PLAY THERAPY BEHAVIOR OF MALADJUSTED AND ADJUSTED CHILDREN

DISSertation

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By

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The diagnostic value of children's play was investigated. The question explored was "Can maladjusted children be discriminated from adjusted children through observation of their play therapy behavior?"

The play of 15 maladjusted and 15 adjusted children 5 to 10 years of age was compared during an initial 36-minute play therapy session. Three scales of the Play Therapy Observational Instrument (PTOI)—emotional discomfort, social inadequacy, and use of fantasy—were used to rate the children's play.

The children in the maladjusted group were referred by their parents for counseling and their teachers reported the children had exhibited one or more problem behaviors indicative of emotional disturbance. The children in the adjusted group were recommended by their teachers as exhibiting none of the problem behaviors and their parents did not believe their children needed counseling.

Discriminant function equations predicted correct group membership for 23 of the 30 children during the second 12-minute time segment and for the entire play
session. The analysis showed the play behaviors on the emotional discomfort scale of the PTOI items discriminated maladjusted and adjusted children. During the second and third 12-minute time segments and when all three time segments were combined, maladjusted children's play expressed significantly more dysphoric feelings, conflictual themes, play disruptions, and negative self-disclosing statements than were expressed by the adjusted children ($p < .01, .03, .01$, respectively). There were no significant differences between the two groups on play behaviors measured by the social inadequacy play and use of fantasy play scales of the PTOI.

Positive correlations were found between the children's age and social inadequacy play behaviors and between the social status of the parents' occupations and social inadequacy play behaviors. The results also suggested a negative correlation between the social status of parents' occupations and the use of fantasy play scores. A negative correlation was present between the use of fantasy and the social inadequacy play scores.
# TABLE OF CONTENTS

LIST OF TABLES ........................................ v

Chapter Page

1. INTRODUCTION ........................................ 1
   - Purpose of the Study .................................. 3
   - Significance of the Study .............................. 3
   - Related Literature .................................... 5
     - Meaning of Play ..................................... 5
     - Use and Meaning of Play in Therapy ................ 6
       - Use of Play in Therapy ............................. 6
       - Differences in Play: A Response to Life Experiences .. 7
   - Diagnostic Use of Play ................................ 11
     - Structured Play ...................................... 11
     - Unstructured Play ................................... 15
   - Summary ................................................ 21
   - Chapter 1 Bibliography ................................ 24

2. PROCEDURES ........................................... 29
   - Definitions ........................................... 29
   - Hypotheses ............................................. 36
   - Limitation ............................................. 37
   - Instrument ............................................. 37
     - Selection of Subjects and Description of Groups .... 42
     - Play Therapists ....................................... 43
     - Collection of Data .................................... 43
     - Procedure for Data Analysis ......................... 44
     - Chapter 2 Bibliography ............................... 47

3. RESULTS AND DISCUSSION ............................. 51
   - Demographic Data ...................................... 51
   - Results ............................................... 53
   - Results Related to the Hypotheses .................... 58
   - Discussion ............................................ 62
     - Emotional Discomfort Play Behaviors ................. 63
     - Social Inadequacy Play Behaviors .................... 66
     - Use of Fantasy Play Behaviors ....................... 69
     - Play Therapy Observational Instrument .............. 70
   - Implications ........................................... 73
Recommendations .................................. 76  
Chapter 3 Bibliography .......................... 79  

APPENDIX  

A Play Therapy Observational Instrument Selected Scales ................................. 81  
B Play Therapy Observational Instrument Rating Forms ......................................... 83  
C Behavioral Indicators of Emotional Disturbance ............................................ 87  
D Parental Information and Consent Form ......................................................... 89  

REFERENCES ........................................ 93
LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Correlations Between Children's Characteristics and Play Behavior Scores</td>
<td>52</td>
</tr>
<tr>
<td>2. Means and Standard Deviations of Play Behaviors During First 12-Minute Segment</td>
<td>54</td>
</tr>
<tr>
<td>3. Means and Standard Deviations of Play Behaviors During Second 12-Minute Segment</td>
<td>55</td>
</tr>
<tr>
<td>4. Means and Standard Deviations of Play Behaviors During Third 12-Minute Segment</td>
<td>56</td>
</tr>
<tr>
<td>5. Means and Standard Deviations of Play Behaviors During All Time Segments</td>
<td>57</td>
</tr>
<tr>
<td>6. Differences in Play Behaviors of Maladjusted and Adjusted Children</td>
<td>59</td>
</tr>
<tr>
<td>7. Predictions of Group Membership</td>
<td>62</td>
</tr>
</tbody>
</table>
CHAPTER 1

INTRODUCTION

Play is children's natural mode of communication (Axline, 1947). According to Piaget (1951), young children do not possess the needed degree of language ability nor cognitive skills to communicate with such an abstract means as words. Toys are their words, and play is their symbolic language of self-expression (Ginott, 1982a). Like speech and social living, play develops from the child's encounter with the environment (Behar & Rapoport, 1983). Moustakas (1953) described play as an expression of the child's emotional inner world. One might hypothesize then that the play of children who are experiencing psychological difficulties would be quantifiably different from the play of children who are experiencing little or no psychological distress.

Play offers a unique psychological tool for viewing the world through the eyes of the child. Erikson (1963) viewed play as the royal road to understanding children's efforts to deal with themselves and their experiences. Amster (1982) also discussed the psychological uses of play stating play offers an opportunity for further diagnostic understanding of children and their difficulties.
Clinicians make assumptions about the reliability and validity of play behavior and use those assumptions in formulating diagnoses, judging the therapy process, and evaluating outcome (Behar & Rapoport, 1983).

Children are brought to the attention of counselors not because they verbally express a need or wish to visit the counselor, but because someone, usually a parent or teacher, is complaining or is concerned about their behaviors (Campbell, 1983). These significant adults are usually disturbed by children's aggressiveness, withdrawal, expressions of poor self-esteem, poor academic performance, and/or disruptive or inappropriate behaviors (Quay, 1972). These adults use words to convey their concerns and perceptions. Play for the child and verbalization for the adult share similar qualities: they are mediums for exploring relationships, expressing feelings, and self-fulfillment (Landreth, 1982a). Counselors use adult's verbal communication for psychological evaluations. Can children's play be used in a similar manner? Do maladjusted children play in ways that are measurably different from adjusted children? Do maladjusted children exhibit a greater degree of emotional discomfort and social inadequacy and fantasy in their play than adjusted children?
According to Moustakas (1955a), the difference between maladjusted and adjusted children was noted in the quantity and intensity of negative attitudes rather than in any particular type of negativism. In adjusted children negative attitudes were expressed with more focus and direction and with less frequency and intensity. Maladjusted children expressed negative attitudes more often and more intensely and with less direction and focus.

Purpose of the Study

The purpose of this study was to compare the play behavior of maladjusted and adjusted children as measured by three scales of the Play Therapy Observational Instrument (PTOI) (Howe & Silvern, 1981). The three scales measure play therapy behavior in the areas of (a) emotional discomfort, (b) social inadequacy, and (c) use of fantasy.

Significance of the Study

Empirical research in the area of play therapy remains sparse due in part to a lack of objective behavioral instruments (Behar & Rapoport, 1983; Howe & Silvern, 1981; James, 1977). Since children's play behavior is highly variable and directly affected by the immediate situation (Behar & Rapoport, 1983), the use of an observational instrument of play therapy behaviors could add knowledge concerning the play of different types of children in a
therapy setting, increase the understanding of children's natural medium of communication which is play, and thereby enable counselors to be more sensitive and therapeutically responsive to children's statements about themselves and their world through their play.

Especially in the case of young children who are limited in their cognitive abilities and language development, play therapy behavior offers another source of information from the clients themselves. Just as adults tell counselors about their emotional and psychological problems, children play out theirs. "As William Blake puts it: 'The child's toys and the old man's reason are the fruits of the two seasons'" (Erikson, 1963, p. 222).

Since play is the child's natural mode of communication and a medium of self-expression, there is a need to clarify the use of play by "normal" or adjusted children and "disturbed" or maladjusted children. What play can tell about children and what children can tell through play are potentially significant sources of information not fully understood at the present time. Professional people in counseling clinics, medical centers, schools, and day care centers must decide whether children's behaviors are expressions of basic personality disturbance or merely variations of normal behavior.
Research is needed to confirm or disconfirm the assumptions often made concerning children's play.

Related Literature

Meaning of Play

Play has fascinated many writers with Rousseau (1883/1762) being among the first to suggest play as a means of understanding and educating children. Along a similar line, Piaget (1951) pointed to play as the means by which the child assimilates reality through the development of concepts concerning the social and objective world.

In the development of personality, play occupies a most important function. According to S. Freud (1950), play is children's attempt to relieve the tension between their sexual and aggressive impulses and the cultural demands for acceptable behavior. Erikson (1963) viewed children's play as their struggle to integrate ego qualities such as trust, autonomy, and identity with their social environment. For Erikson, these personality struggles emerge during critical periods of personality development.

Play is one of the first forms of communication used by humans. Play is for children what verbalization is for adults. Children "play out" their feelings, attitudes, and problems just as adults "talk out" their difficulties.
(Axline, 1947). Through play children deal with their life experiences by "creating model situations and master reality by experiment and planning" (Erikson, 1963, p. 222). Therefore, it can be stated child's play is an active, ongoing, personal research activity (Caplan & Caplan, 1973), as children explore, relive, express, experiment, and master their life experiences (Barber, Strother, & Duckett, 1982).

**Use and Meaning of Play in Therapy**

**Use of Play in Therapy**

The use of play in counseling children was an inevitable process since play provides a natural bridge to the counselor. Children are enabled to reveal naturally and therefore without embarrassment their thoughts, emotions, wishes, attitudes, and fantasies. Socially unacceptable impulses and aggressive behavior can be expressed symbolically through play without children fearing punishment or censure.

Innovators of therapy for children (Allen, 1942; Amster, 1982; Axline, 1947; Conn, 1939; A. Freud, 1946; Hug-Hellmuth, 1921; Klein, 1932; Lowenfeld, 1935; Moustakas, 1953; Solomon, 1938) have acknowledged play as a viable therapeutic medium. Though all the theorists share the commonality of play as a therapeutic modality, they
make different uses of the play media. A. Freud (1946), in her psychoanalytic approach, utilized play media to establish a strong rapport with the child while Klein (1932) interpreted the play as the child's unconscious processes. The structured theorists (Hambidge, 1982; Levy, 1982; Solomon, 1938) used play for its abreactive effects. The nondirective and relationship therapists (Allen, 1942; Axline, 1947; Moustakas, 1953) used play media to facilitate a therapeutic relationship with the child.

