

## THE USE OF ROLE PLAYING AS A TECHNIQUE IN THE PSYCHOTHERAPY OF CHILDREN

RICHARD L. LEVENSON, JR. AND JACK HERMAN

*Pace University*

*Play therapy involves interpreting the play activities of children to promote abreaction, insight, and/or corrective emotional experience. Because much of a child's "play" involves repetition, it seems logical that some forms of child psychotherapy might incorporate techniques involving repetition.*

*Psychotherapy that includes role playing allows the child patient to gain mastery over difficult events and disturbing thought and affects. Role playing, including role reversal, gives the child psychotherapist an opportunity to view how a child construes the world, how the child is treated by others, and insight into the quality of those interactions.*

The goal of child psychotherapy is to help alleviate a child's difficulty in affective, cognitive, or behavioral areas which impede developmental adaptations. According to Dodds (1985, p. 15), child psychotherapy "is designed to change the child in some way either to ease internal pain, change undesirable behavior or improve relationships between the child and other people who are important in the child's life." Interventions typically have ranged from the direct type, for example, analytic, behavioral, client-centered, and family therapies, to the indirect type which include consultation and "parent counseling" (Dodds, 1985), as well as other methods.

As in adult psychotherapy, the relationship between therapist and child is crucial in order to set the stage for the intervention to have a successful outcome. There must be a working alliance and the establishment of a "supportive, nonjudgmental" atmosphere with empathic understanding, in which the child can feel respected, nonthreatened, and free to think, act (within limits), and say what one feels. There must be regularly scheduled sessions ranging from one to three sessions per week. Yet, psychotherapy with children differs from adult psychotherapy in that children do not possess the cognitive abilities to assimilate that which is heavily language oriented. Harter (1977) noted that, within Piaget's (1952) concept, the child is in the midst of a developmental shift from prelogical to logical thought. As Harter (1977, p. 421) stated

for it is this particular transition, and the gradual development and solidification of logical operations during the concrete operational period, that seem intimately related to the child's comprehension and construction of a logical system of emotional concepts that define the affective spheres of his/her life.

For this reason, play therapy techniques, as well as numerous other primarily nonlanguage-oriented methods were developed (*e.g.*, A. Freud, 1965; Klein, 1975). The therapeutic playing out of inner experience, ideas, affects, and fantasies associated with life events seems to aid the child in becoming more aware of the feelings and thoughts, conflicts, and ego dysfunctions that may underlie problematic or disturbed behaviors and affects and that provides an opportunity for the child to revise and resolve psychological and psychosocial problems.

Reisman (1973) provided a brief, but excellent theoretical history of play therapy. Allen (1942) believed play therapy served to help the child become aware of his or her identity as an individual in relation to the therapist and the nature of their relationship. Moustakas (1953) reported that play therapy was "a progression (of) the child's expression of feelings" (p. 111). Anna Freud (1965) saw a similarity between play therapy and psy-

---

Correspondence regarding this article should be addressed to Richard L. Levenson, Jr., 269 West 72nd Street, Suite 16B, New York, NY 10023.

choanalysis and theorized that "there is movement from surface to depth, from the interpretation of unconscious impulses, wishes, and fears or id content" (in Reisman, 1973, p. 111). Anna Freud believed that play therapy reduced anxiety and emotional (neurotic) disturbance by helping the child become more aware of unconscious conflicts and "hidden" material.

Waelder (1933) wrote an interesting and early paper on psychoanalytic play therapy with a special emphasis on the repetition theme. Of course, Sigmund Freud (1961) was the first to posit that some forms of play are repetitious acts, possibly to gain mastery over some particular event that was anxiety producing or frustrating, by reversal of roles from passive to active. Erikson (1950) described play as a form of "hallucinatory mastery" over life experiences that induced feelings of anxiety and helplessness. When children use repetition or repeat an act or game, they are, in a sense, working through, possibly undoing or redoing via displacement and symbolization, and thereby articulating, assimilating, and integrating that which is unconscious and connected to a special set of circumstances. These circumstances might range from separation anxiety to "protection" against unconscious wishes or feelings of dread or hostility, for example, in relation to a parent.

Some children have imaginary playmates or friends; others may "act out" roles or take the part of significant person in their environment. Repetition or role reversal, however, does not seem to be a pathological set of behaviors or solutions to anxiety or conflictual issues, but rather is curative in that it serves to repair hurts and losses. It helps the child separate and individuate by inculcating a sense of mastery and competence, by giving an "illusion of accomplishment" (J. L. Herman, personal communication, February 23, 1987) and by contributing to the healthy adaptation and resolution of the normally stressful or anxiety-producing events that must occur during childhood.

