinet was obtained, and a play area was converted by the school's handyman from an old wooden catering tray. Toys were purchased utilising guidelines from Dr. Elizabeth Newson. Eventually a sufficiency of toys were obtained of the appropriate size. These were then categorised and placed in different trays in the cabinet.

The school has relatively a large amount of free space (two staff rooms, two offices, medical room, pottery room, etc., etc.). However, like many families, a residential school gets used to using the whole space in a flexible manner. Obtaining half to one hour of undisturbed time may seem a small request; however, in practise

this has ramifications for the smooth running of a school. As will be discussed later, the concepts of being able to extract personal time for staff and pupils unmeshed from the continuum of the web of residential schooling was a secondary curriculum for play therapy. This was not hidden, however, but discussed overtly with school staff.

Although I, as Psychologist, undertook to supervise the project, there was a clear expectation that the main function was training. It was envisaged that this would eventually result in a core number of workers being retained in the school who had received a practical training in play therapy. The possibility of these staff acting as further pyramidal trainers was also discussed.

Eventually, the residential staffroom was selected by the school as the most appropriate location for therapy to take place. Although location and time were agreed, the precaution of a notice and even locking the door was envisaged to avoid people rushing over the threshold and disturbing the play.

There was a discussion of who, as the staff, should be considered being involved in play therapy. There was agreement that in principle both teachers and care staff should be trained. There was also some debate on who might be suitable pupil candidates for play therapy. Obviously young children who were emotionally troubled and could not be 'reached' in any other way immediately presented themselves to the consciousness of staff. However, I added the consideration that candidates should not be so difficult as to undermine the training component of the exercise. Unconfident staff could have felt demoralised as a result of such experiences.

Procedural Framework

From the very beginning, a certain procedural framework was set which was broadly maintained throughout the project. Firstly, the school informed parents and any relevant agency of the project, explaining that the session to session content of the therapy possessed a degree of confidentiality.

The child was also informed broadly of the special help he or she was to be given and told it was not the concern of others in the school. Staff were given instructions not to allow the issue of play therapy to be utilised to test boundaries in the rest of school life. The play therapy sessions were to be truly non-conditional; not in any way subtly utilised as a reward or punishment.

On the week before a play therapy intervention was due to be initiated, there was a full run-through with the therapist of the procedures. This was a dress rehearsal with the materials in the staff room at exactly the same time and day that therapy would normally take place. I considered this vital to ensure that the space really was free of other exigences (the collection of snooker cues, clothes and caretaking activity, etc.).

In all subsequent sessions, there was an emphasis on consistency. If, for any reason, some change of time needed to be made then the child was given advanced warning. The sessions were nearly always organised towards the end of the school day so aiming to cause the least institutional disturbance.

There were certain general guidelines to therapists:

1. The therapist should develop a warm and friendly rapport.
2. The therapist should avoid instructing or assisting the child with the play. (This is a very counter-intuitive instruction in an educational institution).
3. The therapist should respect the play therapy setting and value what the child produces.
4. The therapist should maintain only the broad rules necessary to sustain therapy. These should be maintained consistently and as far as possible spelt out before therapy was proceeded with.

The rules for the child were:

a. They should not deliberately damage anything.
b. Nothing should be taken out of the room.
c. All play should take place within the prescribed limits of the Lowenfeld World and tray.

d. The time limits of therapy should be maintained.

On the first therapeutic session, the child was introduced to the materials and asked to make something with them. There was an extra emphasis in this first session of both trainer and therapist being supportive but non-intrusive so as to set the correct atmosphere for therapy. The sessions were a maximum of half an hour long, although the child could terminate them at any time. Approximately five minutes before the end of the session, the child was told how long he had to complete the ‘World’ and then the session was ended as promptly as possible.

At this point a question was asked:

"Is there anything you would like to tell me about your world”.

This was posed to encourage the possibility of verbalisation. However, no further pressure was exerted to insist on any exposition.