Differences in Play: A Response to Life Experiences

Regardless of therapists' different uses of play, examination of children's play therapy behavior indicates observable differences in their play in therapeutic settings. Such differences indicate children express their attitudes, emotions, and ideas about themselves and their world through play in response to their life experiences. Axline (1947) found children's play changing over the course of therapy. She observed patterns of play in early sessions when feelings were expressed from toy to toy, then from toy to an invisible person, next from the child to an imaginary person, and finally from the child to the person or object of his or her feelings. According to Moustakas (1955b) and Kestenbaum (1985), the intensity of negative attitudes in play differentiates disturbed children from adjusted children. A greater frequency of negative
attitudes by maladjusted children was also noted by Moustakas but not Kestenbaum.

In one of the most comprehensive studies of the process of play therapy, Hendricks (1971) analyzed and described the play activities, nonverbal behaviors and verbal comments of 10 boys, ages 8 to 10 years, in various phases of play therapy. She found that initially children engaged in exploratory, noncommittal, and creative play. They made simple descriptive and informative comments, and expressed curiosity. In the second stage of therapy, children began to play more creatively; aggressive play increased, and verbalizations concerning family, self, and their play increased. In the later sessions, anxiety, frustration, and anger were expressed; creative play moved to dramatic and role play, and the establishment of a relationship with the therapist became important.

Withee (1975), in a study using Hendricks' nonverbal and play activity scales and a revised version of the verbal expression scale, also identified changes in 10 children's behaviors over the course of 15 weekly play sessions. During the first three sessions, the children gave the most verbal verification of counselors' reflections of their behaviors, exhibited the highest levels of anxiety, and engaged in verbal, nonverbal and play exploratory activities. During the next three
sessions, curiosity and exploration dropped off while aggressive play and verbal sound effects reached their peaks. During sessions seven through nine, the aggressive play dropped to the lowest point, and creative play, expressions of happiness, and verbal information given about home, school, and other aspects of their lives were at their highest. During the following three sessions, relationship play reached its highest point, and noncommittal play sank to its lowest level. In the final three sessions, noncommittal play and nonverbal expressions of anger peaked; anxiety rose over its previous level, and the highest level of verbal relationship with the counselor and attempts to direct the counselor were found.

Withee (1975) also found differences between boys and girls similar to Sears' (1951) findings. Boys expressed more anger, aggressive statements, aggressive play, and sound effects. Girls exhibited more creative and relationship play, happiness, anxiety, verbal verification of counselor response, and verbalizations of positive and negative thoughts.

According to Moustakas (1955a), during the course of therapy, children's emotional growth follows six levels of development:

First level: prominent undifferentiated and ill-defined positive and negative feelings;
Second level: focused positive and negative feelings emerging in response to parents, siblings, and others;

Third level: distinctive ambivalent feelings;

Fourth level: primary focus on negative feelings, sometimes specific;

Fifth level: ambivalent positive and negative attitudes prominent; and

Sixth level: positive feelings predominant and appear as organized attitudes. Negative attitudes are also present. Both negative and positive attitudes are differentiated, focused, direct, and usually in line with reality.

That children use diverse means in play therapy to tell who they are, how they feel, and how they perceive themselves and their world has been substantiated in the literature. Numerous studies have explored how children express themselves in the play therapy setting by analyzing children's verbalizations (Finke, 1947; Lebo & Lebo, 1957) or types of play activity (Lowenfeld, 1935; Robert's unpublished study cited in Behar & Rapoport, 1983; Routh, Schroeder, & O'Tuama, 1974; Sjolund, 1981; Stephens, Bartley, Rapoport, & Berg, 1980). Other studies have examined tactile contact (Daly & Carr, 1967), and a combination of play activity, verbal comments, and

**Diagnostic Use of Play**

In counseling adults, therapists ask clients to tell about themselves and their life experiences. This information along with other observations form the basis for understanding, evaluating, and planning treatment. Since children communicate their attitudes, ideas, and emotions about themselves and their world through play, play becomes one of the bases for diagnosis.

**Structured Play**

A variety of dramatic play materials have been utilized in a very structured manner by various authorities for diagnostic purposes. Murphy's (1956) miniature toy interview, Lowenfeld's (1935) Sand World Technique, Sjolund's (1981) Erica Method, Woltman's (1964) doll interview, and Irwin's (1983) puppetry are among those procedures which can provide for clinical observation.

For preschoolers and younger school age children, Murphy's (1956) miniature toy interview provides a view of the form or how the child plays and the content or what the play is about. A series of miniature toys including figures of people, domestic and wild animals, sensorimotor materials, and transportation toys are placed on the floor
in a semicircle. Children are encouraged to play with these toys in any way they choose. The clinician takes notes on the process and intervenes to gather further information. The purpose of this interview is to determine the children's drives, needs, problems and ego structures in relationship to their views of their life space and temperaments.

Lowenfeld's Sand World Technique (1935) and Sjolund's Erica Method (1981) appeal greatly to the tactile, sensory expressions of children. Children are given a prescribed collection of miniature toys which include people, animals, transportation toys, and unstructured materials such as stones, paper, wood, and plasticine to play with. They are then asked to create a picture in either a wet or dry sandbox. Lowenfeld found that children created their world with its physical and biological features in ways that were different for every child and expressive of his or her way of perceiving, feeling, wishing, caring, and fearing. Sjolund's Erica Method uses the sequence, form, composition, and content of three consecutive play interview sessions to ascertain diagnostic information in the areas of development, social relationships, psychosomatic symptoms and psychopathological processes.

Puppets have been used for diagnostic purposes in play settings because puppets seem to offer safe and vicarious
outlets for impulse and fantasies. Woltman (1964), following the tradition of psychodrama, was one of the first to describe the use of puppets and marionettes in therapy. Other therapists (Conn, 1939; Hambidge, 1982; Irwin, 1985; Levy, 1982; Solomon, 1938) have also used puppets and dolls in play therapy for diagnostic purposes.

According to Irwin (1985), communicating through puppets is fun, rich in symbolism, and physically and psychically safe. Used as a tool in Irwin's diagnostic assessment, puppet play provides symbolic, nonverbal and interactional data. He provides a range of puppets, a wide choice of materials, and directions such as "Go behind the stage," "Introduce the characters," or "Announce the beginning of the show." Following the play, Irwin interviews the puppets and the puppeteer to decipher the meaning of the story to the child. He also uses an assessment procedure that evaluates the child's selection of toys, story content, and type of play. This information gives clues about children's internal state and degree of organization.

Doll play is another variation of the more structured diagnostic procedures. Children are given a set of dolls, usually a family, and a setting such as a doll house in which to play with the dolls. Children are told to tell a story using the dolls as story characters. Levy's (1982)
release therapy, Hambidge's (1982) structured play therapy, Conn's (1939) play interview, and Solomon's (1938) active play therapy all use dolls in a planned way to understand and evaluate children's experiences as well as to provide a therapeutic treatment modality.

Children reveal themselves through their play in structured doll interviews as adults do through verbalizations in counseling interviews. Levy (1933) reports children have played out problems of rebellious behaviors, stealing, sibling rivalry, and self-punishment. Conn (1939) found that children described emotional, personal, and imaginative aspects of their behavior through structured doll play.

Children's response to their life experiences in areas such as age and sex have also been noted in their doll play. Girls play in a more affectionate and stereotyped manner while boys demonstrate more aggression (Graham, 1955; Sears, 1951). Lynn and Lynn (1959) reported 4-year-olds achieved higher dependency scores in doll play than 6-year-olds and by the age of six more children chose same sex parent dolls. Using the London Doll Play Technique to investigate children's fantasies, feelings, attitudes, and abilities to solve problems in interpersonal relationships, Moore and Ucko (1961) found differences expressed through play in children's ability to cope, degree and kind of
affect, emotionality, freedom of expression, and degree of socialization.

In a summary of research on the diagnostic use of structured doll play, Levin and Wardwell (1962) suggest children express their uniqueness through their play. Boys are more overtly aggressive; children are more aggressive in the second rather than the first session; girls demonstrate more stereotyped behavior than boys; children prefer the same sex parent doll; in families in which parents were separated, girls were more dependent and boys exhibited more aggression with father and boy dolls.

Unstructured Play

The diagnostic unstructured play interview seems particularly important for children whose lack of verbal skills, level of cognitive development, and difficulty with introspection and self-report make a more structured, verbal interview ineffective. Criteria for evaluating unstructured play sessions are numerous and difficult to validate. Using a case study method, Stephens, Bartley, Rapoport, and Berg (1980) found low correlations between the systematic observation of a 30-minute play interview of a normal child with a therapist and more formal behavior ratings by parent, teacher and psychologist in home and school settings. The criterion of children's ability to relate to the counselor in the play setting is considered
to be significant (Allen, 1982; Axline, 1947; Moustakas, 1953). In a research study cited by Behar and Rapoport (1983), 110 3-year-old children were screened for admission to nursery school. The judges felt the most useful diagnostic information was a description of the child's relatedness to the examiner.

The diagnostic use of unstructured play to identify overactive children presents unique considerations of criteria to be used in evaluations. Some children considered unmanageable by teachers and parents appear calm and composed in a play setting. In order to determine if the behavior of hyperactive and aggressive children is different in academic and play settings, Milich, Loney, and Landau (1982) studied 90 boys, ages 6 years to 12 years, labeled either aggressive or hyperactive by their teachers. They observed the boys in a 15-minute free play setting and in a 15-minute restricted academic setting. Hyperactivity was identified in both settings by a significantly greater number of physical movements as measured by ankle and wrist actometers. In the academic setting, hyperactive boys spent significantly less time on task and completed fewer work sheets correctly. Aggressiveness was identified only by a larger number of grid crossings during the free play period. Correct classification was 76% in the free play setting and 67% in the academic setting. Using play
observation, the authors could discriminate boys who had been classified as hyperactive from boys classified as aggressive.

In a similar study, Roberts (cited by Behar & Rapoport, 1983) correctly classified 85% of subjects as to pure hyperactive, pure aggressive, or a combination of both when play was restricted to one toy. In the academic setting, 90% of the children were correctly classified. The greatest differences between normal and hyperactive children in free play were in the number of grid crossings, ankle actometer, time spent out of seat, and proportion of time on task. Barkley and Ullman (1975) found only the wrist actometer score in the free play setting to differentiate significantly among three groups of hyperactive, psychiatric, and nonreferred children. Movement in the playroom and number of toy changes were not discriminative.