It seems logical, then, that some forms of child psychotherapy incorporate techniques involving repetition. An indirect example of this is Gardner's Mutual Story Telling Techniques (1971). Gardner's method involves encouraging the child to tell a story into a tape recorder. According to Schaeffer and Millman (1977), "the child is asked to be the guest of honor on a make-believe television program in which stories are to be told" (p. 38). The therapist then tells a parallel story; but after a psychoanalytic fashion, "healthier adaptations and

resolutions of conflicts are introduced" (p. 38). Gardner's method is essentially a projective technique in which, with a minimum of structure, the child is asked to make up a story that is apprehended psychodynamically by the therapist and then relayed back to the child with more adaptive solutions. We know that in the process the child is going to construct a story based on her construction of herself in relation to the world and her characteristic adaptive or maladaptive ways of emotional problem solving.

The issue of Gardner's technique is that, while it may be a useful diagnostic device, it may be questionable (from a psychoanalytic standpoint) as a therapeutic technique. The psychoanalytic concept of therapy relies on creating a therapeutic climate that promotes natural, evolving, moment-to-moment, spontaneous self-expression through play and verbalization with a *minimum* of structuring and interference by the therapist. The therapist aims to enable the patient to express himself *in his own way*, in a stream of consciousness fashion, whether via verbalization or play, or both. The therapist's job is to help the patient expand on whatever the patient initiated, not to introduce anything new. Introducing an artificial task for the child patient, extraneous to what might be on the child's mind at the moment, is to distract the child from whatever s/he might be immediately experiencing and expressing. It is important to stay within the immediate experience and not disrupt an ongoing experiential process that might bear fruit if followed.

The therapist attempts to follow and expand on whatever the child has introduced rather than distract the child by suggesting a game or a make-believe television show, even when a child may be resisting. In the latter case, the therapist attempts to follow the resistance and verbalize what it might mean, rather than to introduce a device to try to bypass it. The therapist acknowledges, clarifies, and interprets his or her understanding of the defensive reasons for the resistance, rather than trying to distract the child by introducing a new activity. The child's attention must be in the realm of every day experience or occurrences so that there will be some connection between therapeutic interpretations and the child's incorporation of a corrective emotional experience.

The technique of role playing has had a long history in various psychotherapeutic approaches. Traditionally, role playing has been used by gestalt psychotherapists and in behavioral methodologies

for reasons ranging from increasing emotional awareness to expanding repertoires of behaviors. Social psychological theorists such as McGuire (1961) and his "inoculation theory" have sought methods of cognitive-behavioral rehearsal to increase the individual's ability to deal with new and unfamiliar situations. Moreno (1969) utilized psychodrama, a psychotherapeutic technique of structuring, or partially structuring a real or hypothetical life situation, which the patient, along with assistants, is encouraged to dramatize in an improvisational manner while the therapist directs and comments upon the action. Perhaps the most important effort to utilize role playing in psychotherapy was put forth by George Kelly within his *Psychology of Personal Constructs*. Kelly (1955) defined fixed-role therapy as "a sheer creative process in which therapist and client conjoin their talents" (p. 380). Rychlak (1973) reported that prior to fixed-role therapy the client is asked to write a self-descriptive sketch of his own character, which the therapist then rewrites in a role "based upon what the client has said of himself," but in contrasting themes, a role that the client knows s/he can act within as "experimental fantasy" (p. 496). Fixed-role therapy is then carried out for as many as eight sessions during which the client gains insight into the way s/he normally construes events and others, and thereafter s/he may decide to incorporate new behaviors and/or affective changes.

Within a social learning paradigm, Gottman, Gonso, and Shuler (in Walker & Roberts, 1983) used modeling, role playing, and behavioral rehearsal to improve social interactions among "isolated children." LaGreca (in Walker & Roberts, 1983) discussed the efficacy of "role play assessments" that serve to give the clinician insight into a child's repertoire of behaviors in contrived versus "structured observation formats." The contrived format is of particular interest here in that the patient is "asked to respond to a 'pretend' situation as if the situation were really occurring" (p. 121). Kendall and Braswell (1985), in their work with impulsive children, stated that "one reason for even including role-play tasks is to heighten the child's level of emotional involvement and arousal" (p. 135). Kendall and Braswell (1985), like LaGreca (in Walker & Roberts, 1983), also reported that "hypothetical problem situations" which are role-played should be practiced prior to "real problem situations" (p. 136).

