THE CHARACTERISTICS OF PLAY THERAPY SESSIONS WITH CHILDREN: A PRELIMINARY INVESTIGATION

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This research study investigated various characteristics of children in play therapy and their play behaviors during sessions. Specifically, this research investigated how gender, age, ethnicity, household and presenting problem of children impacted the play therapy process.

Thirty-two cases of children who received ten or more sessions of play therapy at the Child and Family Resource Clinic, University of North Texas, Denton, Texas between the years of 1998-2002 and met specified criteria were coded and entered into a computer spreadsheet for analysis. The background information provided by the parent/guardian of each child was analyzed using various measures of central tendency to summarize and describe the data sets. The session summary data completed by play therapists at the CFRC was examined using analysis of variance and multivariate analysis of variance.

Analysis of variance and multivariate analysis of variance revealed statistical significance between the following variables: a) males and use of dolls (.01), animals (.007) and weapons (.014), and males and expression of happy (.048), confident (.042) curious (.007) and flat (.029) during play therapy sessions; b) young children and use of vehicles (.050) during play therapy sessions; c) Caucasian children and expression of happy (.011), and confident (.008) during play therapy sessions; d) children residing in single parent households and use of hammer (.049) and puppets (.048) during play

therapy sessions; and e) a variety of presenting problems and toy use/play behavior, feelings expressed and themes played out during play therapy sessions.

Frequency of toy use and emotional expression were also investigated as well as session peaks of toy use, emotions expressed and themes. Analysis revealed that the toys used most often during play therapy sessions included the following categories: sandbox, easel/paints, dolls, weapons, crafts and money. Feelings expressed most often in play therapy sessions included excited, pleased, focused, interested, proud, curious, frustrated and confident. Analysis also indicated a positive shift in the overall dynamics of play therapy sessions, as reported by play therapists, during sessions 9-13.

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CHAPTER I

INTRODUCTION

Over the past several years the mental health needs of children have received heightened attention. School violence, divorce, abuse and neglect, domestic violence, as well as other emotional and behavioral problems are continually increasing in numbers and are issues faced by many children today. Children are resilient, therefore it is imperative these issues are recognized and addressed so they do not burden a child even into adulthood. Because resolution becomes more difficult the longer issues remain unresolved, mental health professionals must be effective in identifying and working with the problems of children (US Public Health Service, 2001).

In counseling, adults are able to put their thoughts and feelings into words. They can identify issues and discuss them with a therapist. Since children have limited potential for language processing, verbalization is not their ideal way of communicating. Research has indicated that children are not able to effectively engage in abstract reasoning until approximately the age of eleven. Because language is composed of abstract symbols, young children experience difficulty comprehending language and using it to effectively communicate thoughts and feelings (Piaget, 1962).

Play is the natural medium of communication and self-expression for children. What verbalization is to the adult, play is to the child. Toys are the child's words and play, their language. Landreth (1991) stated, "it is a medium for expressing feelings, exploring relationships and self-fulfillment" (p.14). Play advances emotional and cognitive development, promotes language development, communication skills, social skills and the ability to make decisions. Play

allows exploration of relationships, understanding of personal thoughts and feelings, development of sexual identity and experimentation with roles of adulthood (Landreth, 1993).

Play therapy provides children the opportunity to resolve problems that hinder emotional and social development (Axline, 1947). Landreth (1991) defined play therapy as

> a dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child to fully express and explore self (thoughts, feelings, experiences, and behaviors) through the child's natural medium of communication, play (p.14).

Play allows children the opportunity to address problems with a trained play therapist in an environment where children can safely express feelings, thoughts and behaviors.

During play therapy sessions, children can use toys to communicate what they cannot say and express feelings they have difficulty verbalizing. Landreth (1991) stated, "play is the child's symbolic language of self-expression and can reveal (1) what the child has experienced; (2) reactions to what was experienced; (3) feelings about what was experienced; (4) what the child wishes, wants or needs; and (5) the child's perception of self" (p15). Mental health professionals must understand the meaning of play in order to be effective in working with children.

Play therapy is utilized for a variety of presenting problems. These problems include but are not limited to the following: abuse, adjustment problems, aggressive behavior, anxiety, low self-esteem, parent-child relationship problems and school difficulties. Landreth, Homeyer, Glover and Sweeney (1996) compiled an extensive review of play therapy case studies and research. They suggested that play therapy is effective in the following areas: reducing fear, anxiety and aggression; improving adjustment to divorce, hospitalization, blindness and

symptoms of autism; working with abused, neglected and grieving children; and addressing various other adjustment problems (Landreth, et. al. 1996).

While many studies have examined the effectiveness of play therapy with a variety of problems (Ray, Bratton, Rhine & Jones, 2001), few have focused on the actual play therapy process. Therapists have hypothesized about the dynamics of play therapy however, little has been done to study exactly what is transpiring during play therapy sessions with children.

Hendricks (1971) examined nonverbal expression and play activity during play therapy sessions with eight to ten year old boys. Her study was significant because it was the first study to quantitatively analyze these areas. Withee (1975) expounded Hendricks' study by adding female subjects and increasing the number of play therapy sessions. She indicated several patterns of nonverbal and verbal expression as well as play therapy activities. Withee was the first to examine the impact of gender on the process of play therapy.

To focus attention on the play aspect of the play therapy process is needed in the literature. Looking at specific toys used, feelings expressed and themes played out is necessary to truly understand the process of play therapy. Examining the sessions with the same child over consecutive sessions as well as to investigate child variables such as gender, ethnicity and presenting issues will provide useful information on the process of play therapy.

Statement of the Problem

Currently the play therapy research is lacking respect to the process of play therapy. The problem to be investigated is how demographic and play therapy session variables impact the process of play therapy. Specifically, the study is concerned with examining how variables such as gender, age, ethnicity, primary household and presenting problem affect toy use, expression of feelings, themes played out and overall dynamics of play therapy sessions with children.

Synthesis of Related Literature

History of Play Therapy

Before the twentieth century children were to be considered little adults. Human development, particularly the emotional and psychological difficulties of children, was not understood. According to Kanner (1957) at the beginning of the twentieth century no procedure was being applied to children that could be considered as child psychiatry. This began to change as children's issues obtained recognition and attempts were made to administer treatment used on adults to children. Play therapy evolved from attempts to apply psychoanalytic therapy to children (Landreth, 1991).

Sigmund Freud was the first to record his attempts to use a psychological approach with a child. In 1909, he documented his work with "Little Hans". He saw the child for only one session and made suggestions to the boy's father about ways to respond to him based on information gained from observing his play. His work was significant because it was the first case in which a child's problems were believed to be of emotional origination (Landreth, 1991).

Nearly ten years later the foundation of play therapy began to emerge.
One of the first therapists to stress the importance of play in analysis of children was Hermine Hug-Hellmuth. Hug-Hellmuth (1921) discovered that children did not talk about their anxieties like adult patients, therefore, traditional psychoanalysis was futile. She found providing toys to children during therapy sessions helped them to express themselves (Landreth, 1991).

According to Landreth (1991), in 1919, Melanie Klein began using play as a way to analyze young children. She believed that play was the key to a child's unconscious and began to analyze play as a substitute for free association. She emphasized that play was the instrument through which a child could uncover past experiences and help to strengthen the ego. Play was

used to encourage children to relate anxieties, defense mechanisms, private thoughts and fantasies so that they might be examined. Klein interpreted all play behavior and gave it symbolic meaning, usually sexual in content. She believed progress was made when play activities led to transference which was then interpreted for insight and increased self understanding (Klein, 1955).

Unlike Melanie Klein, Anna Freud used play materials as a way to build the relationship and influence children to favor her. She did not believe transference or excessive interpretations were necessary for therapeutic progress. Utilizing play helped children explore feelings and she believed that a safe emotional bond with the therapist was the best way to gain access to the inner private world of a child (Freud, 1946).

The roots of play therapy did not involve the creation of a specific therapeutic way of working with children. It did, however, bring to light the differences in adults and children from a therapeutic standpoint. Mental health professionals began to see the importance of relating to children and learning new ways to view and approach them in a therapeutic setting. Play was primarily used to help build a therapeutic relationship, gain information about the child and interpret or give meaning to the behavior of children.

Another significant advance in the history of play therapy came with the introduction of release play therapy. Release play therapy, developed by David Levy in the 1930's, was a more structured approach to therapy than had been previously employed (Levy, 1939).

Levy (1939) developed this approach to work with children traumatized by a specific situation or event. He believed it was not necessary to interpret the play of his clients because the play in and of itself was therapeutic. He defined his role to select toys in order to recreate the anxiety-provoking event for the child. His belief was that reintroducing the child to the stressful

situation led to the release of painful feelings allowing the child to face, and work through the anxiety and pain that had been caused by the stressful event. The child is then permitted to control the play therefore working through the trauma (Levy, 1939).

Gove Hambidge later expanded Levy's work. Hambidge (1955) reports the Levy devised specific stimulus situations to encourage the child to play out fear and anxiety. He called the method structured play therapy and was an extension of Levy's work.

Hambidge (1955) wrote "the therapist acts to focus attention to stimulate further activity, to gain information, to interpret or to set limits. Structuring the play situation is a form of activity which can serve any of these functions" (p. 601).

Structuring the play situation served as an impetus to expedite the free play of the child. In the free play, the child was encouraged to show thoughts and feelings about the situation rather than talk about them. At the time, structured play therapy was used to increase specificity of treatment and save time by addressing the specific problem and using only the methods of play indicated for each particular case (Hambidge, 1955).