Playroom settings have also been used for diagnostic family interviews (Keith & Whitaker, 1981; Orgun, 1973). In this setting, clinicians can observe family member groupings, willingness to interact, inhibitions to express self through play, power structure, problem-solving, and family roles. The opportunity of play diffuses the family's focused concern. Since material revealed by children is through play, the counselor can choose not to
focus on threatening issues, thus helping children to remain relaxed. As pointed out by Orgun, children cannot be protected from disabling anxiety in an office-type interview since play material is not available to help children deal with their anxiety. In the family play setting, Keith and Whitaker used play as a medium of communication with repeated shifts from metaphor to reality and back again. This technique enables family members to deal with their problems in a less threatening manner.

Some writers, such as Behar and Rapoport (1983), have questioned the diagnostic value of play observations. They maintain formal diagnosis of a disorder must rely more on a standardized, reliable clinical criterion than on analysis of play behavior. Herjanic and Campbell (1977) have developed such a diagnostic interview based on the DSM III criteria. The diagnostic verbal interview covers six areas: relationship problems, behavior at school, school learning problems, neurotic symptoms, psychotic symptoms, and antisocial behaviors. Based on an earlier study (Herjanic, Herjanic, Brown, & Wheatt, 1975) which found an 80% agreement of behavior ratings between parent and child, Herjanic and Campbell chose to ask parents to rate relationship, school behavior, and academic achievement and to ask children to rate neurotic, somatic, and psychotic symptoms. They used 50 pairs of well-matched pediatric and
psychiatric clinic children, ages 6 through 16 years, and their mothers. In the 6- through 8-year-old age group, there were no significant differences in the two populations, but in the 9- through 11-year-old age group and the 12- through 15-year-old age group significant differences were evidenced. In the 9- through 11-year-old age group significant differences were found in all the areas rated by the parents: relationship, school behavior, and learning problems. Not until the children were in the 12- through 15-year-old age group were significant differences reported in every category rated by either children or adults with the exception of school behavior. It would seem from this finding that the younger the child the less likely the child will report behavior symptoms. Perhaps young children are not as reliable reporters as Herjanic et al. (1975) claimed and do not report behavior symptoms in the same manner as parents.

Unstructured play may be found to be a more reliable source of information than structured play interviews or a standardized, self-report verbal interview as valid and reliable assessment instruments are developed. The Play Therapy Observational Instrument, developed by Howe and Silvern (1981), offers such an objective protocol for evaluating children's unstructured play in a therapy setting. Using this instrument, Howe (1980/1981)
identified patterns of behavior during a 48-minute play therapy session which differentiated 13 aggressive, 10 withdrawn, and 20 well-adjusted children. During the first 12 minutes, aggressive children presented frequent play disruptions, conflicted play, self-disclosing statements, high levels of fantasy play, and aggressive behavior toward the counselor and toys. Withdrawn boys were identified by their regression in response to anxiety, bizarre play, rejection of counselor's intervention, and dysphoric content in play. Well-adjusted children exhibited lower levels of emotional discomfort, social inadequacy, and fantasy play. Withdrawn girls could not be differentiated from well-adjusted girls. No differences were found among the groups during the second 12 minutes of the interview. During the third and fourth 12 minutes, disturbed children were differentiated from well-adjusted ones by the play behaviors described in the PTOI.

Play can be used for diagnostic assessment supplementing the historical information. According to Frank (1976), play is not idle unproductive activity rather play is a means of coming to terms with the world and oneself. People can often see how children are building their life space by observing their play. For Amster (1982), play is a "complex distorted assortment of the child's conscious and unconscious expressions" (p. 42).
She believes counselors can "observe the child's capacity to relate himself to others, his distractibility, his rigidity, his area of preoccupation, his area of inhibition, the direction of his aggression, his perception of people, his wishes, and his perception of himself" (p. 34). This study examined the play therapy behaviors of maladjusted and adjusted children to determine if their play is quantifiably different.

**Summary**

The importance of play in understanding and educating children has long been recognized (Rousseau, 1883/1762). Both psychological and developmental theories have addressed the meaning and use of play. Play has been presented as a means by which children assimilate reality through the development of concepts (Piaget, 1951). For Erikson (1963), play is children's attempt to integrate ego qualities such as trust, autonomy and identity with the social environment such as family, school, and society. According to S. Freud (1950), children attempt to relieve the tension between sexual and aggressive impulses and cultural demands for acceptable behavior through play. In the therapy setting, counselors believe children use toys as their words and play as their form of communicating who they are, how they feel, what their problems are, and how they perceive themselves and their life experiences.
(Allen, 1942; Axline, 1947; Levy, 1982; Moustakas, 1953; Solomon, 1938).

Since children speak about themselves through play, play can be utilized as one of the sources of information for diagnosis. The more structured diagnostic protocols include Murphy's (1956) miniature toy interview, Lowenfeld's (1935) Sand World Technique, Sjolund's (1981) Erica Method, Woltman's (1964) doll interview, and Irwin's (1983) use of puppets. In the structured protocol settings, diagnostic information has been revealed through play as children played out problems of rebellious behaviors, stealing, sibling rivalry, and self-punishment (Levy, 1933); girls played in a more affectionate and stereotyped manner than boys, and boys demonstrated more aggression (Graham, 1955; Sears, 1951); younger children played more dependent roles, and 6-year olds chose their same sex parent doll (Lynn & Lynn, 1959); and children acted out emotional, personal, and imaginative aspects of themselves (Conn, 1939).

When children's play is examined, patterns which indicate how children use play to reveal themselves become discernable. Over the course of therapy, children begin to express feelings more directly and realistically and with more focus and specificity (Axline, 1947; Moustakas, 1955a). Hendricks (1971) and Withee (1975) found that children initially engaged in exploratory, noncommittal,
and creative play. In the second stage, aggressive play and verbalizations about family and self increased. In the later sessions, anxiety, frustration, and anger were expressed; dramatic play and relationship with the counselor became important.

The unstructured play interview is particularly appropriate in diagnostic evaluations of younger children. Young children do not verbally report symptoms of behavior problems as do children in their pre- and early teen years (Herjanic & Campbell, 1977). The younger child's lack of verbal skills, level of cognitive development, and difficulty with introspection and self-report often result in the more structured, verbal-based interview being ineffective. Using the Play Therapy Observational Instrument in a diagnostic evaluation of play therapy behaviors, Howe (1980/1981) was able to identify aggressive, withdrawn, and well-adjusted children. The intent of this present study is to use children's play as a diagnostic tool. Since play is a "complex, distorted assortment of the child's conscious and unconscious expressions" (Amster, 1982, p. 42), play can offer counselors a source of data from the clients themselves. Counselors can often see how children are building their life space by observing their play (Frank, 1976).
CHAPTER 1 BIBLIOGRAPHY


CHAPTER 2

PROCEDURES

This study compared the play therapy behavior of 15 maladjusted and 15 adjusted children ages 5 to 10 years on the emotional discomfort, social inadequacy, and use of fantasy behavior scales of the Play Therapy Observational Instrument (PTOI) (Appendix A). The rating form for the PTOI is included in Appendix B and was used to rate the children's play therapy behavior. This chapter describes the procedures followed to complete the study and includes definitions, hypotheses, limitations, the instrument, selection of subjects, description of adjusted and maladjusted groups, description of play therapists, collection of data, and procedure for data analysis.

Definitions

Play as defined in this study followed Erikson's (1963) definition which considered play to be a "function of the ego, an effort to synchronize social and bodily processes with the self" (p. 211). Erikson emphasized the ego's need to master many areas of life, especially when an individual finds his or her self, body, and social roles unfulfilling and lacking. In response to this situation, according to Erikson, the purpose of play is to imagine ego
mastery and practice it in a reality somewhere between fantasy and actuality.

Erikson (1963) described the individual's need to re-enact painful experiences in words or acts, a phenomenon S. Freud labeled repetition compulsion. The child arranges play objects in such a manner that he or she becomes master of the event. Through the play, children turn passivity into activity; they play at doing something that has been done to them (Moustakas, 1953).

For Erikson, play is not recreation; play is the earliest form where individuals deal with experiences by creating model situations and master reality by experimenting and planning. Play is that form of endeavor that is "free from the compulsions of conscience and from impulses of irrationality" (Erikson, 1963, p. 214).

For the purposes of this study, play behavior was limited to the behavioral dimensions described in and measured by the emotional discomfort, social inadequacy, and use of fantasy scales of the PTOI (Appendices A and B).

Fantasy is a particular dimension of play behavior and includes pretend play which employs particular types of communication: negation, enactment, signals, gestures that supply terms, conditions, or setting for pretense, and explicit mention of transformation for the pretend play (Schaefer & O'Connor, 1983). Bettelheim (1976) discussed
the therapeutic qualities of fantasy when he described the value of fairy tales. The story not only must hold children's attention, entertain them, and arouse their curiosity, but the story must stimulate their imagination, help develop their intellect, clarify their emotions, be attuned to their anxieties and aspirations, give recognition to their difficulties, and at the same time suggest solutions to the problems which concern them. Play becomes fantasy as children stimulate and nurture those resources they need most in order to cope with difficult problems such as sibling rivalries; narcissistic disappointments; relinquishing childhood dependencies; gaining a feeling of selfhood and of self-worth; and dealing with anxieties, anger, and even violent thoughts and feelings (Kestenbaum, 1985). In short, the use of fantasy helps children master the psychological problem of growing up (Bettelheim, 1976; Irwin, 1983).

According to Piaget (1951), the use of fantasy aids the cognitive processes of accommodation and assimilation. As children imitate and interact physically with the environment during make-believe play, they practice accommodation. Through the enactment of various roles in fantasy play, children integrate new information into old schemata: This process Piaget calls assimilation.
Research has further emphasized the value of a child's capacity to fantasize. Singer (1973) has experimented extensively in the area of fantasy and found make-believe play to be "one of the important ways in which children practice imagery and rehearse a variety of elaborate skills both imaginal and verbal, and, in addition, develop a learning set which prepares them for later, and in many cases, more effective use of imagery in the learning process" (p. 190). Freyberg (1973) and Smilansky (1968) found that increased role-playing behavior of young children results in more positive affect, less fighting and hyperactivity behavior, use of more parts of speech, and more verbal communication. The results of Bigelow's (1973) study of imaginative play and control of aggression indicated fifth graders who employed a high level of fantasy reduced their level of aggression following the viewing of films showing aggressive behavior as well as films of nonaggressive behavior. However, the low fantasy fifth graders evidenced, not a decrease, but a trend toward an increase in aggression following exposure to the film depicting aggressive behavior.