The final world was always photographed on a polaroid camera. This acted as a record for the therapist. Also, it was designed to help show the child that what they produced was important. They were allowed to watch the exposed film developing.

The length of therapy obviously varied depending on the child and circumstances. A therapist leaving at the end of an academic session as well as therapeutic considerations were factors in determining the cessation of therapy. In all circumstances, the aim was that children should be informed of the ending of therapy at the beginning of the penultimate session. In this way, any ‘unfinished business’ could be completed.

The Lowenfeld World therapy is normally conducted just with child and therapist. Obviously, the inclusion of a third party could be said to make the therapy less personal. However, in a training situation unless there is a two-way mirror, or an intrusive CCTV system then parallel observation is vital. In most instances, the trainer kept an interested but non-intrusive profile leaving the therapist the main task.

Occasionally it was necessary to model ‘good’ behaviour but it was important to always return the focus to the primary therapist.

It was a condition of training that the therapist maintained a record of a child’s therapy. As therapists were likely to vary in their ability to do this, no pressure was exerted as to its quality. Subsequent to therapeutic sessions there were feedback sessions. On some occasions where one therapeutic session followed another, these were group sessions with two therapist joining together with the trainer: to discuss issues; wind down in relation to any emotional trauma and consider the plan for future therapy.

At convenient intervals, the whole group of therapists met to consider issues like new trainees, clients and general progress. If necessary, the future development of the project was considered at a full staff meeting.

The Aims of Therapy

1. To provide some non-conditional individual attention.

2. To enable a child to communicate more effectively on affective issues.

3. To provide opportunities for useful catharsis of emotional feelings.

4. To, if possible, allow a child to resolve some of the emotional problems he or she was experiencing.

Methodology

Investigations on small numbers of clients which aims to document multifactorial change in a reflexive manner and infer systematic influences, is difficult to relate to Fisherian normative analysis sometimes subscribed to as the way to undertake investigations in the social sciences and education.

It must be remembered that B.F. Skinner, often regarded as one of the founders of behavioural science, strongly supported the case study approach to research (Skinner, 1956). Case study has relatively recently been again rehabilitated as a legitimate form of investigation. Space limits an extensive explanation of the case study rationale. Most academics are now aware of the arguments in its favour. Instead I will quote substantive references for those who wish to assess the rationale of this style of research. (Krathochwill, 1978; Chassan, 1979; Eliot and Whitehead, 1980; Dockrell and Hamilton, 1980; Simons, 1980).

Case Studies

Case Study S

The therapist for S was a senior teacher within the school. One of the first people to volunteer, he had great verbal abilities and play therapy required some strength of character for him to work mainly at a practical and responsive level.

S had great difficulty in expressing himself verbally, often he would be generally biddable and charming but became temperamental and aggressive on occasions and at the very least sulked a lot.

S enjoyed coming to play therapy. A general feature of his ‘worlds’ were their obsessive nature. Fences were lined up neatly and S would go to great lengths to try and perfect an operation. Towards the end of therapy, he became less tense and talked much more freely. The general outcome of therapy of less than ten sessions was:

1. Cathartic release within therapy.
2. Personality expression within the ‘Worlds’.

3. The use of a verbal context in therapy.

4. A more outward-going and talkative personality (especially in relation to the therapist).

5. Improved behaviour in classroom and care.

Subsequent to therapy, improvements in social relationships were noted and it was decided that S was ready to attend an ordinary day school while still staying resident at the special school.

Case Study F

The next trainee was a member of the school's care staff who was trained in psychology at an undergraduate level and had taken a number of therapeutic workshops subsequently.

The pupil F was the only child in a middle-class single-parent family. A distinguishing feature of F was her relatively low intellect, but even more limited ego development combined with an introverted nature.

She was a little nervous to start with but was always keen to come to play therapy sessions. Her expressions of emotion often tended to leak out in quite brief verbal asides. She also produced explicit war scenes. F's use of the materials was often quite simple; initially there were often unintegrated scenarios with discontinuities between activities.