Gresham (in Strain, Guralnick, & Walker, 1986) routinely uses role playing when remediating social

skills deficits in children. He reported that "behavioral role play tests or performances in analogue situations have essentially become the hallmark of assessment in social skills research" (p. 161). Among the advantages of using role playing is that the technique depicts "actual behavioral enactment of a skill rather than a rating or perception of that skill" (p. 161). Irwin (in Schaefer & O'Connor, 1983, p. 164) reported that "role playing and pretending" may be used as a diagnostic technique in order to discern

the child's ability to present and solve a problem, tolerance for frustration, capacity for language . . . the ability to talk about and reflect on the experience including a discussion of feelings about the "product" which has just been created.

Irwin also highlighted that role playing gives insight into the quality of the child's ability to relate with his or her therapist.

More recently, research has focused on using role play as a direct therapeutic intervention. Goldstein and Glick (1987) reported successful interventions occurred from the use of role play within their program for "anger control" for adolescents who are "chronically delinquent" (p. 13). Goldstein and Glick's intervention is based, in part, on the premise that these youngsters often demonstrate "impulsiveness and over reliance on aggressive means for goal attainment . . . and characteristically reason at more egocentric, concrete, and in a sense, more primitive levels of moral reasoning" (p. 13). The program for anger control includes the role playing of situations that have led previously to inappropriate expressions of anger. Role plays focus upon achieving insight into underlying cognitive and affective issues that are "triggered" either internally or externally. Trainers use modeling, clear descriptions of conflict situations and behavioral rehearsal with repetitive demonstrations of appropriate behaviors which lead to nonaggressive, positive outcomes.

In child psychotherapy, we are not so much interested in using role play for the traditional uses of learning and rehearsal per se, but rather for its experiential value in promoting an internal corrective emotional experience, in which repressed affects can be integrated with cognitions of the self. We contend that what has been called *catharsis* is really a form of integration and mastery since, in apparently discharging pent-up affects, the child patient is undoing via reversal of roles or identities situations that created feelings of helplessness, but now serve to create a sense of completeness and control. It is suggested that children may not

be especially insightful, but are willing to directly examine problematic areas in their emotional life. As noted, the necessary cognitive, language-based structures may not be sufficiently mature to allow for direct verbal intervention. Children, especially troubled children, lack the capacity for psychosynthesis, that is, the integration of intellectual and affective data. For these reasons, the technique of role playing in children psychotherapy is seen as a valuable aid in reducing psychopathology and increasing awareness, understanding, and mastery in children and adolescents.

Preliminary reasons for the positive potential of this method are straightforward. First, it is simple to employ and involves the child in direct, everyday experiences in which they have interacted. Second, although it is a verbal technique and requires some sophistication in language use and comprehension, it taps the stream of consciousness and underlying conflictual material by allowing the child to use repetition as a tool toward mastery over an event that stimulated unresolved issues or conflicts. Unlike Gardner's (1971) Story-Telling Technique, role playing with children allows for direct participation and discussion in an area of conflict, and, through controlled therapeutic guidance, an implicit insightful experience might be achieved.

Role playing in child psychotherapy may be utilized in any number of ways. Simply, it may be of use to help the angry child, for example, become aware of possible dysphoric feelings. The child may be enlisted in a role in which one can reexperience an upsetting conversation or event, one that centers around significant relationships or strong, disturbing affects or thoughts that perhaps are related to referral questions as to why the child was initially brought to therapy. Here is a typical example:

*Brief Background:* This child, a 9.6-year-old boy was referred for outpatient psychodiagnostic evaluation, after which an interview was conducted for about 30 min. He was referred for evaluation as he had expressed suicidal ideation, but would not discuss this. The following are verbatim excerpts of parts of a session, about 10 min into the interview.