According to Singer (1973), the "as-if" play of children provides the basis for the later capacity to entertain possibilities. He wrote, "what is perhaps most truly human about man, what is perhaps his greatest gift in
the evolutionary scheme and indeed his greatest resource in the mastery of the environment and of himself, is his capacity to fantasize. . . . To be able to make-believe gives both the child and the adult a power over the environment and an opportunity to create one's own novelty and potential joy" (pp. 258-259). For the purposes of this study, fantasy play was limited to the behavioral dimensions described in and measured by the fantasy scale of the PTOI.

Emotional discomfort is a critical indicator of maladjustment and conversely of therapeutic improvement as pointed out in the literature. Analytical-oriented writers (Erikson, 1963; S. Freud, 1950; Klein, 1932) agree that anxiety as transference infers pathological defensive processes. Children exhibiting constriction or anxious withdrawal behavior constitute a large proportion of children referred to mental health facilities (Quay, 1972). Person-centered writers (Axline, 1947; Moustakas, 1955a) stress the importance of the quality of children's feelings toward themselves and others. For the purposes of this study, emotional discomfort was limited to the behavior dimensions described in and measured by the emotional discomfort scale of the PTOI.

Social inadequacy covers differing descriptive terms suggested in the literature as important in the assessment
of pathology and therapeutic change. When individuals manifest deficits in social interactions, such as willingness to interact with the counselor or acceptance of therapy limits, then maladjustment is considered present. Both analytic theorists (A. Freud, 1946; Klein, 1932) and person-centered theorists (Allen, 1982; Axline, 1947; Moustakas, 1953) emphasize the therapeutic relationship although they do so for different reasons. Similarly, play therapists who stress limit setting (Bixler, 1982; Ginott, 1982b) relate children's social competence to children's ability to follow rules and accept limits during the play therapy hour. For the purposes of this study, socially inadequate play was limited to the behavior dimensions described in and measured by the social inadequacy scale of the PTOI.

Maladjusted and adjusted are terms complex in nature and diverse in form. According to Ollendick and Hersen (1983), the present understanding of child psychopathology must be considered rudimentary, deeply embedded in developmental processes but nonetheless promising. Childhood behavior problems can only be examined from a developmental perspective and are often a function of parents' expectations (Campbell, 1983). Common developmental problems, however, may be a warning signal of more severe and persistent difficulties.
No definition is universally accepted by professionals, but there seem to be two broad areas of common concern: children with behavior disorders "(1) deviate from standards or expectations for behavior, and (2) impair the functioning of others or themselves" (Cullinan, Epstein, & Lloyd, 1983, p. 103). In a similar fashion, internalizing or inner-directed clusters of behavior and externalizing or outer-directed clusters of behavior are two primary categories of children's problem behavior used by a number of researchers to codify children's behavior (Achenbach, 1982; Achenbach & Edelbrock, 1983; Behar & Rapoport, 1983; Campbell, 1983; Ollendick & Hersen, 1983; Quay, 1979). The internalizing clusters of behavior such as neurotic, withdrawn, depressed, and somatic problems match closely the behaviors included in the emotional discomfort scale of the Play Therapy Observational Instrument which was selected for use in this study. The externalizing behaviors such as conduct problems, hyperactivity, and aggressive and antisocial disorders follow closely the behaviors included in the social inadequacy scale of the PTOI.

For the purposes of this study, maladjusted children were those who have been referred for counseling services and who exhibit one or more behaviors which Hammer (1970) found present in emotionally disturbed children (Appendix
C). Adjusted children were those who have never been referred for counseling and are described by teachers and parents as exhibiting none of the behaviors indicative of emotionally disturbed children (Appendix C).

Hypotheses

To address the purposes of this study, the following hypotheses were investigated:

1. There will be no significant differences in the emotional discomfort play of maladjusted and adjusted children as measured by the PTOI during the first 12-minute segment of a play session.

2. There will be no significant differences in the social inadequacy play of maladjusted and adjusted children as measured by the PTOI during the first 12-minute segment of a play session.

3. There will be no significant differences in the fantasy play of maladjusted and adjusted children as measured by the PTOI during the first 12-minute segment of a play session.

4. There will be no significant differences in the emotional discomfort play of maladjusted and adjusted children as measured by the PTOI during the second 12-minute segment of a play session.

5. There will be no significant differences in the social inadequacy play of maladjusted and adjusted children
as measured by the PTOI during the second 12-minute segment of a play session.

6. There will be no significant differences in the fantasy play of maladjusted and adjusted children as measured by the PTOI during the second 12-minute segment of a play session.

7. There will be no significant differences in the emotional discomfort play of maladjusted and adjusted children as measured by the PTOI during the third 12-minute segment of a play session.

8. There will be no significant differences in the social inadequacy play of maladjusted and adjusted children as measured by the PTOI during the third 12-minute segment of a play session.

9. There will be no significant differences in the fantasy play of maladjusted and adjusted children as measured by the PTOI during the third 12-minute segment of a play session.

Limitation

Subjects were limited to children ages five to ten years.

Instrument

The Play Therapy Observational Instrument (PTOI), selected to examine these hypotheses, was developed by Howe
and Silvern (1981) as a rating scale for play behaviors which theorists believe significant in therapy. Three scales of the PTOI (Appendix B) were used for rating videotaped segments of an initial play therapy session. A preliminary research study by Howe and Silvern constructed a 31-item child play behavior rating instrument as a result of an extensive review of the play therapy literature. On the basis of the review, the behaviors selected for inclusion in the scale were identified as behaviors described in the literature as indicators of important clinical concepts. In addition, the behaviors clustered into internally consistent groupings which are similar to dimensions of playroom behavior outlined by major schools of play therapy as important to psychodiagnosis, therapy process, and outcome, i.e., use of fantasy, play for dealing with personal issues, the competency and quality of the child's interaction with the therapist, and behaviors indicative of emotional discomfort.

The behavioral items that measure the dimensions of emotional discomfort, social inadequacy and use of fantasy and some of the citations which Howe and Silvern (1981) used to corroborate the inclusion of the behavior are as follows.
Dimensions of emotional discomfort

1. Talk more about worries and troublesome events (Axline, 1947; S. Freud, 1950; Klein, 1932)
2. Inappropriate aggression toward the therapist (Bixler, 1982; Ginott, 1982b; Klein, 1932)
3. Frequency of conflicted play (S. Freud, 1950; Klein, 1932)
4. Quality and intensity of affect (Moustakas, 1955b; Schaefer, 1976)
5. Frequency and degree of play disruption (Erikson, 1963)

Dimensions of social inadequacy

1. Degree of body stiffness (Quay, 1972)
2. Use of incoherent or bizarre content (Cain, 1964)
3. Therapist excluded from child's activities (Quay, 1972)
4. Therapist's interventions met with hostility or withdrawal (Axline, 1947; Bixler, 1982; Ginott, 1982b; Klein, 1932; Quay, 1972)

Dimensions of the use of fantasy play

1. Number of variations in fantasy story scenes (Cain, 1964; Gardner, 1976)
2. Number of qualitatively different fantasy roles (Gould, 1974)
3. Frequency of abrupt fluctuations between fantasy and reality (Erikson, 1963; Gould, 1974)

4. Time spent concentrating play on characters rather than things (Cain, 1964)

In the original study, two nonclinicians, who had received 20 hours of training and who used a prepared manual, reached a level of exact agreement with the trainer's judgment on most of the rating categories on the practice ratings. They then rated 76 12-minute segments of videotaped play therapy sessions using videotapes and verbatim transcripts. The raters viewed and scored the segments individually and in a different random order.

The taped segments were from 10 play therapy sessions and involved five girls and five boys, ages 4 to 10 years. The children were being seen by nine doctoral or post-doctoral clinical psychology students. The children had been in therapy from two weeks to over a year. Various stages of time in therapy were equally represented in the 76 segments. The diagnoses for the children varied from neurotic to borderline to psychotic. Diversity was included in an attempt to insure that interjudge agreement in the behavior categories could be established within these broad dimensions. The video segments were drawn from two consecutive therapy sessions a week apart for each of 10 children to insure stability of a behavior across time.
The scores for each child remained stable within an hour-long play session with the exception of the fantasy play which occurred significantly more often at the end rather than the beginning of sessions. Scores on the scales also remained stable over the one-week period for each child indicating stability of the behavior.

Interjudge reliability was found adequate on 13 of the 31 items according to a criterion of an intraclass correlation of at least .48 and rater agreement within one-point range of 80% or better across the 76 segments. The 13 reliable items were grouped into four scales which met the criteria of reliability of .70 or better, homogeneity ratios of .30 or better, and correlations between the items and the scales themselves of .50 or better. The resulting scales of the PTOI were labeled social inadequacy, emotional discomfort, use of fantasy play, and maladjustment.

The maladjustment scale consisted of all the behavioral items in the social inadequacy scale and all but one of the items in the emotional discomfort scale. That one item was "talk about worries and troublesome events." As pointed out by Howe and Silvern (1981), there has been theoretical controversy between psychoanalytic and person-centered theorists concerning the extent to which such self-disclosing talk indicates improved emotional health
and should be encouraged for long lasting therapeutic success.

The play behavior scales and their respective behavior items appear in Appendix A. The rating forms for the behavior items are in Appendix B. Since the maladjustment scale represents an overlap of behavior categories in the emotional discomfort and social inadequacy scales, the maladjustment scale was omitted from this study.

Selection of Subjects and Description of Groups

The maladjusted group of subjects selected for this study consisted of 15 children, ages 5 to 10 years, selected from children referred by their parents for counseling to university or community counseling facilities in the north Texas area. To be included in the maladjusted group, the children's school teachers must have reported one or more problem behaviors which Hammer (1970) believed indicative of emotional disturbance (Appendix C).

The adjusted group of subjects consisted of 15 children, ages 5 to 10 years, recommended by school teachers or a university nursery school director as children who exhibited none of the problem behaviors which Hammer (1970) associated with emotional disturbance (Appendix C). The parents of the adjusted children did not believe their children needed counseling now, nor had any of the adjusted children been referred for counseling in
the past. The 15 adjusted subjects were matched on age and sex to the maladjusted subjects. None of the children in either group had been in counseling nor in a play therapy room prior to their participation in this study. Informed consent and demographic information were obtained for each child (Appendix D).

Play Therapists

Two post-doctoral and three doctoral counselors, two males and three females, conducted the play therapy sessions. All counselors had received play therapy training and supervision and were evaluated as qualified play therapists by a nationally recognized authority in the field of play therapy. The counselors were not informed of the specific behaviors rated for this study. Play therapy procedures outlined by Axline (1947) were used by all counselors.