For example, the farmyard scene in session four consisted of animals placed in rows and no integrating of complexity. Ruth Bowyer (1970) would have probably considered the World to have been at the cognitive level of about a four-year-old. The theme represented one of conflict with a simple separating fence.

The trainee had definite views of his own about therapy and suggested that F be asked at the completion of a 'World' to act the part of each participant in what to

me seemed like a 'Gestalt therapy' type technique. This was outside the initial brief of the play therapy and I thought would be unlikely to work. To my surprise, when this was introduced in session nine, F took to this quite well and it represented a very positive step in F verbalising her thoughts.

In commenting on the usefulness of play therapy, the trainee commented:

"She liked doing it; appreciated the company and the attention. She responded well to encouragement and she tried to please us and participate. ... She did relate better with me as a consequence, outside the sessions and possibly will develop well in one-to-one relationships with a special person. It was good for her also in an expressive sense, there were signs of attempts at the integration of various psychic qualities and attempts at ego expression".

I would agree with this summing up, emphasising the tentative nature of the progress highlighted in the last sentence.

In studying a school review completed independently of play therapy, it was commented that:

"She still tends to withdraw inwardly from time to time but there are now increasing signs of interest and awareness of events...".

Case Study Dd

A further trainee although a qualified teacher who occasionally did 'supply' teaching at the school more normally acted as a member of the care staff. She later submitted a study of 'Play Therapy' for a care staff certificate at the local technical college.

Dd was 9 years old when the play therapy was initiated. He had a history of verbal abuse and disruptive behaviour and had previously attended three primary

schools. Dd had only been attending the present residential school three weeks when therapy was initiated; therefore, the main initial objective was diagnostic.

In the first session, he fenced off animals into categories. "So no-one would get hurt". He gave every evidence of enjoying sessions.

Dd's parents were making plans to move out of Kirklees about one hundred miles. He went to the town first on a week's holiday. After coming back (third session), he very carefully and a little anxiously persisted in trying to make a building with blocks (problems trying to keep the roof on).

"This was where the soldiers lived".

There were also tanks placed in the sand. He described how he had seen tanks and soldiers while on holiday.

Before the next session Dd had moved. He made a town scene with houses and a church. Dd stated that the place was a location he used to live where his Grandma still has a flat. He indicated that there had been some recent dispute between Grandma and his parents.

Dd attended seven play therapy sessions in all. These sessions promoted quite active scenes which clearly related to. changes in his life. The vividness and activity contributed a great deal to their usefulness as a medium for training the therapist. The sessions allowed the boy to narrate the changes in his life and his concerns about them. However, although this was a stressful time for Dd, the maturity and flow of his worlds did not indicate any essential disturbance. We both felt that this boy's rational life was pretty normal, and the sessions were concluded with this feedback to the school in general.

Case Study J

The next trainee play therapist was a mature and experienced child care officer who was well respected by the pupils and had a very warm empathic nature. In relation

to training in play therapy, she lacked a little confidence. This I strongly considered was misplaced as I felt she would make an ideal candidate for such training.

The candidate for therapy, J, at seven years of age, was the youngest pupil in the school. She was an apparently emotional child. On occasions, she would become very angry. I was a very physical child and had to be discouraged from being too over-affectionate with adults. It was thought that her boisterous nature might make her readily accessible to play out her problems and provide a reasonable training experience for the therapist.

J at the early sessions often made a ritual of the initiation of therapy. She would ask if the therapist was sleeping in and often made a thing about smoothing out the sand. On one occasion, she asked the therapist how old she was, and would she be her mother. J sometimes would try to play outside the sand tray.

Typically, her play was rumbustious and rapidly changing. In the early sessions, generally, they had little form. Another feature was that there was often little human content. Indeed, although J talked a great deal, much of this chatter was superficial and peripheral. We realised we had made a mistake in thinking that J would be an easy subject in the provision of therapeutic training. In fact, on further reflection, we considered that in general outside therapy, although verbose, she often avoided direct emotional confrontation.