Therapist: *The previous doctor who talked with you, S, let me know you have had thoughts of hurting yourself. Have you had thoughts like that lately?*

Child: (Removing eye contact.) *No, not for over a year. Now I feel better because I can talk to my mommy more.*

T: *S, when you have had these thoughts, what are you doing at the time: I mean, where are you when you think like that?*

C: *They happen when I go to the store for my mommy.*

T: *What happens when you go to the store—do other boys or people bother you? Does something happen to make you afraid?*

C: *No. (Becoming anxious, restless, and distracted.)*

T: *S, let's try something here. I'm going to play a game with you. I'll be your mommy and you be you.*

C: *Okay.*

T: (Playing the role of the mother.) *S, I'm sending you down to the store again.*

C: *I don't want to go.*

T: *You have to. Get me a quart of milk, some eggs, and a loaf of bread.*

C: *But mommy, I don't want to go again. That makes six times today—I won't go again.*

(Note: At this time, the therapist is struck by S's revelations of the "sixth" time and stops the role play.)

T: *Okay, let's stop here S. You said six times? Why does your mommy send you to the store so many times? Does this happen a lot?*

C: *It happens when I'm home, on weekends and nights. I don't like it.*

T: *When do you have thoughts of hurting yourself?*

C: *Sometimes when I'm outside or when I'm walking down those stairs. We live on the fourth floor. I just say that I'm going to jump in front of a car or off a roof.*

T: *You know, it must make you feel very upset to have to go up and down those stairs so many times a day. I wonder if you ever feel angry about having to do that?*

C: *I feel upset, but I'm not angry. I just don't want to go to the store so many times.*

This information clearly demonstrates that valuable information may be obtained by both the therapist and child patient. The therapist has gained awareness of the typical situations in which these disturbing thoughts occurred, and the child has begun the process of catharsis. The child has also been given an opportunity to indirectly express his true feelings and knows consciously what is happening, but feels less threatened because he is "acting" within a role.

After this information is obtained, another role play takes place, but this time the therapist may use role reversal and play the child, while the child model's the therapist role character. It is within this second role play that the therapist must reformulate, interpret, and provide clear and simple language so that the child may incorporate what he is hearing into the beginning of a corrective emotional experience. Here the therapist clearly models what he perceives the child to be feeling. Such an example follows:

T: *S, let's play another game. This time I'll be you, and you play your mother.*

C: *Okay, I'll do it.*

T: *Okay, you tell me to go to the store, and we'll play-act again.*

C: *S, go to the store and get me some cupcakes, some soda, some cigarettes, and some pie.*

T: *But, mommy, please, I don't want to go to the store again. You made me go five times already today.*

C: *You go or else!*

T: *Please, mommy, sometimes when I go I feel awful, like sad. I don't ever get to do what I want to do.*

C: *You better go!*

T: *Mommy, just listen. When I go to the store, I feel upset and sad. Sometimes, I might feel angry, too, but I also feel tired, because I'm little and I have to carry those big bags up to the fourth floor. Couldn't you go? Why do I always have to go?*

C: *Well, I guess I could go sometimes.*

T: *Maybe if I told you sometimes I'm very angry, you'd know I don't want to go.*

C: *Yes, from now on, you and I will both go, but I'll go more.*

T: *Good, but I also want you to know that I sometimes feel sad or angry at other times too—maybe we could talk about that, too.*

C: *Okay.*

T: (Concluding role play.) *Okay, S, let's stop here. Do you think you let me know how you feel?*

C: *I guess so, but I never talked about that before. I'm nervous.* (Starts to move around the room.)

T: *S, let's see if maybe we could just play now. What would you like to do?*

(Session continues.)

There is precedent within the literature for using role play as a psychotherapeutic technique with children. Smith (1977) found that role playing had a significant impact upon the behavior of children. Aggressive children exposed to counter-attitudinal measures became less aggressive after role playing than those children who were "adult informed" (p. 400-b). Sarnoff (1976) reports of a case in which, during "displaced fantasy play," the therapist acted out the role of a slave boy and used this opportunity to help make the child more aware of his anger. Although displaced fantasy play utilizes imaginary characters, role playing relies on the child's real experience with significant others, such as parents, siblings, friends, and teachers. Even if the child cannot say "I," a role play may be created in which children play the parts of others with whom they interact. Sarnoff (1976, p. 199) stated that

Once fantasy play has been established, it can be used as a means for working through conflicts and complexes. It is frequently wise for a therapist to approach a fantasy in terms of its affects. Often a child who cannot otherwise express his feelings can talk of them when speaking for a third person. There is an organizing and focusing effect that results from the experience of talking about a fantasy and affect in organized fashion with the therapist.