Collection of Data

The initial 36-minute individual play therapy session with each of the 30 children was videotaped from behind a one-way mirror. All play therapy sessions took place in a university or community counseling clinic. The play rooms were fully equipped with materials suggested by Landreth (1982b). The videotapes and information sheets were number coded so the author could rate the tapes blind. The
child's diagnostic category, age, sex, and parent's occupation were added to the data following the ratings of the videotapes. Parents' occupations were number coded following the occupational classifications set forth in Hollinghead's Four Factor Analysis of Social Status (1975).

Procedure for Data Analysis

The investigator rated all the play therapy videotapes. Her training included studying the PTOI manual and rating forms, rating nonexperimental play therapy videotapes, and discussions and rating sessions with a doctoral degree professor of counseling who has 22 years experience teaching play therapy courses and working with children. Dr. Louise Silvern, one of the PTOI authors, was contacted for additional clarification of the manual and rating forms. The author rated play therapy videotapes independently and the accuracy of her ratings was checked against the ratings of the advanced play therapist. She spent 40 hours individually and 15 hours with the advanced play therapist and reached an 85% to 90% interrater agreement prior to the ratings of the videotapes for this research. Consistency of the author's ratings was established by having the author and the advanced play therapist rate a play therapy videotape at the midpoint of rating the experimental tapes. There was a 100% interrater agreement.
The 36-minute sessions were divided into 12-minute segments and rated separately. The decision to use a 36-minute play session and to rate 12-minute segments of the session was based on four considerations. First, the original design of the PTOI was based on observations of 12-minute intervals. Second, it is more likely clinicians will use a shorter play session for diagnostic purposes than the usual 45- to 60-minute therapeutic play session. The third and fourth factors to support using the three 12-minute segments were based on research findings. Using the PTOI, Howe (1980/1981) found significant differences in the play behavior of disturbed and adjusted children during the first, third, and fourth 12-minute segments of an hour play session but not during the second 12-minute segment. Howe and Silvern (1981) found all segments of an hour session yielded similar findings with the exception of fantasy play. Fantasy play appeared more prominently in the third 12-minute segment (25 through 36 minutes) and the fourth 12-minute segment (37 through 48 minutes).

To test the nine hypotheses a discriminant function statistical analysis was used to determine if there was a significant difference in the play therapy behavior of maladjusted and adjusted children. Play therapy behavior was measured by the emotional discomfort, social inadequacy, and use of fantasy scales of the PTOI in each
of three 12-minute time segments. Univariate $F$-ratio tests were utilized to determine significance.

A chi-square was performed to determine if there were significant differences in the parents' occupations of maladjusted and adjusted children. A Pearson product moment correlation was conducted to explore the relationship of age, sex, and parents' occupations to the three play behavior scales.


Hollingshead, A. (1975). Four factor index of social status. (Available from Department of Sociology, Yale University, P.O. Box 1965, New Haven, CT 06520).


Chapter 3

RESULTS AND DISCUSSION

The purpose of this chapter is to present the demographic data of the sample, the results of the data analysis concerning each hypothesis tested in this study, a discussion of the results, implications, and recommendations.

Demographic Data

The 15 adjusted children were matched on age and sex with the 15 children in the maladjusted group. In each group, there were three 5-year-old boys, one 5-year-old girl, five 6-year-old boys, one 6-year-old girl, one 7-year-old boy, one 7-year-old girl, one 8-year-old boy, and two 9-year-old girls. The total sample included 27% 5-year-olds, 40% 6-year-olds, 13% 7-year-olds, 7% 8-year-olds, and 13% 9-year-olds. The sex composition of the sample data consisted of 67% boys and 33% girls or 10 boys and 5 girls in each group.

Hollingshead’s Four Factor Index of Social Status (1975) was used to classify parents’ occupations. In the total sample, the parents' occupational categories reflected 7% unskilled workers, 20% skilled manual workers, 13% clerical or sales workers, 10% technicians or small
business owners, 17% managers or minor professionals, 13% administrators or lesser professionals, and 20% major professionals or higher executives. A chi-square analysis produced no significant differences in the occupations of parents of maladjusted and adjusted children \(X^2(6, N = 30) = 6.8; p > .30\).

Pearson product-moment correlations were used to analyze the relationships between the play behavior scores of the 30 children for the entire play session and their sex, age, and parents' occupations. The data are presented in Table 1. There is a significant positive correlation \(r = .40\) between age and social inadequacy scores.

Table 1

**Correlations Between Children's Characteristics and Play Behavior Scores**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Play Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Emotional discomfort</td>
</tr>
<tr>
<td>Sex(^a)</td>
<td>-.30</td>
</tr>
<tr>
<td>Age</td>
<td>-.13</td>
</tr>
<tr>
<td>Social Status of Parents' Occupations</td>
<td>-.18</td>
</tr>
</tbody>
</table>

Note. \(N = 30\).
\(^a\)Sex coded as 1 = male and 2 = female.
\(*p < .01. \ **p < .004. \ ***p < .002. \)
Surprisingly, older children received higher scores on the social inadequacy play scale, and younger children, lower scores. Other unexpected findings were the relationships of parents' occupations to scores on the social inadequacy and use of fantasy play scales. The higher the status of the parents' occupations (i.e. unskilled being lowest and professional being highest), the higher the children scored on the social inadequacy scale ($r = .51$), and the lower the children scored on the use of fantasy scale ($r = -.47$). It must be noted that the variables of age, sex, and parents' occupations were not included in the hypotheses though through purposeful sampling the children were matched on age and sex. In addition, the chi square produced no significant differences in the social status of the parents' occupations among maladjusted and adjusted children. The correlations are, of course, sample specific.

Results

Discriminant function analyses were performed to test all nine hypotheses, and univariate F ratios were employed to determine significant differences. A level of significance of .05 was established as the criterion for either retaining or rejecting the hypotheses.

The first step in statistical analysis was to examine the descriptive statistics. Table 2 contains the means and
standard deviations for the three play therapy behavior scales obtained during the initial 12-minute time segment for maladjusted and adjusted children. The last column of the table contains the means and standard deviations calculated when all cases are combined into a single sample.

Table 2

Means and Standard Deviations of Play Behaviors During First 12-Minute Segment

<table>
<thead>
<tr>
<th>PTOI Scales</th>
<th>Maladjusted</th>
<th>Adjusted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional discomfort (5-25)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>10.07</td>
<td>8.73</td>
<td>9.40</td>
</tr>
<tr>
<td>SD</td>
<td>2.25</td>
<td>1.57</td>
<td>2.03</td>
</tr>
<tr>
<td>Social inadequacy (4-20)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>6.47</td>
<td>6.60</td>
<td>6.53</td>
</tr>
<tr>
<td>SD</td>
<td>2.42</td>
<td>1.76</td>
<td>2.08</td>
</tr>
<tr>
<td>Use of fantasy (4-18)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>7.60</td>
<td>6.93</td>
<td>7.27</td>
</tr>
<tr>
<td>SD</td>
<td>4.03</td>
<td>3.15</td>
<td>3.57</td>
</tr>
</tbody>
</table>

an = 15 for each group. Possible range of scale.

This information is initially used in the Box's M test which tests the assumptions underlying the use of the linear discriminant function analysis. The assumptions are
the play behaviors were samples from a multivariate normal population and the population covariance matrices were all equal. The Box's $M$ test for the initial 12-minute segment produced a Box's $M = 9.43$ and an $F = 1.39$ which is not significant. This analysis assures that the assumptions have been met and the linear discriminant function is the most accurate classification rule to follow (Norusis, 1985).

Tables 3 and 4 contain the means and standard deviations for the scores on the three play therapy

**Table 3**

**Means and Standard Deviations of Play Behaviors During Second 12-Minute Segment**

<table>
<thead>
<tr>
<th>PTOI Scales</th>
<th>Group$^a$</th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Maladjusted</td>
<td>Adjusted</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Emotional discomfort (5-25)$^b$</td>
<td>10.53</td>
<td>8.60</td>
<td>9.57</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>1.88</td>
<td>1.99</td>
<td>2.14</td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social inadequacy (4-20)$^b$</td>
<td>6.53</td>
<td>6.40</td>
<td>6.47</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>2.03</td>
<td>1.68</td>
<td>1.83</td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of fantasy (4-18)$^b$</td>
<td>8.53</td>
<td>6.80</td>
<td>7.67</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>4.27</td>
<td>3.45</td>
<td>3.92</td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

$^a_n = 15$ for each group. $^b$Possible range of scale.
behavior scales during the second and third 12-minute time segments, respectively. The Box's M tests for the second and third time segments were not significant (Box's M = 9.25, F = 1.36; Box's M = 2.91, F = .43; respectively).

Table 4

Means and Standard Deviations of Play Behaviors During Third 12-Minute Segment

<table>
<thead>
<tr>
<th>PTOI Scales</th>
<th>Groupa</th>
<th>Maladjusted</th>
<th>Adjusted</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional discomfort (5-25)b</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>10.13</td>
<td>8.67</td>
<td>9.40</td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td>1.55</td>
<td>1.91</td>
<td>1.87</td>
<td></td>
</tr>
<tr>
<td>Social inadequacy (4-20)b</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>6.33</td>
<td>5.80</td>
<td>6.07</td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td>1.91</td>
<td>1.61</td>
<td>1.76</td>
<td></td>
</tr>
<tr>
<td>Use of fantasy (4-18)b</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>9.53</td>
<td>8.87</td>
<td>9.20</td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td>3.38</td>
<td>4.56</td>
<td>3.96</td>
<td></td>
</tr>
</tbody>
</table>

an = 15 for each group. bPossible range of scale.

Though the hypotheses did not address the total scores obtained on the three play behavior scales over the entire 36-minute play therapy session, those statistics were calculated. This information is described in Table 5.
Table 5

Means and Standard Deviations of Play Behaviors During All Time Segments

<table>
<thead>
<tr>
<th>PTOI Scales</th>
<th>Groupa</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Maladjusted</td>
<td>Adjusted</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Emotional discomfort</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(15-75)b</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>30.73</td>
<td>26.00</td>
<td>28.37</td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td>5.01</td>
<td>4.44</td>
<td>5.24</td>
<td></td>
</tr>
<tr>
<td>Social inadequacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(12-60)b</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>19.33</td>
<td>18.00</td>
<td>19.07</td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td>6.02</td>
<td>4.67</td>
<td>5.30</td>
<td></td>
</tr>
<tr>
<td>Use of fantasy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(12-54)b</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>25.67</td>
<td>22.60</td>
<td>24.13</td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td>8.58</td>
<td>9.26</td>
<td>8.91</td>
<td></td>
</tr>
</tbody>
</table>

a_n = 15 for each group.  bPossible range of scale.