The role of the therapist, as defined by Hambidge (1955) was to facilitate play, not to participate in it. The therapist was to set the scene, change it when necessary and promote the child's release of anger, fear, and anxiety.

Relationship play therapy was later developed from the work of Otto Rank. Rank (1936) believed that the emphasis in relationship play therapy should be on the (curative) power of the emotional relationship between child and therapist. He did not place importance on the past or unconscious memories and focused on present experiences.

Allen (1934) stated

> I am interested in creating a natural relation in which the patient can acquire a more adequate acceptance of himself, a clear conception of what he can do and feel in relation to the world in which he continues to live…I am not afraid to let the patient feel that I am interested in him as a person. (p.198)

In relationship play therapy, all attention is focused on present feelings and behavior. The child is believed to possess the capacity for self-determined growth and therefore is given the liberty to choose the desired action and level of participation during each session. The child rather than the therapist is responsible for personal productivity and growth (Landreth, 1991).

Virginia Axline later applied the nondirective ideals of Carl Rogers (1942) to children, developing non-directive play therapy. She believed that children's behaviors are internally incited by the need for self-realization. The objectives of therapy were to increase the self-awareness and self-direction of the child. The client has the freedom to play and lead the session. The therapist actively reflects feelings and thoughts expressed by the child during the session and trusts in the self-direction of the child (Axline, 1947).

Axline (1950) defined play therapy as "a play experience that is therapeutic because it provides a secure relationship between the child and the adult so that the child has the freedom and room to state himself in his own terms, exactly as he is at that moment in his own way and in his own time" (p.1). She stressed that in play therapy it is imperative that the child be given a place of safety to state his individuality through play. The therapist was to be totally accepting, of the child and keep personal attitudes, feelings and beliefs out of the play experience.

Rogers (1942) believed about the nature of adults, likewise, Axline (1947) believed children possess the necessary components for personal growth and becoming. She believed a therapeutic relationship conveying empathy, warmth and understanding enabled growth to occur. Through this experience a child could grow to emotional maturity through expression of feelings. The drive toward self-realization could be fully experienced by the child in a relationship of acceptance, respect and understanding with an adult.

Numerous other approaches have utilized conditions of the previous developments in play therapy. Adlerian play therapy uses toys and play to build a therapeutic relationship and increase communication with the child. According to Adlerian play therapists, play is used to

> gather information about the child to provide a conceptual framework for understanding the child's personality and relationships…to (a) build relationships with children; (b) explore the way children view themselves, others and the world; (c) help children understand the ways they gain significance in their families; and (d) help them explore new ways of gaining significance and interacting with others. (Kottman and Johnson, 1993, p. 42)

In Gestalt play therapy the job of the therapist is to listen to children (Campbell, 1993). Play is used so that the child is better able to experience the pain of unfinished business in his or her life. The child can examine and choose to accept or reject parts of the self. In this approach, play is used to make contact with the child, help the child develop self-support and integrate experiences. Being more integrated allows the child to feel internal resolution and be more wholly functioning (Carroll & Oaklander, 1997).

Filial therapy has also been developed as a parent training program based on child-centered play therapy principles and techniques. Originating with Bernard Guerney (1964) filial therapy was developed to train parents of children with emotional problems. His training program lasted more than thirty weeks. Similar to child-centered play therapy, filial therapy serves to strengthen the relationship between parent and child rather than therapist and child. In this model, play is used to train parents to become the therapeutic agent in the life of their child (Guerney, 1964).

Later, Landreth (1991) concentrated this program into a ten-week model of training provided in a group format. Child-centered play therapy techniques are taught to the parents in the group and reinforced by role-play and supervision of parent child interaction. Both models are a result of the developments in the field of play therapy (Landreth, 1991).

Rationale for Using Play Therapy

Adults communicate with verbal language and often attempt to understand or communicate with children in this manner. Adults have the intellectual capacity to effectively engage in abstract reasoning. According to Piaget (1962), children do not develop this ability until approximately age eleven. Because they are not small-scale adults, young children have restricted potential for language processing and experience difficulty comprehending language and using it to communicate thoughts and feelings.

Play is the natural medium of articulation and self-expression for children. Toys are the words and play is the language. According to Landreth (1991),

> children express themselves more fully and more directly through self-initiated spontaneous play than they do verbally because they are more comfortable with

> play…Play is a medium of exchange and restricting children to verbal expression automatically places a barrier to a therapeutic relationship… (p.10).
>
> Particularly for young children who are limited in language development and cognitive ability, play provides counselors an alternative source of information about the child. Play acts as a connection between concrete experience and abstract thought. Play requires the use of concrete actions of a sensori-motor nature (Piaget, 1962). Using toys as symbols allows a child the opportunity to express feelings and thoughts more freely (Landreth 1991).

Feelings can often be difficult for a child to identify and express. A child can be frustrated when asked to explain how he or she feels. Axline (1950) stated

> there is an honesty, a frankness and a vividness in the way children state themselves in 'play' situations. Their feelings, attitudes and thoughts emerge, unfold themselves, twist and turn and lose their sharp edges. The child learns to understand himself and others a little better and to extend emotional hospitality to all people more generously. (p.1)

Intimidating feelings and opinions can be expressed symbolically with the use of toys and released by the child through play (Axline, 1969).

"Through the manipulation of toys the child can state more adequately than in words how he feels about himself and the significant people and events in his life. To a considerable extent, the child's play is his talk and the toys are his words." (Ginott, 1960, p. 243).

According to Bettelheim (1967), therapists can obtain awareness of how a child constructs the world, what a child desires to be and what the problems and concerns are by watching a child play.

> Through his play he expresses what he would be hard pressed to put into words. A child does not play spontaneously only to while away the time…even when he engages in play partly to fill empty moments, what he chooses to play at is motivated by inner processes, desires, problems anxieties. (p.36)

He wrote that even the most typical child encounters what seem like overwhelming problems of living. By playing them out, the child becomes better able to cope with life.

Process of Play Therapy

Numerous studies have examined the efficacy of play therapy. Studies have been performed on children with a variety of presenting problems Bratton et al., 2002). Few, however, have focused on the actual process of play therapy (Axline, 1947; Hendricks, 1971; Withee, 1975). For many years, therapists have hypothesized about the dynamics occurring during play therapy sessions with children yet only a handful of researchers have examined exactly what is transpiring during play therapy sessions with children.

Axline (1947) was the first to investigate and report on the process of play therapy. She found that children's play changed through the process of therapy. She noticed that children initially expressed feelings between toys. Next feelings were expressed from toy to invisible person, then from child to invisible person and finally from child to the person or object of the feelings.

In one of the most extensive investigations of the play therapy process, Hendricks (1971) examined and described the verbalization, nonverbal expression and play activity during play therapy sessions with boys who were eight to ten years old. Her study was significant because it was the first study to quantitatively analyze these areas. She discovered that in the beginning of the play therapy process children engaged in exploratory, noncommittal and creative play.

Verbalization at this stage included simple informative comments or the expression of curiosity. During the next stage of therapy, children began to exhibit more creative play behavior, an increase in aggression and an increase in verbalization that included information about self and family. The later sessions included expression of anxiety, anger and frustration. Play behavior shifted from creative to dramatic with role-play and increased importance was placed on the relationship with the therapist (Hendricks, 1971).

Withee (1975) expounded Hendricks' study by adding female subjects and increasing the number of play therapy sessions examined to fifteen. She indicated several patterns of nonverbal and verbal expression as well as play therapy activities.

She found that in the first three play sessions, the children gave the most verbal validation of the counselors' reflections of behavior, manifested high levels of anxiety and engaged in verbal, nonverbal and exploratory play activities. During the following three sessions, exploratory play decreased and aggression and verbal sound effects reached their peaks (Withee, 1975).

In sessions seven through nine, aggressive play behavior dropped to its lowest point and creative play, expression of happiness and sharing verbal information were at their peaks. During sessions ten through twelve, relationship play was at its highest and noncommittal play behavior was at its lowest point. In sessions thirteen through fifteen, noncommittal play and nonverbal expression of anger peaked while anxiety and verbalization with the counselor rose (Withee, 1975).

Withee (1975) was also the first to examine the impact of gender on the process of play therapy. She found that boys exhibited more expression of anger, aggressive play behavior, aggressive verbalization and sound effects during play activities. Girls exhibited more creative

and relationship play, feelings of happiness, validation of therapists' reflections, and overall verbalization.

Perry (1988) examined play behavior and compared the play of maladjusted children to that of adjusted children in an initial play therapy session. She addressed the question "can maladjusted children be discriminated from adjusted children through a single minute observation of their play therapy behavior". The play behavior during the initial play therapy session was analyzed and rated on the Play Therapy Observational Instrument (PTOI) (Howe & Silvern, 1981). The scales of the PTOI utilized were emotional discomfort, social inadequacy and use of fantasy.

Perry (1988) found that the children in the maladjusted group expressed significantly more dysphoric feelings, conflicted themes and negative statements about self. She found no significant difference between the two groups on the social inadequacy and use of fantasy scales of the PTOI. She found a positive correlation between children's age and social inadequacy in play behavior as well as parent's occupation/social status and social inadequacy in play behavior. She found negative correlation between parents' occupation/social status and use of fantasy in play behavior.