Harter (1977) employed role playing in the cognitive-behaviorally oriented psychotherapy of a 6-year-old girl. Harter believed that, following a Piagetian model, a child whose cognitive skills are a function of the concrete operations stage "cannot yet think about his/her own thinking" (p. 425). Even if logical thought is present, it is probable that

the conceptualization of an emotional network of concepts may lag considerably behind the application of logical principle . . . thus it is not surprising that children in the seven to ten year old range are still struggling with emotional concepts and are still subject to the kind of unidimensional all-or-none thinking that has been the focus of this (work). (p. 425)

Harter believed that children of the latency stage have extreme difficulty expressing contradictory emotions or "polarized feelings that seem incompatible" (p. 425). In her case study, Harter utilized role playing to model feelings for a girl who was depressed and exhibiting lack of success in school, but would not express herself through standard play materials. Harter reported that her attempts to deal "indirectly" with the child's feelings were consistently hampered, especially during a game in which the child role played her teacher, while Harter played the role of the child. Harter, in this role, had typically remained passive, modeling the child's behaviors and feelings, until one session when she spoke up and told the child what it felt like to be frustrated in school and to feel upset. Within several sessions, the child began to assimilate this type of communication of feelings through discussion as well as blackboard drawings. Harter (1977, p. 428) interpreted her success to the child's being able to concretize her "powerful but conflictual feelings," and the drawings they did "provided a concrete visualizable symbol to which we could attach real experiences."

Perhaps the most interesting and detailed description of the technique of role playing within child psychotherapy was provided by Halberstadt-Freud (1975). Halberstadt-Freud conducted psychoanalytic psychotherapy with a 4-year-old girl, Lara, for a period of 4 years. Lara's traumatic history included the divorce of her parents, two hospitalizations for eye surgery, and suicide attempts by her mother. Her verbal expressiveness was meager and limited to one- or two-word responses; her level of play was extremely limited in that "she assembles the play-material and piles it in a big heap without taking pleasure in this activity" and gives no expression of affect, neither "pleasure or of pain" (pp. 164-165).

As Lara's ability to interact with standard play materials is inadequate, Halberstadt-Freud employed two types of role play as a therapeutic technique. First, standard role play with the child and therapist alternating roles was used. During this type of role play, Halberstadt-Freud took note of the actions of Lara as indicators of what she was feeling. Then, these actions were discussed

and further developed within role playing, but they were not interpreted directly. According to Halberstadt-Freud, "interpretation follows only later when reconstruction has taken place . . . besides voicing the thoughts and feelings of the (therapist's) part he also accompanies it with clarification and interpretation wherever he sees fit" (p. 167). Second, role playing can be further removed if it is played out through dolls. Halberstadt-Freud stated that "feelings most defended against and defenses hardest to point out can thus be visualized and verbalized in an unobtrusive way" (p. 168).

In the case of Lara, Halberstadt-Freud reported that her depression improved in 3 months as she "gradually expressed more feelings, both positive and negative," and, at the end of treatment, Lara was doing well in school, able to form relationships, and work through her difficult, early stages to be able to develop a "good and stable sense of self" (p. 175). Halberstadt-Freud further stated that employing role play as a technique was valuable because, in the case of Lara, "direct interpretation of defense and content would lead to shame, withdrawal, and denial . . . though very direct in dealing with feelings, this technique is indirect as regards ego participation or conscious awareness of the hitherto unconscious" (p. 175).

In summary, it has been shown that role playing, a psychotherapeutic technique used with adult patients in numerous psychotherapy models, may be a useful technique in the psychotherapy of children and adolescents. Role playing may be used in psychodynamic psychotherapy as a prerequisite to clarification and interpretation, and by cognitive-behaviorally oriented psychotherapists who may need an action-oriented method of increasing the power of a talking, reality-oriented intervention. Role playing may be used with children whose emotional difficulties may manifest themselves in depression, hyperkinesis, or phobic reactions, for example, to dealing verbally with affects or feelings behind conditions of enuresis, aggressiveness, impulsiveness, and interpersonal difficulties. It is a significant and powerful technique for the child and adolescent psychotherapist.

Yet, role playing is not only a valuable technique within the therapist's repertoire; it provides much information that can enlighten the therapist as to the background of the child. First, role playing gives the therapist an opportunity to view how the child construes his or her world; what impact the world has had on the child; and how the child

moves toward, against, or away from it (after Horney, 1945). Second, insight into how the child is treated by significant others (parents, siblings, peers, etc.) and the quality of those interactions may be noted. Lastly, role playing is a nonthreatening technique in which most any child will become engaged, even those who may be guarded, suspicious, phobic, or dysphoric. Perhaps the most vital function role playing may serve is to immediately and unequivocally provide a direct, child-centered view of the feelings and/or affects one may be experiencing. Dramatic improvement may be seen in the matter of weeks, or months, when role playing is employed as the psychotherapist may quickly focus on specific issues or affective domains in which the child is experiencing some difficulty or conflict.