A Box's M test produced a nonsignificant Box's M = 4.20, F = .62.

The second step in the statistical analysis was to examine the discriminant function equations calculated for each of the three 12-minute time segments and for the total 36-minute play session. The discriminant function equations for the second time segment and for the entire play session offered the only significant predictive qualities for correctly classifying maladjusted and adjusted children [X²(3) = 8.82, p < .03 and X²(3) = 8.69,
\( p < .03, \) respectively. The discriminant function equation for the first and third 12-minute segments of the play session did not accurately predict maladjusted and adjusted children.

Results Related to the Hypotheses

To examine the hypotheses, the next step in the statistical procedure was to determine where the maladjusted and adjusted children differed significantly on the three play behavior scales. This was a test of the equality of group means and is measured by the Wilks' lambda statistic. The Wilks' lambda is converted into an \( F \) value which is then compared against a critical \( F \) value for the purpose of deciding whether the null hypothesis should be rejected or accepted (Norusis, 1985).

Table 6 describes the results of the Wilks' lambda and the univariate \( F \) ratio computations used to test the hypotheses. Again, although the hypotheses for this study did not address the differences of play behaviors between the two groups of children over the total 36-minute play session, the data for this time period are included in Table 6 for the reader's information.

Hypothesis 1 stated there would be no significant differences in the emotional discomfort play of maladjusted and adjusted children as measured by the PTOI during the first 12-minute segment of a play therapy session. The
difference in the emotional discomfort play behaviors was not significant with an $F(1,28) = 3.53, p < .07$.

Therefore, null hypothesis 1 was accepted.

Table 6

Differences in Play Behaviors of Maladjusted and Adjusted Children

<table>
<thead>
<tr>
<th>PTOI Scales</th>
<th>Wilks' lambda</th>
<th>$F$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional discomfort</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time segments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>.89</td>
<td>3.53</td>
</tr>
<tr>
<td>2</td>
<td>.79</td>
<td>7.45**</td>
</tr>
<tr>
<td>3</td>
<td>.84</td>
<td>5.31*</td>
</tr>
<tr>
<td>Total</td>
<td>.79</td>
<td>7.51**</td>
</tr>
<tr>
<td>Social inadequacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time segments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>.99</td>
<td>.03</td>
</tr>
<tr>
<td>2</td>
<td>.99</td>
<td>.04</td>
</tr>
<tr>
<td>3</td>
<td>.98</td>
<td>.68</td>
</tr>
<tr>
<td>Total</td>
<td>.99</td>
<td>.07</td>
</tr>
<tr>
<td>Use of fantasy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time segments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>.99</td>
<td>.25</td>
</tr>
<tr>
<td>2</td>
<td>.95</td>
<td>1.50</td>
</tr>
<tr>
<td>3</td>
<td>.99</td>
<td>.21</td>
</tr>
<tr>
<td>Total</td>
<td>.97</td>
<td>.88</td>
</tr>
</tbody>
</table>

Note. df = 1,28.

*p < .03. **p < .01.

Hypotheses 4 and 7 stated there would be no significant differences in the emotional discomfort play of maladjusted and adjusted children as measured by the PTOI during the second and third 12-minute segments of the play...
session. During the second and third 12-minute time
segments the differences in the emotional discomfort play
behaviors were significant \( F(1,28) = 7.45, p < .01 \) and
\( F(1,28) = 5.31, p < .03 \). Therefore, null hypotheses 4 and
7 were rejected.

Hypotheses 2, 5, and 8 stated there would be no
significant differences in the social inadequacy play of
maladjusted and adjusted children as measured by the PTOI
during each of the three 12-minute segments of the play
therapy session. Hypotheses 3, 6, and 9 stated there would
be no significant differences in the use of fantasy play of
maladjusted and adjusted children as measured by the PTOI
during each of the three 12-minute segments of the play
session. During each of the three 12-minute time segments
the differences in the social inadequacy and use of fantasy
play behaviors were not significantly different.
Therefore, hypotheses 2, 3, 5, 6, 8, and 9 were accepted.

When all time segments were combined, only the play
behaviors measured by the emotional discomfort play scale
of the PTOI were significantly different for the two groups
\( F(1,28) = 7.51, p < .01 \). The social inadequacy play
scores and the use of fantasy play scores produced no
significant differences among the maladjusted and adjusted
children.
Finally, the analysis examined the contribution of each play behavior scale to the effectiveness of the predictive ability of the discriminant function equations for the second time segment and for the entire play session. A stepwise selection of play behavior scales which would result in minimizing the overall Wilks' lambda verified that the emotional discomfort play behavior scores alone were better predictors for correct classification of children than any other combination of play behavior scores. An additional discriminant analysis was performed based solely on the social inadequacy and use of fantasy play scores to check for a possible masking effect by the highly influential emotional discomfort play scores. Again the adjustment of the children could not be predicted successfully from the children's scores on the social inadequacy and use of fantasy play scales.

Table 7 presents the number of correct case classifications made during the second 12-minute time segment and for the entire play session when the discriminant function equations were used. During the second 12-minute segment, the discriminant function equation predicted correct group membership for 12 of the 15 maladjusted children and 11 of the 15 adjusted children. When the discriminant function equation for the entire play session equation was used to predict group membership, 13
of the 15 maladjusted children and 10 of the 15 adjusted children were classified correctly. There were 23 of the 30 children or 77% correctly classified in both the second 12-minute time segment and for the entire 36-minute play session.

Table 7
Predictions of Group Membership

<table>
<thead>
<tr>
<th>Actual Membership</th>
<th>n</th>
<th>Predicted Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Maladjusted</td>
</tr>
<tr>
<td>Second 12-minute segment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maladjusted</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(80%)</td>
</tr>
<tr>
<td>Adjusted</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(27%)</td>
</tr>
<tr>
<td>Total play session</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maladjusted</td>
<td>15</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(87%)</td>
</tr>
<tr>
<td>Adjusted</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(33%)</td>
</tr>
</tbody>
</table>

Discussion

The stepwise selection of play scales and the additional discriminant analysis omitting the emotional discomfort play scores show the play behaviors on the emotional discomfort scale of the PTOI were the items
discriminating maladjusted and adjusted children. The scores on the social inadequacy and use of fantasy play scales actually added no significant data to the predictive ability of the discriminant function equation at the $p < .03$ level of significance during the second 12-minute time segment. When the discriminant function equation was examined for the entire 36-minute play session, the only scale which contributed significantly to the equations' predictive ability at the $p < .03$ level of significance was the emotional discomfort play scale. The discriminant function equation for the first and third 12-minute segments of the play session did not accurately predict maladjusted and adjusted children.

**Emotional Discomfort Play Behaviors**

Initially, maladjusted and adjusted children played in similar ways but by the end of the first 12 minutes maladjusted children began to exhibit play behavior indicative of emotional discomfort. During the second and third time segments as well as when all time segments were combined, maladjusted children's play behavior expressed significantly more dysphoric feelings, conflictual themes, play disruptions, and negative self-disclosing statements than did that of the adjusted children ($p < .01, .03, .01$, respectively). This finding supports Howe's (1980/1981)
research concerning the play behavior of preschool aggressive boys.

Other studies have found similar results. As in this study's findings, Kestenbaum (1985) and Moustakas (1955b) also reported maladjusted children expressed dysphoric feelings in their play with greater intensity than did the adjusted children. Contrary to Kestenbaum's research but in agreement with Moustakas' findings, the maladjusted subjects also spent a larger portion of their play time feeling angry, sad, fearful, unhappy, and anxious than did the adjusted subjects.

This study found maladjusted children talking and playing out their problems and conflicts during more of the play session than the adjusted children. According to Moustakas (1953), children play at doing something that has been done to them. As pointed out by Erikson (1963), play can offer children a means of mastering life experiences. Possibly because maladjusted children in this study engaged in more conflictual type play behavior and perhaps do not effectively use play to diffuse their anxiety, they also experienced more episodes of play disruption which Erikson believed was indicative of emotional disturbance.

An interesting finding was the discriminatory ability of the "negative talk about self, feelings, and worries" play behavior item. Howe and Silvern (1981) constructed
the maladjustment scale of the PTOI using all play behavior items on the emotional discomfort and social inadequacy play scales with the exception of the "negative talk" item. Howe and Silvern did not find "negative talk" item grouping with the other play behavior items in the two scales. Since Howe and Silvern's data were gathered from the tenth and eleventh play therapy sessions, the children may not use talk about themselves to work through their problems in the therapy as A. Freud (1946) and Klein (1932) thought. Perhaps rather than talk, children play out their difficulties as suggested by Allen (1942), Axline (1947), and Moustakas (1953). It may be that until a therapeutic relationship has been established, however, children in the initial session chose the more abstract symbol of language rather than the concrete media of play to express their concerns and worries. It is as if children believe play therapists are like most other adults who prefer the more adult form of communication, verbalization, over the more primitive and basic mode of communication, play.

The behavior item on the emotional discomfort play scale, "frequency and degree of aggression directed inappropriately toward the therapist" was not present in any of the play sessions and therefore was not a discriminating behavior. Aggression is a play therapy behavior present in later play sessions (Hendricks, 1971;
Howe & Silvern, 1981; Withee, 1975) and may be a valuable discriminating behavior at a later point in the therapy process.

**Social Inadequacy Play Behaviors**

The maladjusted and adjusted children were not rated as being significantly different on the social inadequacy play scale during any of the 12-minute time segments nor for the entire play session. Only two of the four play behavior items, however, contributed to the scale's scores. The two play behavior items were "exclusion of the therapist from activities" and "body stiffness."

Neither the play behaviors "incoherent and bizarre content" nor "therapist interventions met with hostility" received a range of scores with any variability that would provide a meaningful measurement of play behavior. The extreme nature of the "bizarre or incoherent" play themes defined in the PTOI manual and required for inclusion in this scale contributed to the absence of this play behavior among the children in this study. An illustration of this play behavior in the manual was a child pretending to eat feces and keeping people in a casket until their eyeballs rotted and then licking off the blood and chewing up the eyeballs. The children referred for counseling to the facilities in this study were not disturbed to the degree that would produce such repugnant and fantastic play
behaviors. Perhaps the more severely disturbed children described by Howe and Silvern (1981) would be referred for inpatient psychiatric care and the "bizarre content" item would be an appropriate play behavior to be rated in that setting.