Oe (1989) also examined the play behavior of maladjusted and adjusted children and compared the play behavior of their initial counseling sessions. She examined the initial play behavior to investigate whether play could be used as a diagnostic tool in the treatment of children. Thirteen separate categories of play behavior were analyzed for frequency and intensity to assist in discriminating between maladjusted and adjusted children. These categories included: exploratory, incidental, creative or coping, dramatic or role, relationship building, relationship testing, self-accepting, self-rejecting, acceptance of environment, ambivalent attitudinal and

negative attitudinal. Oe (1989) found that maladjusted children manifested significantly more self-accepting behavior as well as nonacceptance of environment behaviors. This group also exhibited more intensity in dramatic or role behaviors and acceptance of environment behaviors than did the adjusted group.

Extended analysis also indicated the following: (a) maladjusted girls expressed dramatic or role behaviors more often and more intensely than maladjusted boys; (b) maladjusted boys exhibited more self-accepting and nonacceptance of environment behaviors than maladjusted girls; (c) adjusted boys showed more self-accepting behaviors than maladjusted boys; and (e) adjusted boys engaged in more exploratory play and were more intense in negative attitudinal play than adjusted girls (Oe, 1989).

Fall (1997) posed the research question "what is the nature of children's play in play therapy sessions?" (p.1). She stated that the specific play of children during play sessions is not clearly addressed in the literature. She performed a quantitative research study to examine this issue. Her results defined four categories of play behavior: "connection", "safe play", "unsafe play" and "resolution".

Fall (1997) found that all children needed to connect with both the room and the therapist. Children would look around the room, touching and examining the toys. Also, each child would attempt to connect with the therapist by either asking questions or talking about the world outside of the playroom.

All of the children involved in the study also engaged in "safe play". This is defined as a situation where the child is in complete control therefore maintaining a level of physical and emotional safety. Activities included sorting, creative play, ordered or patterned play (Fall, 1997).

Another category defined in her study was "unsafe play". This included play where behavior or emotions were out of control. Activities included smashing, crashing, killing or helplessness and hopelessness. She found that animals were the primary source for the expression of violence (Fall, 1997).

The final category defined in her study was resolution. This play behavior was characterized when the child found a solution or new way to encounter the unsafe play situation. The child was able to regain control and learn new ways to deal with formerly unsafe feelings. Fall's (1997) study results support the existence of four different categories of children's play during play therapy session.

Summary

It is necessary that mental health professionals who work with children understand the process of play therapy. Examining the play of the same child over consecutive sessions as well as comparing the process with children experiencing a variety of presenting problems will provide insight and better understanding of the process. The play aspect of play therapy also needs to be explored. Investigating specific toys used, feelings expressed and themes played out is necessary to truly understand the process of play therapy.

CHAPTER II

METHODS AND PROCEDURES

The purpose of this study is to examine the play of children during play therapy sessions. This chapter provides the research questions, definition of terms, selection of participants, instrumentation, collection of data, and procedures for analysis of data.

Research Questions

To carry out the purpose of the study, the following research questions were formulated:

1) Does the gender of a child affect the process of play therapy?
2) Does the age of a child affect the process of play therapy?
3) Does the ethnicity of a child affect the process of play therapy?
4) Does the primary household of a child affect the process of play therapy?
5) Does the presenting problem of a child affect the process of play therapy?
6) Do the overall dynamics of the session affect the process of play therapy?

Definition of Terms

Abuse

The physical, sexual or emotional abuse or neglect of a child as reported by a parent or guardian on the University of North Texas (UNT) Child and Family Resource Clinic (CFRC) Child/Adolescent Background Information form (Appendix A).

Academic Problem

Struggling with school performance or learning difficulties as reported by a parent or guardian on the UNT CFRC Child/Adolescent Background Information form (Appendix A).

Adjustment to Life Changes

Difficulties adjusting to life experiences that include changing schools, divorce, moving, parent remarriage or death of a family member or friend as reported by a parent of guardian on the UNT CFRC Child/Adolescent Background Information form (Appendix A).

Anger Problem

Displaying anger, irritability, aggression or temper tantrums as reported by a parent or guardian on the UNT CFRC Child/Adolescent Background Information form (Appendix A).

Anxiety

Being nervous, clingy, fearful, worried, panicky or distrustful as reported by a parent or guardian on the UNT CFRC Child/Adolescent Background Information form (Appendix A).

Hyperactivity

Restlessness, fidgeting, excessive talking or moving around as reported by a parent or guardian on the UNT CFRC Child/Adolescent Background Information form (Appendix A).

Inattention

Difficulty sustaining attention, organizing, forgetful or easily distracted as reported by a parent or guardian on the UNT CFRC Child/Adolescent Background Information form (Appendix A).

Parent-Child Relationship Problem

Difficulty with discipline, adoption or struggles of single parenting as reported by the parent or guardian on the UNT CFRC Child/Adolescent Background Information form (Appendix A).

Play Therapy

Landreth (1991) defined play therapy as "a dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child to fully express and explore self (thoughts, feelings, experiences, and behaviors) through the child's natural medium of communication, play" (p.14).

Play Therapists

The play therapists in this study were advanced doctoral level and master's level students majoring in counseling at the University of North Texas who have received special training and supervision in play therapy. All therapists were completing internship requirements at the Child and Family Resource Clinic on the campus of the University of North Texas. All of the therapists have completed a minimum of introductory course in play therapy including both didactic and experiential training and a supervised practicum including clinical supervision of play therapy clients.

Presenting Problem

The primary concern reported by the parent or guardian on the UNT CFRC Child/Adolescent Background Information form (Appendix A) at the beginning of treatment. This is the focus of the play therapy sessions.

Session Dynamics

A description of the child's overall behavior/affect on a continuum from noncoping/maladaptive to coping/adaptive during a play therapy session as documented by the play therapist on the Play Therapy Session Summary form (Appendix A).

Sadness

Feelings of sadness or depression not related to grief as reported by the parent or guardian on the UNT CFRC Child/Adolescent Background Information form (Appendix A).

Theme

Landreth (1991) stated "a theme is the recurrence of certain events or topics in the child's play either within a session or across several sessions" (p.324). This does not mean the use of the same toy in consecutive sessions

Unusual Behavior

Bizarre actions, speech, compulsive behavior, tics, or motor behavior problems as reported by the parent or guardian on the UNT CFRC Child/Adolescent Background Information form (Appendix A).

Unusual Experiences

Loss of periods of time or sensing unreal things as reported by the parent or guardian on the UNT CFRC Child/Adolescent Background Information form (Appendix A).

Selection of Participants

For the purpose of this study, participants were selected from the child clients who have received play therapy at the Child and Family Resource Clinic (CFRC) on the campus of the University of North Texas in Denton, Texas. The CFRC master's and doctoral level interns provide services to community clients for individual, marriage and family, and play therapy. Children are brought to the CFRC by a parent or guardian for play therapy. They present with a variety of difficulties such as abuse, adjustment to life changes, anger problems, anxiety, academic problems, feelings of sadness or depression, inattention, hyperactivity, parent-child relationship problems, unusual behavior and unusual experiences.

All subjects were selected to participate in the study based on the following criteria: a) child must have received play therapy at the CFRC from 1998-2000; b) a consent for counseling form which contains consent for use of session information for research purposes must be signed by a parent/guardian; c) a complete background information form answered must have been answered by a parent or guardian; d) sessions must have been documented by play therapist on a play therapy session summary form; e) must have received treatment from 1998 to present so that the sessions well be documented on the current Play Therapy Session Summary form.

Instrumentation

In order to determine what happens in play therapy sessions with children, demographic/background information and individual session data for each subject was examined. For the purpose of this study, instrumentation includes the Child/Adolescent Background Information Form and the Play Therapy Session Summary Form.

Child/Adolescent Background Information Form

The Child/Adolescent Background Information Form was created by Dr. Sue Bratton for use at the Child and Family Resource Clinic on the campus of the University of North Texas. A parent or guardian for each minor who receives counseling services at the CFRC completes this form. Information obtained from this form includes the child's name address, age, gender, prior treatment history, information about child's mother and father, health concerns, diagnosis and medication history, current concerns, and significant family experiences.

Play Therapy Session Summary

Dr. Sue Bratton and Dr. Linda Homeyer developed the Play Therapy Session Summary form for use at the Child and Family Resource Clinic as well as several other universities. It utilizes a SOAP format and was created so that significant events occurring during play therapy

sessions observed by different therapists can be documented in a standardized manner and utilized for research purposes. Each play therapist completes this form for every session held with a child receiving play therapy services at the clinic. Significant information about each session is documented including: feelings expressed, toys/play behavior, significant verbalization, limits set, dynamics of the session, play themes, client conceptualization and plans/recommendations.

Collection of the Data

After verifying that informed consent was documented by the parent/guardian for each subject was assigned a code number. The information contained on the background information form and play therapy session summary forms were coded, eliminating all identifying data, and entered into a database for analysis. All information provided is confidential and the mane of the children will not be disclosed in any publication or discussion of this material.

The data on the background information forms was completed by the parent/guardian of the child as part of the clinic intake process. The therapists who completed the play therapy session summary forms were graduate students who are pursuing either a master's degree or doctorate in counseling specializing in play therapy, and who are fulfilling their internship requirements at the Child and Family Resource Clinic.