We have used role playing with children and have found it to be a valuable technique and an exciting experience in that it increases rapport and gives the child a sense of being understood, cared for, and respected. Role playing may be employed in a variety of settings, for example, during child psychotherapy, or prior to or after a diagnostic evaluation. Future clinical research should assess the efficiency of role playing within the psychotherapy or difficult children, such as the silent child. Perhaps these children need to be shown, indeed, that they are waiting to be helped into helping themselves.

## References

- ALLEN, F. H. (1942). *Psychotherapy with children*. New York: Norton.
- DODDS, J. B. (1985). *A child psychotherapy primer*. New York: Human Sciences Press.
- ERICKSON, E. H. (1950). *Childhood and society*. New York: Norton.
- FREUD, A. (1965). *Normality and pathology in childhood*. New York: International Univ. Press.
- FREUD, S. (1961). *Beyond the pleasure principle*. New York: Norton. (Original work published 1920.)
- GARDNER, R. A. (1971). The mutual story-telling technique in the treatment of anger inhibition problems. *International Journal of Child Psychoanalysis*, 1, 34-64.
- GOLDSTEIN, A. P. & GLICK, B. (1987). *Aggression replacement training: A comprehensive intervention for aggressive youth*. Champaign, IL: Research Press.
- GOTTMAN, J. M., GONSO, J., & SHULER, P. (1976). Teaching social skills to isolated children. *Journal of Abnormal Psychology*, 4, 179-197.
- GRESHAM, F. M. (1986). Conceptual issues in the assessment of social competence in children. In P. S. Strain, M. J. Guralnick & H. M. Walker (eds.). *Children's social behavior: Developmental, assessment, and modification*. Orlando, FL: Academic Press.
- HALBERSTADT-FREUD, I. (1975). Technical variations in the

- psychoanalytic treatment of a pre-school child. *Israel Annals of Psychiatry and Related Disciplines*, **13**, 162-176.
- HARTER, S. (1977). A cognitive-developmental approach to children's expression of conflicting feelings and a technique to facilitate such expression in play therapy. *Journal of Consulting and Clinical Psychology*, **45**, 417-432.
- HORNEY, K. (1945). *Our inner conflicts*. New York: Norton.
- IRWIN, E. C. (1983). The diagnostic and therapeutic use of pretend play. In C. E. Schaefer & K. J. O'Connor (eds.), *Handbook of play therapy*. New York: Wiley.
- KELLY, G. A. (1955). *The psychology of personal constructs*, Vol. 2, *Clinical diagnosis and psychotherapy*. New York: Norton.
- KENDALL, P. C. & BRASWELL, L. (1985). *Cognitive behavioral therapy for impulsive children*. New York: Guilford Press.
- KLEIN, M. (1975). *The psycho-analysis of children*. New York: The Free Press.
- LA GRECA, A. M. (1983). Interviewing and behavioral observations. In C. E. Walker & M. C. Roberts (eds.), *Handbook of clinical child psychology*. New York: Wiley.
- MCGUIRE, W. J. (1961). The effectiveness of supportive and refutational defenses in immunizing and restoring beliefs against persuasion. *Sociometry*, **24**, 184-197.
- MORENO, J. (1969). *Psychodrama*. New York: Beacon House.
- MOUSTAKAS, C. E. (1953). *Children in play therapy*. New York: McGraw Hill.
- PIAGET, J. (1952). *The origins of intelligence*. New York: Norton.
- REISMAN, J. M. (1973). *Principles of psychotherapy with children*. New York: Wiley.
- RYCHLAK, J. F. (1973). *Introduction to personality and psychotherapy: A theory-construction approach*. Boston: Houghton Mifflin Company.
- SARNOFF, C. (1976). *Latency*. New York: Aronson.
- SCHAEFFER, C. E. & MILLMAN, H. L. (1977). *Therapies for children*. San Francisco: Jossey-Bass.
- SMITH, C. D. (1977). Counter attitudinal role-playing and attitude change in children. *Dissertation Abstracts International*, **39**, 400-B.
- WAELDER, R. (1933). The psychoanalytic theory of play. *Psychoanalytic Quarterly*, **2**, 208-224.