The absence of the play therapy behavior, "hostility or withdrawal behavior as response to therapist's intervention," could be explained by the therapists' behavior. All therapists in this study followed procedures suggested by Axline (1947), Bixler (1982), and Ginott (1962b). These procedures include primarily verbal interventions which reflect feelings, restate content, track play behavior, give little or no interpretations, and state limits in a nonthreatening manner. These procedures engender less anxiety in children and thereby produce less hostile or withdrawn behavior.

Though age was controlled through the matching of subjects in this study and therefore did not affect the findings, a significant relationship was found between social inadequacy play scores and age. Surprisingly as the age of the children increased, so did their scores on the social inadequacy play scale. This finding was unexpected. Social skills are developed as children play with others in socially appropriate ways initially in the family and then with teachers and peers in school settings. Since older
children have lived longer and possibly have more opportunities to observe models of socially adequate play and to practice those models, older children could be expected to score lower on this scale.

As previously stated the two play behaviors which contributed the entire value to scores on the social inadequacy scale were "therapist not included in activities" and "body stiffness." Older children may not feel the need to include the counselor in their play. They could feel more self-confident and less dependent in their play activity as found by Lynn and Lynn (1959). Older children may be accustomed to more structure as experienced in the classroom setting, and therefore feel unsure of themselves, and "freeze" in an unstructured play therapy setting. Younger children have experienced fewer restrictive situations and have more recently spent the majority of their time with toys and in play than the older children and thereby may feel more at ease in a play setting.

Another unexpected relationship was found between children's social inadequacy play scores and parents' occupations. The higher the status of the parents' occupations (i.e. unskilled workers being the lowest, major professionals being the highest) the higher the child scored on the social inadequacy play scale. Perhaps
children of professionals spend more time in solitary play and feel no need to enlist the company of the therapist in play activity. It could be that the parenting style of unskilled workers encourages their children to check more often with adults for help and reassurance. Perhaps children of professionals have learned to express their uneasiness through their body language when they find themselves in new unfamiliar situations, while children of unskilled workers ease their anxiety by increased contact with the adult. Or perhaps children of professional workers have been pressured to become emotionally independent at an early age as described by Elkind (1979) and no longer seek social play with adults.

Use of Fantasy Play Behaviors

Maladjusted and adjusted children did not score significantly different on the fantasy scale during any of the 12-minute time segments nor for the entire play session. The children did not differ significantly on the number of roles portrayed, the number of scenes and stories described, the amount of time spent in fantasy as opposed to reality nor the amount of time spent on animate as opposed to inanimate objects.

An unexpected significant relationship was found between children's fantasy play and parents' occupations. The higher the status of the parents' occupations the less
the child used fantasy in their play. Perhaps parents who are professionals and executives push their children to excel in sports and school work and to give up "childish" fantasy play and grow up faster. The demands on children for early academic competence and emotional independence, described by Elkind (1979), certainly affect all parts of children's lives including play. Elkind believes the difficulties rest in societal values rather than parental pathology. Social change affects children indirectly through its effect upon the adults who nurture them. Perhaps as children are encouraged to become academically competent and emotionally independent they no longer spend their energies in fantasy play, practicing social roles. They no longer seek to interact with adults in play and may feel ill at ease in the play setting.

Perhaps lower social status workers value play. Parents employed in unskilled and semi-skilled occupations may model a playful behavior for their children and thereby encourage and accept their children's own fantasy play.

**Play Therapy Observational Instrument**

Since all the scales were measures of play behavior, intercorrelation of the PTOI scales was anticipated. An interesting finding appeared in the intercorrelation matrix. Significant negative correlations were present between the scores on the use of fantasy play scale and the
scores on the social inadequacy play scale during each time segment and over the total play session (-.47, -.60, -.42, -.60, respectively). No other significant correlations were found. The more the children used fantasy in their play, the less stiff they appeared and the more they included the counselor in their play activities. This finding supports the research of Freyberg (1973) and Smilansky (1968) who found increased role-play behavior results in less hyperactivity and more verbal communication as well as the theoretical beliefs of Bettelheim (1976) and Irwin (1983) that fantasy play helps master the psychological problems of growing up and practice the essential social skills in the maturing process.

The results of this research suggest some modifications in the PTOI manual and rating forms. As previously stated, the "bizarre content" play behavior was not present in any of the play sessions rated in this study. The degree of pathology suggested by the description of this play behavior was so extreme as to be nonexistent in a counseling outpatient population. This play item should be deleted from the manual and the rating form when the PTOI is used to evaluate the play of clients in an outpatient counseling clinic setting.

The manual's description of the play behavior item "exclusion of the therapist in the play activity" should be
expanded. Children's running verbal account of their activities in the playroom such as "I'm putting all the soldiers in the sand" should be included as an activity that includes the therapist even though the children do not solicit the counselor's participation in the conversation. The children are sharing their experiences in an interpersonal manner. The author included this modification in the ratings for this study.

The manual should include the nonverbal dramatic representations of fantasy scenes and roles. The manual requires children to verbalize a role or describe a scene for the play behavior to be included in the fantasy scale. The author found children often acting out scenes and roles such as stirring, cooking, bowing, fighting, shaking hands using dolls, puppets, and themselves but never saying a word. The imagination was evident; the verbalization, absent; the fantasy, present. This study did not expand the fantasy play scale to include nonverbal representations in the ratings.

Finally, the manual needs to enlarge the description of play disruption which limited play disruption incidents to fantasy play entirely. As pointed out by Erikson (1963) in the recount of his play sessions with Sam, play disruption occurred during a domino game. The manual should describe play disruption as children's "sudden and
complete or diffused and slowly spreading inability to play" (pp. 223-224) as a result of inner conflicts in both reality-oriented and fantasy-type play. Ratings in this study included reality-based as well as fantasy-type play disruptions.

Implications

Based on this study's findings, counselors need to make special note of particular play behaviors during the initial play therapy session for diagnostic purposes. This study found emotional discomfort play behaviors discriminated maladjusted and adjusted children beginning 13 minutes into the session and continuing until the end of the 36 minute play. For diagnostic evaluations, counselors should be aware of the amount of time and degree of intensity of children's dysphoric mood, the amount of time that play and speech are expressive of conflicts, the number of play disruptions, and the number of negative self-disclosing statements. Counselors should also be aware that neither the number of fantasy roles, scenes, and stories nor the amount of time spent in fantasy or on inanimate as opposed to animate objects are indicators of maladjustment or adjustment in an initial play therapy session. For initial diagnostic purposes, counselors can not use the amount of time spent interacting with the
counselor nor the degree of body stiffness as criteria for evaluating adjusted and maladjusted children.

The results of this study relate to other areas of play therapy. In the theoretical area, support can be given to the theory held by Moustakas (1953) and Axline (1947) that children who are experiencing psychological difficulty will play out themes expressive of conflict. As suggested by Erikson (1963), maladjusted children do attempt to master things that have been done to them through their play activity. In addition, Erikson's emphasis on the significance of play disruption as an indicator of emotional disturbance was supported by the results of this study.

The results of this study can be utilized to conceptualize a model of play behavior showing the relationship of fantasy play and social inadequacy play. The less children make use of fantasy the more they tend to exclude the counselor from their play and the more stiff and constricted they appear. As Bettelheim (1976) and Irwin (1983) have stated, fantasy enhances children's ability to interact in a socially appropriate manner. Through fantasy, children are able to experiment and practice models they see or would like to be.

Both the age of the child and the parents' occupations must also be considered as counselors evaluate fantasy and
social inadequacy play. Older children tend to exclude the therapist from their play and appear stiff and uneasy in the playroom as compared to younger children. Also children whose parents hold high social status occupations use fantasy less, exclude the counselor more often, and appear more stiff and uneasy in the playroom setting than do children whose parents are employed in the low social status occupations.

Parents who hold high status jobs should be aware of the negative relationship between use of fantasy play and social inadequacy play. They may lessen their children's apprehension and facilitate appropriate social interactions through accepting and encouraging their children to engage in fantasy play.

This study's findings suggest the second 12-minute segment of the initial play session offers the most discriminating play behaviors. This finding supports the concept of time sampling of play therapy sessions for diagnostic evaluations.

The results of this study suggest to parents, teachers, and childcare workers the importance of children's negative self-disclosing statements. Adults are advised to consider children's negative talk about themselves, their worries, feelings, and problems as a viable measure of children's emotional difficulty.
Recommendations

As a result of the findings of this study, the following recommendations have been formulated.

1. Similar research should be conducted using different protocols to evaluate the videotapes used in this study to compare other play protocols with the PTOI as to their usefulness and effectiveness.

2. A similar research study should be conducted matching maladjusted and adjusted children on parents' occupational status.

3. A similar research study should be conducted grouping subjects so that they vary in age by no more than two years.

4. Additional research should be conducted to compare play behaviors during different time segments of a play session to see if time sampling is a viable method to examine children's play therapy behavior.

5. Future research should be conducted to explore the relationship of use of fantasy play and social adequacy.

6. Future research should compare the play of children in their early and later play therapy sessions using the PTOI as a measure of play evolvement during the therapy process.
7. Future research should measure the counselor's behavior as well as the child's play since therapy is an interactional process.

8. An initial diagnostic play therapy session should be limited to 24 minutes. Children's maladjustment and adjustment should be assessed during the second 12-minute time segment based on the evaluation of the play behaviors on the emotional discomfort scale of the PTOI.

9. Research should be conducted to compare the play therapy behaviors of younger and older children.

10. Parents, teachers, day care workers, and others who care for children should be aware that children who often use fantasy play are more likely to interact with others in a more appropriate social manner.

11. Revisions recommended for the PTOI manual and rating form are:

   a. The "bizarre content" play item should be deleted for evaluations of outpatient clients.

   b. The manual should expand the description of play disruption to include disruption in reality play as well as fantasy play.

   c. The manual and rating form should be expanded to include the nonverbal representation of a fantasy scene as the dolls, puppets, or children act out a scene without dialogue.
d. The manual and rating form should be expanded to include the nonverbal representation of fantasy roles when children act out roles such as one puppet bowing and shaking hands with another puppet without verbalizations.

e. The manual should include children's comments about their activities in the playroom such as "This is medicine" or "I'm going to draw a bigger circle" under the play behavior item illustrating play activities which are structured to include the therapist.


Hollingshead, A. (1975). *Four factor index of social status*. (Available from Department of Sociology, Yale University, P.O. Box 1965, New Haven, CT 06520).