The information contained on the Child/Adolescent Session Summary form and the Play Therapy Session Summary forms for each subject were entered into a computer spreadsheet. Once all the data was entered in a uniform fashion, it was analyzed both within subject and between subjects. Data will be analyzed to identify significant happenings and trends in play therapy and to suggest areas for further study.

Analysis of Data

Data for each participant was coded and entered into a spreadsheet in Microsoft Excel and was analyzed using SPSS for Windows. Measures of central tendency were used to summarize and describe the data sets. Age, gender, ethnicity, family structure and presenting problem of participants will be reported and compared. Other data such as patterns of toy use, expression of feelings, themes and session dynamics were also examined and frequencies of toy use, feelings expressed and themes were tabulated.

An Analysis of Variance (ANOVA) was computed to examine the variability among the sample means relative to the spread of the observations within each group. Data sets calculated included gender, ethnicity, and age, family structure, presenting problem, toys, feelings and themes. Significant differences between the means were tested at the .05 level. Below .05 are reported as significant and below .10 are reported as trends.

Limitations

This study has the following limitations:

1. Subject selection will be limited to children receiving play therapy at the Child and Family Resource Clinic in Denton, Texas and is not likely to be an ethnically balanced sample.
2. Different therapists with various levels of training and expertise are performing the play therapy sessions.
3. Each therapist will have a slightly different style of documentation on the Play Therapy Session Summary Form.
4. The subjects will be placed into categories based on the parent/guardian report of the presenting problem at the beginning of treatment.

CHAPTER III

RESULTS AND DISCUSSION

This chapter presents the results of the analysis of the data. Included also is a discussion of the results, implications and recommendations.

Results

Thirty-two cases of children who completed at least ten sessions of play therapy at the Child and Family Resource Clinic (CFRC) at the University of North Texas, Denton, Texas between the years 1998 and 2002 were coded and entered into a computer database. Background and clinical information from these cases was analyzed to investigate and clarify the process of play therapy.

Because previous research (Moustakas, 1955; Hendricks, 1971; Withee, 1975) has indicated a type of resolution phase in the play therapy process (somewhere between sessions 9-12), the children included in this study completed ten or more sessions. These cases were included to obtain a more complete picture of the process of play therapy. Also, the same children who completed ten sessions remained through session thirteen and provided a consistent number for analysis of this phase of the play therapy process.

Analysis included an investigation of the impact of the following variables: gender, ethnicity, age, family household and presenting problem on the use of toys, emotions expressed, themes played out and overall dynamics of play therapy sessions with children.

Background Information

The thirty-two children included in this study ranged in age from 2-9 years with a mean age of 5.6 years and were comprised of 17 males and 15 females. Children of different ethnic

groups were represented in the analysis. The breakdown included 29 Caucasian children, 2 Bi-racial children and 1 Hispanic child. The study also included 18 children from dual parent households and 14 children from single parent households.

On the Child/Adolescent Background Information Form (Appendix A) parents were asked to mark their concerns about the child at the onset of play therapy sessions. This information was used by the play therapist to identify the presenting problem for treatment. The parent/guardian was encouraged to mark up to 10 concerns at the onset of treatment, as well as to indicate the primary concern or most significant issue. This issue became the presenting problem to be addressed in play therapy sessions. Not all of the participants specified a single most significant issue. Table 1 reflects the percentages of problems rated by the parent/guardians as the **most** significant issue at the beginning to treatment.

Table 1

Issues Reported as Most Significant

Issue	Percent Marked
Adjustment Problems	16%
Feelings of Anger/Irritability	16%
Parent/Child Relationship	11%
Feelings of Anxiety/Nervousness	9%
Feelings of Sadness	6%
Abuse (physical, sexual,emotional)	5%

Adjustment problems and feelings of anger/irritability (16%) were considered the primary problem by the majority of parents at the beginning of therapy. This was followed closely by parent/child relationship problem (11%}, feelings of anxiety/nervousness (9%), feelings of sadness (not related to grief) (6%) and abuse (5%).

Session Summary Information

Play therapy sessions were investigated by analysis of the information documented on the Play Therapy Session Summary Forms for each case

(Appendix B). Data contained on the Play Therapy Session Summary Forms were coded and entered into a spreadsheet for further analysis.

The total number of sessions completed by participants in the study ranged from 13 to 55. Only one child completed 55 play therapy sessions. The average number of play therapy sessions attended by children included in the study was 22.8. Table 2 contains the session totals for the participants in the study.

Table 2

Session Totals for Children Participating in at least Ten Play Therapy Sessions

Session Number	Subject	Session Number	Subjects
10	32	33	9
11	32	34	8
12	32	35	8
13	32	36	8
14	31	37	8
15	30	39	8

16	27	40	8
17	26	41	6
18	24	42	6
19	20	43	6
20	18	44	6
21	17	45	5
22	17	46	4
23	17	47	3
24	16	48	2
25	15	49	2
26	14	50	2
27	13	51	2
28	13	52	2
29	13	53	1
30	11	54	1
31	10	55	1
32	9		

Total cases = 32

The following are results from the analysis of the cases in table 2.

Toy Use. The toys used and play behavior of each child for every session was recorded on the Play Therapy Session Summary Form. All of the sessions were analyzed to determine the

toys used most often in the playroom. Each toy used and play behavior exhibited during a play therapy session was recorded on the form in the following categories:

a) hammer/log/woodworking; b) sandbox/water/sink; c) theater/puppets; d) kitchen/cooking/food; e) easel/paint/chalkboard; f) bean bag/pillows/sheet/blanket; g) bop bag/foam bat; h) dress up clothes/fabrics/shoes/jewelry/hats/masks/wand; i) crafts/clay/markers; j) doll house/doll family/ bottle/pacifier/baby; k) cash register/money/phone; l) camera/flashlight; m) medical kit/bandages; n) musical instruments; o) games/bowling/ring toss/balls; p) cars/trucks/bus/emergency vehicles/planes/boats; q) animals/domestic/ zoo/alligator/ dinosaurs/ shark/snake; r) soldiers/guns/knife/sword/handcuffs/rope; s) constructive toys/blocks/barricade.

Although the category is included on the Play Therapy Session Summary Form (Appendix B), the use of sand tray and miniatures was not included in the analysis because the Child and Family Resource Clinic has a separate room and documentation form for sand tray therapy. Table 3 includes a list of the categories of toys included in each playroom and the percentage of children who used each one during every session.

Table 3

Percentage of Children That Used the Toy Category in Every Play Session

Toy Category	Percent	Toy Category	Percent
Sandbox	100.00%	Easel/Paints	100.00%
Dolls	93.8%	Weapons	93.6%
Crafts	90.6%	Money	90.6%
Musical	87.5%	Bopbag	84.4%

Dress Up	81.3%	Medical	81.3%
Animals	78.1%	Games	71.9%
Hammer	68.8%	Vehicles	65.6%
Blocks	34.4%		

Total cases = 32

Feelings Expressed. The feelings expressed in by children during each play therapy session were also assigned to categories (Appendix B) and entered into the database. The categories are as follows: a) Happy: happy, relieved, satisfied, pleased, delighted, excited, surprised and silly; b) Sad: sad, disappointed, hopeless, pessimistic, discouraged and lonely; c) Angry: angry, impatient, annoyed, frustrated, mad, mean and jealous; d) Afraid: afraid, vulnerable, helpless, distrustful, anxious, fearful, scared, terrified; e) Confident: confident, proud, strong, powerful, determined, free; f) Hesitant: hesitant, timid, confused, nervous, embarrassed, ashamed; g) Curious: curious, interested, focused; and h) Flat: flat, contained, ambiguous and restricted. Feelings expressed during play therapy sessions were examined for statistical significance by gender, ethnicity and presenting problem.

Multivariate Analysis of Variance (MANOVA) and Analysis of Variance (ANOVA) were calculated to examine the variability among the sample means relative to the spread of the observations within each data set. Data sets that were investigated included gender, ethnicity, age, primary household, presenting problem, toys, feelings and themes. Significant differences between the means were tested and .05 is reported as statistically significant and .10 is reported as a trend.

Research Question 1

Does the gender of a child affect the process of play therapy?

The 32 cases included in this study were divided by gender for comparison. Included were 17 males and 15 females. The results are reported in Tables 4 and 5.