There was a gradual change. In one session, a pile of dead soldiers were produced very quickly. This coincided with the recent death of her grandfather.

The sessions proceeded over nearly two and a half terms. Progress was extremely slow. In general, she often avoided any comment on the play. There was outside evidence however that she took the play therapy sessions very seriously and considered them important. Her relationships with the therapist deepened to the extent that some concerns were discussed in verbal terms.

A comment at a subsequent review was:

"... it is felt that there has been a great deal of encouraging progress with regard to her maturity and general behaviour".

Case Study D.W.

The final trainee therapist, although young in relation to the rest of the staff, had recently been appointed Principal Child Care Officer. She had previously acted up in this role and as a student achieved a B.Ed. Degree.

DW was a young seven-year-old boy who had only been at school a short time when therapy was instituted. He was considered highly dependent, attention-seeking and generally immature. A bit of a lovable pest.

In general, his play was not particularly constructive and did not promote communication. He enjoyed himself, however, and on occasions produced scenes of a more graphic nature. For example, in the seventh session, he incorporated the therapists in a story, creating an imaginary father figure who was a policeman. This scene was then flooded and all the people were destroyed as a result of war.

In total, DW experienced ten sessions of play therapy. Although we judged no intra-therapy change, in school and care considerable improvements in social skills were noted over the time period of therapy.

The same therapist who saw S later saw (largely unsupervised) another client JK as a result of their initial training. The therapy was continuing as this report was in progress, therefore no firm conclusions can be drawn. What was heartening from a project point of view was that some second order staff involvement was being precipitated.

Outcomes

Organisational

The whole project took place over eighteen months. As well as internal monitoring by those directly involved in the project, Play Therapy was the subject of three full staff meetings.

After just under a year, it was decided to continue the project. At the ultimate staff meeting, I was no longer the Psychologist to the school, and it was considered an appropriate time to complete my formal involvement in the project. The following organisational outcomes were apparent.

1. Five therapists had been trained, four of which remained on the staff. This seemed to represent a reasonable core of ‘experts’.
2. Two therapists had undertaken some unsupervised work, one case being followed almost completely autonomously.
3. One therapist had assisted others in their training.
4. The school had become generally more used to the requirements of individual therapy. Generally, later sessions were less disturbed by practical exigencies.

Training

All five trainee therapists had varied personalities and professional back-grounds. In providing training, I identified a number of general issues which needed consideration to a greater or lesser extent in providing support:

1. Ensuring adequate confidence to the trainee.
2. Making the distinction between therapeutic facilitation and instruction.
3. Dealing with general personal philosophic concepts of child care or teaching and any conflict with the concept of therapy.
4. Dealing with the switch between the contained framework of therapy and the enmeshment of the institutional milieu.

These issues were informally considered with all trainee therapists and provide a conceptual framework for any further therapeutic input.

Client Outcome

Individual outcomes have already been considered. Because each child is a different personality with varying adjustment problems, it is difficult to draw general conclusions. However, to a greater or lesser extent, the following outcomes apply.

1. All children respected the therapy session and did not externally manipulate the context. No child was teased by others in relation to coming to therapy.
2. Most children, initiated play activity.
3. All children expressed pleasure and interest in the play activity.
4. Some children were able to express concerns verbally consequent upon play therapy.
5. Some children's play scenes became more 'normal' (Bowyer, 1970) over the course of play therapy.
6. Some children developed a closer general relationship with their therapist.
7. In relation to independent judgements, some of the children's behaviour improved over the course of therapy.

Conclusion

Overall, I feel that on a number of accounts, training the staff in a residential school in play therapy techniques is a useful activity in terms of the reasons given above. However, such activity needs to be very carefully planned with negotiation at every level of concern. As an activity, it is very time-consuming of a trainer's time. Live supervision is necessary as no pre-ordinate programmes can be prescribed. Sometime subsequent to the author's involvement, further play therapy was temporarily suspended due to staff involvement in a new project. An innovator needs to be philosophical about the wheel of history and the stimulation of the new.

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