APPENDIX A

PLAY THERAPY OBSERVATIONAL INSTRUMENT

SELECTED SCALES
PLAY THERAPY OBSERVATIONAL INSTRUMENT

Emotional Discomfort Scale

1. Quality and intensity of affect—mood (4)
2. Inappropriate aggression at therapist (5)
3. Conflicted play (10)
4. Play disruption (11)
5. Talk about worries and troublesome events (13)

Social Inadequacy Scale

1. Incoherent or bizarre content (1)
2. Therapist not included in activities (2)
3. Therapist's interventions met with hostility or withdrawal (3)
4. Body stiffness (12)

Use of Fantasy Play Scale

1. Abrupt fluctuations between fantasy and reality (6)
2. Time spent concentrating play on characters rather than things (7)
3. Variations in fantasy story scenes (8)
4. Qualitatively different fantasy roles (9)

( ) Rating form item number appearing in Appendix B.
RATING FORMS FOR THE PLAY THERAPY
OBSERVATIONAL INSTRUMENT

Rater's Name ____________________________ Child's Code #____

1. COMPREHENSIBILITY OF PLAY SEQUENCES, INTERACTIONS;
   BIZARRE CONTENT
   1) Always comprehensible and never uses bizarre content
   2) Incomprehensible occasionally or uses bizarre content occasionally
   3) Incomprehensible occasionally and uses bizarre content occasionally
   4) Incomprehensible and/or bizarre a good deal of the time
   5) Bizarre and incomprehensible for nearly the entire time

2. FREQUENCY WITH WHICH ACTIVITIES ARE STRUCTURED TO INCLUDE THE THERAPIST*
   1) Activities include therapist for nearly the whole time
   2) Clearly spends more time in activities with therapist
   3) Spends about half the time in solitary activities
   4) Clearly spends more time in solitary activities
   5) Therapist included in activities for no more than 2 minutes

3. FREQUENCY OF REJECTIONS OF T'S INTERVENTIONS
   1) Rejects no more than 2 of therapist's interventions
   2) Clearly accepts more interventions than he rejects
   3) Rejects about half of therapist interventions
   4) Rejects more interventions than he accepts
   5) Rejects nearly all therapist interventions, accepts no more than 2

4. MOOD
   1) Seems extremely elated and delighted for virtually the entire time
   2) Occasionally seems extremely elated
   3) Seems happy and pleased most of the time
   4) Vacillates between being happy and dysphoric
   5) Appears to be experiencing a predominance of unpleasant feelings
   6) Unclear
5. **FREQUENCY AND DEGREE OF AGGRESSION DIRECTED INAPPROPRIATELY AT THERAPIST**
   1) Never directs aggression inappropriately at the therapist
   2) Occasionally directs low level aggression inappropriately to the therapist
   3) Persistently directs low level aggression or directs high level aggression inappropriately at therapist once or twice
   4) Frequently directs high level aggression at therapist
   5) Persistently directs high level aggression at therapist

6. **FREQUENCY OF FLUCTUATIONS BETWEEN FANTASY PLAY AND REALITY**
   1) In reality nearly the whole time, 1 or 2 slips into fantasy
   2) Clearly spends more time in reality, occasional slips into fantasy
   3) Spends nearly equal time slipping in and out of fantasy
   4) Clearly spends more time in fantasy, occasional slips into reality
   5) In fantasy nearly the whole time; 1 or 2 slips into reality

7. **TIME SPENT CONCENTRATING PLAY ON CHARACTERS RATHER THAN THINGS**
   1) Spends nearly whole time concentrating play on things
   2) Spends most of time concentrating play on things
   3) Spends about half the time on things rather than characters
   4) Clearly spends more time on characters than on things
   5) Spends virtually the whole time on characters

8. **NUMBER AND VARIATIONS IN SCENES FROM FANTASY STORIES**
   1) Enacts no fantasy scenes
   2) Enacts 1 scene or repeats same scene with slight variation
   3) Enacts 2 or more different scenes from the same story
   4) Enacts 2 different stories, each having different characters, plots
   5) Enacts 3 or more different stories
9. **NUMBER OF ROLES IDENTIFIED WITH DURING FANTASY PLAY**
   1) Identifies with no role or character
   2) Identifies with 1 role or many characters representative of 1 role
   3) Identifies with 2 different roles
   4) Identifies with 3 different roles
   5) Identifies with 4 or more different roles

10. **FREQUENCY WITH WHICH BEHAVIOR IS EXPRESSIVE OF CONFLICTS**
    1) Behavior is non-expressive for nearly the entire time
    2) Behavior is non-expressive most of the time; occasionally expressive
    3) Behavior expressive about half the time
    4) Behavior expressive most of the time; occasionally non-expressive
    5) Behavior expressive for virtually the whole time

11. **FREQUENCY AND DEGREE OF PLAY DISRUPTION**
    1) Never evidences play disruption
    2) Abruptly stops play once or twice but resumes that play momentarily
    3) Abruptly stops play 3 or 4 times but resumes that play momentarily
    4) Abruptly stops play once but unable to resume that play activity
    5) Abruptly stops play 2 or more times but unable to resume that play

12. **NOTICEABLE STIFFNESS IN SMALL AND LARGE BODY MOVEMENTS**
    1) Rarely, if ever, appears stiff, rigid, and constricted
    2) Occasionally appears stiff, rigid, and constricted
    3) Appears stiff, rigid, and constricted for most of time

13. **FREQUENCY OF NEGATIVE TALK ABOUT SELF, FEELINGS, WORRIES**
    1) Never makes negative statements
    2) One negative statement
    3) Two negative statements
    4) Several negative statements

*Items 2, 7, and 12 were adapted by Lessie Perry for use in this study.
APPENDIX C

BEHAVIORAL INDICATORS OF EMOTIONAL DISTURBANCE
Compared to other children, does this child often exhibit any of the following behaviors?*

1. DISTURBED CLASSROOM BEHAVIOR. YES ☐ NO ☐
   (e.g., daydreams almost incessantly; is extremely impulsive or hyperactive; is destructive of property; is chronically fearful or depressed)

2. CHILD HAS GENERALIZED SENSE OF INFERIORITY. YES ☐ NO ☐
   (e.g., criticizes self; feels he/she does not have to do what he/she does not want to do because he/she is special; feels guilty without appropriate cause)

3. DISTURBED BEHAVIOR WITH TEACHER. YES ☐ NO ☐
   (e.g., rebellious or aggressive; easily hurt or rejected; extremely dependent on teacher; overly shy; unwilling to share teacher's attention with others)

4. DISTURBED RELATIONSHIP WITH PEERS. YES ☐ NO ☐
   (e.g., overly aggressive; teases or tattles on others; overly bragging or boastful; shy or fearful of peers; used as a scapegoat)

5. INAPPROPRIATE INFANTILE BEHAVIOR. YES ☐ NO ☐
   (e.g., unable or unwilling to separate from parents; whining, crying, or temper tantrums; thumb sucking; enuretic or encopretic)

6. DISTURBANCE IN PHYSICAL FUNCTIONING OR APPEARANCE. YES ☐ NO ☐
   (e.g., chronically fatigued; constantly picking or biting fingernails; tics or facial twitches; accident prone; frequent vomiting)

7. DISTURBANCE IN SPEECH. YES ☐ NO ☐
   (e.g., baby talk; overly fearful of speaking or reciting; stutter or inaudible speech)

8. SEXUAL DISTURBANCES. YES ☐ NO ☐
   (e.g., masturbates frequently; makes sexual advances to others; uses "dirty" words frequently)

9. DIFFICULTIES IN LEARNING. YES ☐ NO ☐
   (e.g., discrepancy between achievement test or IQ and school performance; lack of motivation to learn or to try)

*Adapted from Hammer (1970) by Lessie Perry for use in this study.
APPENDIX D

PARENTAL INFORMATION AND CONSENT FORM
Dear Parent,

Your help with a very important study about children's play is being asked. My name is Lessie Perry, and I am a doctoral student at North Texas State University in the Counselor Education Department. I am interested in using play while counseling with children.

Play is one of children's most important and useful means of communication. There is a real need to understand better what and how children communicate through play.

This study, which has the approval of the university, asks that you permit your child to be videotaped in a play session with a counselor. This tape will be viewed and the play behavior analyzed by me to determine the different play behaviors of children.

Please sign the attached informed consent for your child to help in this important study. Confidentiality of your child's play behavior will be maintained by the counselor and me. Tapes and information will be identified by numbers rather than names. Participation in this study is voluntary and will require approximately an hour of your child's time; you and your child may choose to withdraw at any time.

Since it has been found that children play differently when they know they are being recorded, please tell your child only that he or she will be playing in a special playroom by himself or herself and that a counselor or grown up will be there also.

If you have any questions or concerns please contact me (collect) at 817-383-1745 or 817-387-2475.

Sincerely,

Lessie Perry, M.S.
INFORMATION SHEET

Name of Child _____________________________ Age ___ Sex ___

Occupation of Father ___________ Mother __________

Yes No

My child

- has received counseling in the past ___ ___
- has school problems ___ ___
- has enough friends ___ ___
- has been referred for counseling ___ ___
- is happy most of the time ___ ___
- gets along all right with family members ___ ___
- needs counseling ___ ___

Paragraph I

By participating in this study, the following will occur:

1. Your child will be asked to play in a playroom for 40 minutes by himself/herself with a trained counselor present.

2. The session will be videotaped.

3. Since knowledge of videotaping changes children's behavior, you are asked not to tell child about the recording.

4. Videotapes and information will be number coded to help maintain right of privacy and confidentiality.

5. The videotapes will be viewed and analyzed by only the researcher, Lessie Perry.

6. Participation in this study is voluntary. You and/or your child may choose to withdraw at any time.

7. If you have any questions or concerns about the procedures, please call me, Lessie Perry, collect at 817-383-1745.
INFORMED CONSENT

Child's Name ___________________________ Code # _______

I hereby give consent for Lessie Perry to perform the following investigative procedure:

1. Videotape my child in a play session with a counselor present.

2. View and score the taped session.

I have seen a clear explanation and understand the nature of the procedure, possible appropriate alternative procedures that would be advantageous to me and my child, and the attendant discomforts or risks involved and the possibility of complications which might arise. I have a clear explanation and understand the benefits to be expected. I understand that the procedure to be performed is investigational and that I and/or my child may withdraw our consent for our status. With my understanding of this, having received this information and satisfactory answers to the questions I have asked, I voluntarily consent to the procedure designated in Paragraph I above.

Signed ____________________________
Legal parent/guardian

Witness: __________________________

Date: ____________________________
REFERENCES


Hollingshead, A. (1975). *Four factor index of social status*. (Available from Department of Sociology, Yale University, P.O. Box 1965, New Haven, CT 06520).