Table 4

Descriptive Statistics for Gender and Toy Use in Play Therapy Sessions

Toy Category	Gender	Mean	Standard Deviation	N
Hammer	Male	4.76	3.19	17
	Female	2.53	3.52	15
Sandbox	Male	12.29	5.55	17
	Female	8.53	4.94	15
Puppets	Male	5.35	5.13	17
	Female	3.20	2.54	15
Kitchen	Male	4.00	3.45	17
	Female	6.33	4.84	15
Easel	Male	7.65	5.17	17
	Female	8.80	5.85	15
Bopbag	Male	5.29	3.35	17
	Female	3.07	4.08	15
Dressup	Male	5.53	5.61	17
	Female	5.47	4.34	15

Crafts	Male	5.82	4.59	17
	Female	7.53	5.51	15
Dolls	Male	9.20	4.90	17
	Female	4.59	4.58	15
Money	Male	7.41	5.80	17
	Female	5.47	4.60	15
Medical	Male	3.71	2.80	17
	Female	4.27	3.47	15
Musical	Male	5.12	3.90	17
	Female	4.47	4.12	15
Games	Male	3.47	2.72	17
	Female	2.33	2.47	15
Constru	Male	.47	1.01	17
	Female	.80	1.15	15
Vehicles	Male	3.41	3.68	17
	Female	1.67	2.97	15
Animals	Male	8.06	7.00	17
	Female	2.53	2.33	15
Guns	Male	10.82	6.24	17
	Female	5.33	5.56	15
Blocks	Male	1.59	2.09	17
	Female	.67	1.68	15

Total cases = 32

Table 5

Multivariate Analysis of Variance for Gender and Toy Use in Play Therapy Sessions

Gender vs.	Sum of Squares	Df	Mean Square	F Ratio	Sign. Of F
Hammer	39.677	1	39.677	3.534	.070
Sandbox	112.706	1	112.706	4.048	.053
Puppets	36.936	1	36.936	2.163	.152
Kitchen	43.385	1	43.385	2.516	.123
Easel	10.593	1	10.593	.351	.558
Bopbag	39.537	1	39.537	2.876	.100
Dressup	3.137	1	3.137	.001	.972
Crafts	23.296	1	23.296	.917	.346
Dolls	169.482	1	169.482	7.560	.010
Money	30.149	1	30.149	1.085	.306
Medical	2.506	1	2.506	.255	.617
Musical	3.377	1	3.377	.210	.650
Games	10.306	1	10.306	1.519	.227
Constru	.865	1	.865	.749	.394
Vehicles	24.268	1	24.268	2.145	.153
Animals	243.294	1	243.294	8.480	.007
Guns	240.196	1	240.196	6.825	.014
Blocks	6.768	1	6.768	1.855	.183

Total cases = 32

In the first MANOVA, gender was the independent variable and toy use during play therapy sessions was the dependent variable examined for significance ($p < .05$). The following categories of toys were found to be statistically significant with males in the study: dolls (.01), animals (.007), and weapons (.014). The following were found to be trends: hammer (.07), sandbox (.053) and bopbag (.10). A correlation was found between males and the use of these toys during play therapy sessions when compared with females.

Table 6

Descriptive Statistics for Gender and Feelings Expressed in Play Therapy Sessions

Feelings Category	Gender	Mean	Standard Deviation	N
Happy	Male	29.53	21.79	17
	Female	17.27	7.83	15
Sad	Male	6.47	8.16	17
	Female	3.27	2.22	15
Angry	Male	10.82	8.86	17
	Female	7.80	7.39	15
Confident	Male	23.88	17.39	17
	Female	14.87	8.43	15

Hesitant	Male	7.76	9.44	17
	Female	2.80	3.38	15
Curious	Male	18.94	10.64	17
	Female	10.40	4.42	15
Flat	Male	2.88	2.93	17
	Female	.93	1.58	15

Total cases = 32

Table 7

Multivariate Analysis of Variance for Gender and Feelings Expressed in Play Therapy Sessions

Gender vs.	Sum of Squares	Df	Mean Square	F Ratio	Sign. Of F
Happy	1198.300	1	1198.300	4.251	.048
Sad	81.800	1	81.800	2.162	.152
Angry	72.848	1	72.848	1.081	.307
Confident	647.721	1	647.721	4.513	.042
Hesitant	196.416	1	196.416	3.712	.064
Curious	581.334	1	581.334	8.358	.007
Flat	30.271	1	30.271	5.258	.029

Total cases = 32

Significance was found for gender and expression of feelings with males and the categories happy (.048), confident (.042), curious (.007) and flat (.029).

Multivariate analysis of variance was investigated between gender and the following play themes: exploratory, relationship, power/control, helpless/inadequate, aggression/revenge, safety/security, mastery, nurturing, death/loss/grieving, sexualized and other. No significance or trends were found between gender and themes.

Research Question 2

Does the age of a child affect the process of play therapy?

The subjects were also coded into two groups by age for examination of session variables: 2-5 and 6-10. The young child category contained 18 cases and the older child category contained 14 cases. The results are reported in the following tables.

Table 8

Descriptive Statistics of Age and Toy Use in Play Therapy Sessions

Toy Category	Age	Mean	Standard Deviation	N
Hammer	Young	3.50	3.47	18
	Older	4.00	3.62	14
Sandbox	Young	10.39	4.85	18
	Older	10.71	6.49	14
Puppets	Young	4.83	4.96	18
	Older	3.71	3.05	14
Kitchen	Young	4.39	4.16	18
	Older	6.00	4.35	14

Easel	Young	6.72	4.01	18
	Older	10.07	6.53	14
Bopbag	Young	4.72	4.34	18
	Older	3.64	3.08	14
Dressup	Young	5.11	4.89	18
	Older	6.00	5.23	14
Crafts	Young	6.17	5.00	18
	Older	7.21	5.21	14
Dolls	Young	5.94	4.50	18
	Older	7.79	6.02	14
Money	Young	5.72	4.05	18
	Older	7.50	6.81	14
Medical	Young	4.11	3.12	18
	Older	3.79	3.17	14
Musical	Young	4.15	4.36	18
	Older	4.86	3.42	14
Games	Young	2.56	2.41	18
	Older	3.43	2.90	14
Constru	Young	.61	1.03	18
	Older	.04	1.00	14
Vehicles	Young	3.61	3.97	18
	Older	1.29	2.02	14
Animals	Young	6.33	6.81	18
	Older	4.36	4.68	14

Guns	Young	7.832	6.62	18
	Older	8.78	6.47	14
Blocks	Young	1.22	1.80	18
	Older	1.07	2.16	14

Total cases = 32

Table 9

Multivariate analysis of Variance for Age and Toy Use in Play Therapy Sessions

Age vs.	Sum of Squares	Df	Mean Square	F Ratio	Sign. Of F
Hammer	1.969	1	1.969	.158	.694
Sandbox	.834	1	.834	.026	.872
Puppets	9.862	1	9.862	.549	.465
Kitchen	20.441	1	20.441	1.135	.295
Easel	88.335	1	88.335	3.198	.084
Bopbag	9.175	1	9.175	.622	.437
Dressup	6.222	1	6.222	.245	.624
Crafts	8.643	1	8.643	.334	.568
Dolls	26.698	1	26.698	.982	.330
Money	24.889	1	24.889	.890	.353
Medical	.834	1	.834	.084	.773
Musical	4.960	1	4.960	.003	.956
Games	6.002	1	6.002	.866	.359

Constru	7.937	1	7.937	.007	.935
Vehicles	42.584	1	42.584	3.978	.050
Animals	30.754	1	30.754	.860	.361
Guns	7.143	1	7.143	.166	.686
Blocks	.179	1	.179	.046	.831
Total cases = 32					

Results of the analysis indicate a statistically significant relationship between children ages 2-5 use of vehicles (.050). A trend was noted between children ages 2-5 easel/paints/chalkboard (.084). No significance or trends were found between toy use and the older children in the study.

Multivariate analysis of variance was also investigated between age, feelings expressed and the following play themes: exploratory, relationship, power/control, helpless/inadequate, aggression/revenge, safety/security, mastery, nurturing, death/loss/grieving, sexualized and other. No significance or trends were found between age and feelings or age and play themes.

Research Question 3

Does the ethnicity of a child affect the process of play therapy?

Ethnicity was also examined as a variable impacting toy use of the participants in the study. Table 10 includes the results of this analysis.

Table 10

Multivariate Analysis of Variance for Ethnicity and Toy Use in Play Therapy Sessions

Ethnicity vs.	Sum of Squares	Df	Mean Square	F Ratio	Sign. Of F
Hammer	23.790	1	23.790	2.024	.165
Sandbox	4.862	1	4.862	.155	.697
Puppets	38.612	1	38.612	2.269	.142
Kitchen	3.754	1	3.754	.202	.656
Easel	6.446	1	6.446	.212	.648
Bopbag	.000	1	.000	.000	1.000
Dressup	28.571	1	28.571	1.159	.290
Crafts	37.786	1	37.786	1.516	.228
Dolls	.286	1	.286	.010	.920
Money	1.143	1	1.143	.040	.843
Medical	4.290	1	4.290	.440	.512
Musical	5.161	1	5.161	.323	.574
Games	2.161	1	2.161	.306	.584
Constru	1.786	1	1.786	1.589	.217
Vehicles	6.112	1	6.112	.513	.480
Animals	23.790	1	23.790	.661	.423
Guns	41.143	1	41.143	.984	.329

Blocks	8.254	1	8.254	2.294	.140

Total cases = 32

Caucasian = 29

Minority = 3

The results of this MANOVA indicate that there is no correlation between ethnicity and toy use during play therapy sessions.

Table 11

Descriptive Statistics for Ethnicity and Feelings Expressed in Play Therapy Sessions

Feelings Category	Ethnicity	Mean	Standard Deviation	N
Happy	Caucasian	44.25	23.67	29
	Other	20.86	14.98	3
Sad	Caucasian	4.75	6.12	29
	Other	6.50	8.06	3
Angry	Caucasian	16.75	5.97	29
	Other	8.36	8.03	3
Confident	Caucasian	34.75	10.76	29
	Other	17.50	10.76	3

Hesitant	Caucasian	5.79	7.98	29
	Other	3.00	3.46	3
Curious	Caucasian	14.14	9.45	29
	Other	20.50	6.24	3
Flat	Caucasian	1.89	2.17	29
	Other	2.50	5.00	3

Total cases = 32

Table 12

Multivariate Analysis of Variance for Ethnicity and Feelings Expressed in Play Therapy Sessions

Ethnicity vs.	Sum of Squares	Df	Mean Square	F Ratio	Sign. Of F
Happy	1915.290	1	1915.290	7.423	.011
Sad	10.79	1	10.79	.267	.609
Angry	246.540	1	246.540	4.004	.055
Confident	1041.469	1	1041.469	7.987	.008
Hesitant	27.161	1	27.161	.464	.501
Curious	141.446	1	141.446	1.680	.205
Flat	1.290	1	1.290	.192	.664

Total cases = 32

Significance was found between subjects of Caucasian ethnic background and expression feelings in the happy (.011), and confident (.008). A trend of with Caucasian children and angry (.055) was also found.

Multivariate analysis of variance was investigated between ethnicity and the following themes: exploratory, relationship, power/control, helpless/inadequate, aggression/revenge, safety/security, mastery, nurturing, death/loss/grieving, sexualized and other. No significance or trends were found for themes and the aforementioned variables.

Research Question 4

Does the primary household of a child affect the process of play therapy?

Each child's primary household was investigated as impacting a child's choice of toys during play therapy sessions.

Table 13

Descriptive Statistics for Primary Household and Toys Used in Play Therapy Sessions

Toy Category	Household	Mean	Standard Deviation	N
Hammer	Dual	2.36	2.82	18
	Single	4.78	3.66	14
Sandbox	Dual	9.72	5.21	18
	Single	11.57	5.94	14
Puppets	Dual	3.06	2.24	18
	Single	6.00	5.52	14
Kitchen	Dual	5.61	4.79	18
	Single	4.43	3.50	14

Easel	Dual	8.33	5.62	18
	Single	8.00	5.41	14
Bopbag	Dual	4.33	3.56	18
	Single	4.14	4.26	14
Dressup	Dual	4.94	4.21	18
	Single	6.21	5.91	14
Crafts	Dual	6.83	5.17	18
	Single	6.36	5.03	14
Dolls	Dual	6.83	5.53	18
	Single	6.64	4.97	14
Money	Dual	6.33	5.53	18
	Single	6.71	5.14	14
Medical	Dual	3.44	3.31	18
	Single	4.64	2.76	14
Musical	Dual	5.26	3.92	18
	Single	4.21	4.06	14
Games	Dual	3.17	2.43	18
	Single	2.64	2.92	14
Constru	Dual	.56	1.04	18
	Single	.71	1.14	14
Vehicles	Dual	1.94	3.08	18
	Single	3.43	3.78	14
Animals	Dual	5.17	4.71	18

	Single	5.86	7.46	14
Guns	Dual	7.83	5.23	18
	Single	8.79	7.96	14
Blocks	Dual	1.44	2.25	18
	Single	.79	1.42	14

Total cases = 32

Table 14

Multivariate Analysis of Variance for Primary Household and Toy Use in Play Therapy Sessions

Household vs.	Sum of Squares	df	Mean Square	F Ratio	Sign. Of F
Hammer	46.143	1	46.1430	4.191	.049
Sandbox	26.929	1	26.929	.877	.356
Puppets	68.274	1	68.274	4.259	.048
Kitchen	11.012	1	11.012	.601	.444
Easel	.875	1	.875	.029	.867
Bopbag	.286	1	.286	.019	.891
Dressup	12.698	1	12.698	.504	.483
Crafts	1.786	1	1.786	.068	.796
Dolls	.286	1	.286	.010	.920
Money	1.143	1	1.143	.040	.843
Medical	11.310	1	11.310	1.188	.284
Musical	8.907	1	8.907	.561	.460

Games	2.161	1	2.161	.306	.584
Constru	.198	1	.198	.169	.684
Vehicles	17.346	1	17.346	1.502	.230
Animals	3.754	1	3.754	.102	.751
Guns	7.143	1	7.143	.166	.686
Blocks	3.417	1	3.147	.909	.109

Total cases = 32

Single Parent = 14

Dual Parent = 18

The results of the MANOVA for household and toys used during play therapy sessions indicate a significant relationship between single parent households and use of hammer (.049) and puppets (.048) during play therapy sessions.

The primary household of each child participating in the study was also examined as a variable impacting the feelings expressed during play therapy sessions. There was no significance or trends found in the results of this MANOVA.

The total number of limits set during play therapy sessions was also examined and a trend was established with single parent household and total number of limits set (.10).

Research Question 5

Does the presenting problem of a child affect the process of play therapy?

Toy use was also examined in relation to a variety of presenting problems. Tables 15-21 reflect these ANOVA results. Scores below .05 are reported as significant and below .10 are reported as trends.

Table 15

Analysis of Variance for Abuse and Toy Use in Play Therapy Sessions

Abuse vs.	Sum of Squares	df	Mean Square	F Ratio	Sign. Of F
Hammer	9.862	1	9.862	.807	.376
Sandbox	10.719	1	10.719	.343	.562
Puppets	15.540	1	15.540	.874	.357
Kitchen	3.254	1	3.254	.175	.679
Easel	111.446	1	111.446	4.151	.050
Bopbag	10.286	1	10.286	.699	.410
Dressup	34.571	1	34.571	1.414	.244
Crafts	120.071	1	120.071	5.413	.027
Dolls	7.143	1	7.143	.257	.616
Money	114.286	1	114.286	4.573	.041
Medical	27.862	1	27.862	3.106	.088
Musical	50.161	1	50.161	3.462	.073
Games	21.875	1	21.875	3.418	.074
Constru	1.786	1	1.786	1.589	.217
Vehicles	5.469	1	5.469	.458	.504
Animals	7.504	1	7.504	.205	.654
Guns	28.571	1	28.571	.676	.417
Blocks	.754	1	.754	.196	.661

Total cases = 5

When the presenting problem of abuse (physical, sexual and emotional) was the independent variable and toys used during play therapy sessions the dependent variable, significance was found in the categories of crafts (.027) and money (.041) and easel (.050). Trends were discovered for medical (.088) and musical (.073).

Table 16

Analysis of Variance for Adjustment Problem and Toy Use in Play Therapy Sessions

Adjustment vs.	Sum of Squares	df	Mean Square	F Ratio	Sign. Of F
Hammer	14.005	1	14.005	1.159	.290
Sandbox	.251	1	.251	.008	.93
Puppets	44.864	1	44.864	2.669	.113
Kitchen	1.255	1	1.255	.067	.797
Easel	.657	1	.657	.022	.884
Bopbag	6.145	1	6.145	.414	.525
Dressup	52.509	1	52.509	2.202	.148
Crafts	.445	1	.445	.017	.897
Dolls	.327	1	.327	.012	.915
Money	11.782	1	11.782	.415	.524
Medical	8.596	1	8.596	.894	.352
Musical	9.020	1	9.020	.569	.457

Games	3.111	1	3.111	.443	.511
Constru	.227	1	.227	.193	.663
Vehicles	2.255	1	2.255	.187	.668
Animals	29.796	1	29.796	.832	.369
Guns	22.727	1	22.727	.535	.470
Blocks	4.602	1	4.602	.012	.914

Total cases = 22

There was no significance or trends found between adjustment problems and toy use.

Table 17

Analysis of Variance for Feelings of Anger/Irritability and Toy Use in Play Therapy Sessions

Adjustment vs.	Sum of Squares	df	Mean Square	F Ratio	Sign. Of F
Hammer	26.669	1	26.669	2.195	.149
Sandbox	48.769	1	48.769	1.627	.212
Puppets	4.345	1	4.345	.239	.628
Kitchen	21.252	1	21.252	1.182	.286
Easel	11.408	1	11.408	.378	.543
Bopbag	18.148	1	18.148	1.255	.272
Dressup	99.615	1	99.615	4.471	.043
Crafts	33.848	1	33.848	1.393	.247

Dolls	102.059	1	102.059	4.138	.051
Money	31.348	1	31.348	1.129	.296
Medical	11.102	1	11.102	1.165	.289
Musical	14.934	1	14.934	.953	.337
Games	42.008	1	42.008	7.333	.011
Constru	.300	1	.300	.256	.617
Vehicles	5.852	1	5.852	.491	.489
Animals	58.102	1	58.102	1.667	.207
Guns	51.570	1	51.570	1.243	.274
Blocks	9.167	1	9.167	2.569	.119

Total cases = 5

In this ANOVA, feelings of anger/irritability were the independent variable and the toys used during play therapy sessions were the dependent variables. Significance was found between anger/irritability and dress up (.043), games (.011) and a trend was found with dolls (.051).

Table 18

Analysis of Variance for Feelings of Anxiety/Nervousness and Toy Use in Play Therapy Sessions

Anxiety vs.	Sum of Squares	df	Mean Square	F Ratio	Sign. Of F
Hammer	1.710	1	1.710	.137	.714
Sandbox	10.750	1	10.750	.344	.562
Puppets	3.242	1	3.242	.178	.676
Kitchen	1.087	1	1.087	.058	.811
Easel	202.047	1	202.047	8.480	.007
Bopbag	14.368	1	14.368	.985	.329
Dressup	48.644	1	48.644	2.029	.165
Crafts	148.971	1	148.971	7.021	.013
Dolls	103.195	1	103.195	4.190	.050
Money	15.540	1	15.540	.549	.464
Medical	.440	1	.440	.045	.834
Musical	.116	1	.116	.007	.933
Games	1.760	1	1.760	.249	.621
Constru	6.259	1	6.259	6.421	.017
Vehicles	3.811	1	3.811	.318	.577
Animals	6.070	1	6.070	.002	.958
Guns	97.126	1	97.126	2.430	.129

Blocks	8.082	1	8.082	.021	.886

Total cases = 4

Feelings of anxiety and nervousness were the independent variable and toys used during play therapy sessions the dependent variable in this analysis. Significance was found with easel (.007), crafts (.013), dolls (.05), and constructive toys (.017).

Table 19

Analysis of Variance for Attention Problems and Toy Use in Play Therapy Sessions

Attention Prob vs.	Sum of Squares	df	Mean Square	F Ratio	Sign. Of F
Hammer	1.928	1	1.928	.154	.697
Sandbox	225.804	1	225.804	9.380	.005
Puppets	.562	1	.562	.031	.862
Kitchen	7.917	1	7.917	.430	.517
Easel	1.510	1	1.510	.000	.982
Bopbag	7.043	1	7.043	.475	.496
Dressup	108.560	1	108.560	4.939	.034
Crafts	13.587	1	13.587	.528	.473
Dolls	9.662	1	9.662	.000	.985
Money	134.531	1	134.531	5.533	.025
Medical	16.341	1	16.341	1.747	.196
Musical	43.049	1	43.049	2.923	.098
Games	.377	1	.377	.053	.819

Constru	.292	1	.292	.249	.621
Vehicles	9.062	1	9.062	.767	.388
Animals	110.877	1	110.877	3.349	.077
Guns	21.343	1	21.343	.502	.484
Blocks	1.040	1	1.040	.271	.607

Total cases = 9

The analysis of variance for Attention Problems and Toys used during session resulted in significance with sandbox (.005), dress up (.034), money (.025) and a trend with animals (.077).

Table 20

Analysis of Variance for Hyperactivity and Toy Use in Play Therapy Sessions

Hyperactivity vs.	Sum of Squares	df	Mean Square	F Ratio	Sign. Of F
Hammer	2.251	1	2.251	.180	.674
Sandbox	28.623	1	28.623	.9340	.342
Puppets	7.539	1	7.539	.418	.52
Kitchen	56.270	1	56.270	3.346	.077
Easel	83.080	1	83.080	2.989	.094
Bopbag	2.513	1	2.513	.168	.685
Dressup	24.821	1	24.821	1.002	.325

Crafts	19.500	1	19.500	.764	.389
Dolls	55.846	1	55.846	2.131	.155
Money	5.128	1	5.128	.179	.675
Medical	1.623	1	1.623	.165	.688
Musical	9.696	1	9.696	.612	.440
Games	9.003	1	9.003	1.318	.260
Constru	1.282	1	1.282	.011	.918
Vehicles	1.219	1	1.219	.101	.753
Animals	83.597	1	83.597	2.458	.127
Guns	86.205	1	86.205	2.138	.154
Blocks	.873	1	.873	.227	.637
Total cases = 6					

Between hyperactivity and toy use during play session, no significance occurred. Trends were found for kitchen (.071) and easel (.094).

Table 21

Analysis of Variance for Parent/Child Relationship Problem and Toy Use in Play Therapy Sessions

Par/Child Rel vs.	Sum of Squares	df	Mean Square	F Ratio	Sign. Of F
Hammer	9.862	1	9.862	.807	.376
Sandbox	47.362	1	47.362	1.578	.219
Puppets	32.254	1	32.254	1.872	.181
Kitchen	38.612	1	38.612	2.219	.147
Easel	105.875	1	105.875	3.916	.057
Bopbag	48.286	1	48.286	3.588	.068
Dressup	18.286	1	18.286	.732	.399
Crafts	1.786	1	1.786	.068	.796
Dolls	.286	1	.286	.010	.920
Money	28.571	1	28.571	1.026	.319
Medical	18.862	1	18.862	2.035	.164
Musical	4.018	1	4.018	.251	.620
Games	15.018	1	15.018	2.266	.143
Constru	.643	1	.643	.553	.463
Vehicles	8.254	1	8.254	.697	.411
Animals	17.719	1	17.719	.489	.490
Guns	.286	1	.286	.007	.936

Blocks	8.254	1	8.254	2.294	.140

Total cases = 4

A presenting problem of parent/child relationship problem was the independent variable and toys used during play therapy sessions the dependent variable in this analysis. Significance was not found, however, trends were found for easel (.057), and bopbag (.068).

Each presenting problem discussed previously was also examined for correlations with feelings expressed and themes played out during play therapy sessions and are reported in Tables 22-24.

Table 22

Analysis of Variance for Abuse and Feelings Expressed in Play Therapy Sessions

Abuse vs.	Sum of Squares	df	Mean Square	F Ratio	Sign. Of F
Happy	1174.862	1	1174.862	4.156	.050
Sad	17.719	1	17.719	.443	.511
Angry	26.469	1	26.469	.384	.540
Confident	791.254	1	791.254	5.703	.023
Hesitant	13.018	1	13.018	.221	.642
Curious	70.875	1	70.875	.819	.373
Flat	9.862	1	9.862	1.532	.225

Total cases = 5

The presenting problem abuse showed significance with feelings in the confident category (.023). The only statistically significant discovery between abuse and theme was power/control (.036). Abuse was only one of two presenting problems showing a correlation with theme.

Table 23

Analysis of Variance for Attention Problems and Feelings Expressed in Play Therapy Sessions

Attention vs.	Sum of Squares	df	Mean Square	F Ratio	Sign. Of F
Happy	82.000	1	82.000	.257	.616
Sad	192.428	1	192.428	5.635	.024
Angry	391.806	1	391.806	6.906	.013
Confident	.127	1	.127	.001	.978
Hesitant	260.658	1	260.658	5.134	.031
Curious	411.005	1	411.005	5.463	.026
Flat	8.196	1	8.196	1.262	.270

Total cases = 9

Children with attention problems expressed the feelings sad (.024), angry (.013) hesitant (.031) and curious (.026) more often than other feelings during play therapy sessions.

Table 24

Analysis of Variance for Hyperactivity and Feelings Expressed in Play Therapy Sessions

Hyperactivity vs.	Sum of Squares	df	Mean Square	F Ratio	Sign. Of F
Happy	276.097	1	276.097	.883	.355
Sad	120.007	1	120.007	3.282	.080
Angry	95.373	1	95.373	1.432	.241
Confident	451.924	1	451.924	3.012	.093
Hesitant	351.157	1	351.157	7.353	.011
Curious	18.029	1	18.029	.204	.655
Flat	.289	1	.289	.043	.837

Total cases = 6

Analysis of variance was also examined with each presenting problem and the play themes. The only correlations found were with abuse and power/control (.036) and hyperactivity and exploratory (.033). A trend was found between parent/child relationship problem and aggression/revenge (.085).

The following presenting problems were also examined and showed no significance or trends with feelings expressed or themes: adjustment problems, feelings of anger/irritability and feelings of anxiety/nervousness.

Research Question 6

Do the overall dynamics of the session affect the process of play therapy?

The dynamics of the play session including the child's overall behavior and affect was also considered. Each variable was coded and entered into the spreadsheet using a Likert scale rating 1-5 for the following categories: a) sad/depressed/angry/fearful to content/satisfied (appropriate affect); b) anxious/insecure to confident/secure; c) dependent/clingy/needy to autonomous/independent; d) immature/regressed/hypermature to age appropriate; e) low frustration tolerance to high frustration tolerance; f) external locus of control to internal locus of control; g) impulsive/easily distracted to purposeful/focused; h) inhibited/constricted to creative/expressive/spontaneous/free; and (i) isolated/detached to connected/sense of belonging. One was considered maladaptive/non-coping behavior and five an adaptive/coping behavior.

In general, session dynamics differed each session both within subject and between subjects. However, a few peaked and began an upward trend around particular sessions. These results are found in table 25.

Table 25

Peaks of Overall Session Dynamics

Dynamic Shifted	Session Number
Content	12
Confident	11
Locus of Control	13
Creative	11-13
Total cases = 32	

The child's overall behavior began to move from sad/depressed/angry/fearful to content/satisfied around session 12. Anxious/insecure behavior moved toward confident/secure behavior about session 11. The locus of control shifted from external to internal about session 13 and play changed from inhibited/constricted to creative/expressive/spontaneous and free during sessions 11-13.

Other Interesting Findings

The frequency of each individual emotion (not category of emotion) was computed for each child across play therapy sessions. The total number of times an emotion was noted by the therapist during each session was totaled and then divided by the number of children reaching that session. The average frequency for all emotions was 0.174 with a standard deviation of 0.203. Any emotion with a frequency above 0.377 was noted as having statistically significant frequency. Table 26 contains a list of the most common emotions.

Table 26

The Most Frequently Noted Emotions Across Play Therapy Sessions

Emotion	Frequency
Excited	.678
Pleased	.560
Focused	.550
Interested	.474
Proud	.446
Curious	.409
Frustrated	.386

Confident	.377
Total cases = 32	

The majority of emotions were consistently expressed by children over the course of play therapy. A few, however, had definite trends and are listed in Table 27.

Table 27

Trends for Emotions Expressed in Play Therapy Sessions

Emotion	Trend	Start of Therapy	End of Therapy
Surprised	Down	.47	.1
Annoyed	Up	0	.38
Free	Up	.11	.5
Timid	Down	.316	0
Nervous	Down	.263	0

These results indicate that children expressed surprise, timid and nervous more often at the beginning of therapy and expressed annoyed and free more often toward the end of therapy.

Emotions were also analyzed for consistency of expression during each play therapy session. The average was taken of the documented incidence of each category of emotion. The following emotions had notable peaks during specific play therapy sessions. Results are included in Table 28.

Table 28

Session Peaks of Emotional Expression

Emotion	Peak	Average	Session Number
Delight	.421	.281	1
Interested	.8	.474	6
Powerful	.533	.354	6
Angry	.4	.135	6
Curious	.615	.409	9
Confident	.692	.377	9

These results indicate that children express delight/excitement at the beginning of play therapy due to the novelty. Around session 6, there is an emotional burst as issues are being addressed followed by resolution around session 9 with feelings of curiosity and confidence dominating sessions.

The average of the documented occurrence of toy use was also examined. The following toy categories had notable peaks during specific play therapy sessions. Results are included in Table 29.

Table 29

Session Peaks of Toy Use

Toy Category	Peak	Average	Session Number
Hammer	.647	.285	2,7
Kitchen	.786	.579	7
Crafts	1.077	.788	10
Dolls	1.5	.731	7
Money	1.0	.607	6
Medical	.714	.325	7
Musical	.833	.448	11
Vehicles	.615	.336	7

Hammer is the only toy category with peaks in two sessions. The initial peak is in session 2 and it occurs again around session 7. The first occurrence is probably due to the novelty of the activity and second for actual therapeutic purpose.

Play themes were also examined for trends over the course of therapy. Most trends were played out over the entire course of therapy. The following had definite trends and are listed in Table 30.

Table 30

Trends for Themes Played Out in Play Therapy Sessions

Theme	Trend	Start of Therapy	End of Therapy
Safety	Up	.105	.5
Exploratory	Down	1.0	0

Exploratory is not actually a play theme but the way a child gets comfortable with the playroom and is expected to decrease as the child gets to know the therapist and activities in the room. Children playing out the theme safety/security through their toy choice/play behavior rose through the course of therapy.

The averages of documented incidence of themes were also examined for notable peaks during specific session numbers. Table 31 contains the results of this examination.

Table 31

Session Peaks of Themes

Theme	Peak	Average	Session Number
Aggression	.4	.179	14
Nurturing	.277	.467	6

The theme of aggression/revenge peaked in session 14 and nurturing (self-care, reparative/healing) in session 6. None of the other play themes examined had significant peaks around specific session numbers. They remained constant throughout the course of therapy.

Discussion

A wealth of data was gleaned from the review of case records of children receiving play therapy at the Child and Family Resource Clinic on the campus of the University of North Texas in Denton, Texas. This data was analyzed to explore the process and examine the play behavior and session dynamics of children in play therapy. The following is a discussion of the significant findings.

Toy Use

Because toys become the words of children, a very important part of play therapy is the selection of toys and materials for the playroom (Axline, (1947); Landreth (1991). Landreth (2002) addressed the importance of toy selection because "…toys and materials will serve as a medium for children to express feelings, explore relationships, and understand self" (p.115). Since toys become the words of children, their selection is of utmost importance to the process of play therapy. Landreth proposed guidelines for selecting toys and materials for play therapy and suggested the inclusion of these three categories of toys: real-life toys, aggressive release toys, and toys for creative expression/emotional release. The playrooms used to conduct the play therapy sessions included in this study contained toys consistent with Landreth's recommendations.

Results showed that the majority of children participating in play therapy used most of toys in the playrooms at the CFRC. As shown in Table 5 the toys used most often were the sandbox and easel/paints. Each playroom utilized in the study contained a sandbox on the floor

in the center of the room. It is large enough for children to get inside and sit in. One explanation for its initial popularity is that many children have only seen a sandbox of this size outside. It is unique and therefore warrants initial exploration. According to Allan and Berry (1987) "sand often acts as a magnet for children".

However, the sandbox continued to be popular throughout the play therapy process. This prevalence was probably due to the variety of purposes served by the sandbox. The texture of sand is soothing and offers a sensory motor experience. Water can also be added to change the texture. Carey (1991) described:

> Sand and water lend themselves to the demonstration of a large variety of fantasies, for example, tunnel-making, burying or drowning, land and seascapes. When wet, the sand may be molded and when dry it is pleasant to feel…(pp.47-48).

Children were able to dig or bury things and were free to choose any behavioral direction when playing with the sandbox. Experiences of this type in play therapy have tremendous therapeutic value.

Each room also contained an easel that children can walk up to and paint with large brushes in a variety of colors. The easel/paints offered the opportunity for creative expression by mixing or smearing the paints. The paper has no lines and children were free to create anything they chose. According to Rogers (1993), part of the therapeutic process was to awaken creativity and that what is creative is often therapeutic. Creative arts have therapeutic value for children who naturally use play and art materials to express themselves symbolically (Rubin, 1984).

Both the sandbox and easel/paints are completely open-ended and allowed the subjects freedom to choose the direction of play. The use of these toy categories was documented for

each child during every session over the course of play therapy. At 100%, both of these categories were obviously significant to the process of play therapy.

As shown in Table 5, several other toy categories were used by the majority of the children participating in this study. Dolls, weapons, money and crafts were used by over 90% of the participants in every session over the course of therapy. Likewise, between 60% and 80% of children used toys in the following categories: musical, bopbag, dress up, medical, animals, games, hammer and vehicles. Only 34% of participants used the blocks. This category included constructive toys and large cardboard blocks in a variety of colors often used to make a barricade.

The majority of the participants, regardless of gender, ethnicity or presenting problem, used a wide variety of toys within and across sessions. These results indicate the importance of including a wide variety of toys when creating a therapeutic playroom and specifically support the use of the toys proposed by Landreth (2002) for a well-equipped playroom. The significance of the toys used by children relative to gender, age, ethnicity and presenting problem is discussed later in this section.

Gender

The impact of gender on the play therapy process was investigated by analyzing the session summary information of 18 males and 14 females. Significance was found for males with toy use when compared with females during the same play therapy sessions. No statistically significant toy use was found with females when compared with males during the same play therapy sessions.

As shown in Table 4, categories statistically significant for males were the doll category including doll house, doll family, bottle, pacifier and baby doll, the animal category including

domestic animals, zoo animals, alligator, dinosaurs, shark and snake, and the weapon category including soldiers, weapons, knife, sword, handcuffs and rope. The use of soldiers, weapons, handcuffs and rope are often thought of as typical toy choices for males. Toys in the animal category are considered to be more gender neutral however, dolls, pacifier and bottle tend to be thought of as typical toy choices for girls.

The results showed a statistically significant relationship between males and the use of dollhouse, doll family, bottle, pacifier and baby doll during play therapy sessions. One possible reason for this correlation is that boys may have limited exposure to these kinds of toys at home or with peers. Parents often encourage boys to play with toys considered by society to be gender appropriate and playing with dolls is not considered to be an important part of the socialization of males. Another explanation is that because boys may be dissuaded from playing with dolls their need to nurture or be nurtured may be stronger than that of girls in the playroom. It also makes sense that boys who have been experiencing problems in their family relationships or struggling with the birth of a new sibling used the doll or doll family to help express feelings and resolve conflict in this area. The playroom offers a safe, non-judgmental environment in which children can play with toys chosen to "play out" their real world experiences or to meet certain needs rather than playing only with gender accepted toys. The finding of significance between males and toys from the doll category is noteworthy and warrants further investigation.

As shown in Table 5, the analysis of the data also showed a correlation between males and expression of feelings in the following categories: happy (happy, relieved, satisfied, pleased, delighted, excited, surprised and silly), confident (confident, proud, strong, powerful, determined and free), curious (curious, interested and focused) and flat (flat, contained, ambiguous and restricted). The findings of this analysis differ slightly from previous reports. Withee (1975)

found that boys expressed more anger and aggression and girls expressed more happiness and anxiety in therapy sessions. The current study, however, concluded that boys expressed the feelings in the happy, confident, curious and flat categories more often than girls did during play therapy sessions.

Age

Because there are significant developmental distinctions between children of different ages, the children in the study were divided into two groups ranging from 2-5 years of age and 6-10 years of age. Approximately 50% of children were in each age group. Age was analyzed with toy use, feelings expressed and themes played out during play therapy sessions.

This study indicated that the children in the younger group were more partial to using the vehicles than the children in the older group. Toys in the vehicles category included cars, trucks, bus, emergency vehicles, planes, boats and a riding car and offer younger children the opportunity to use gross motor skills. Vehicles could be driven, flown or crashed and people can be placed inside and taken out. Also, the riding car is of more interest to younger children than older ones who may be too big to ride it. Toys in this category are easily manipulated and offer opportunity for both reality and fantasy play.

Ethnicity

Another variable examined was the impact of ethnicity on the process of play therapy. Results of this analysis indicated that ethnicity of the child did not impact the toy choice and play behavior of the children in this study. Ethnicity did, however, influence the feelings expressed during play therapy sessions. As shown in Table 8 a correlation was found between Caucasian children in play therapy and the expression of feelings in the following categories: happy (happy, satisfied, pleased, delighted, excited, surprised and silly), angry (angry, impatient, annoyed,

frustrated, mad, mean and jealous) and confident (confident, proud, strong, powerful, determined and free). Children of Caucasian background may have expressed these feelings more often than non-Caucasian children in play therapy sessions, however, the reader is urged to take caution when interpreting this result due to the unequal number children represented by each ethnic group (Caucasian, 87%, non-Caucasian, 13%).

Primary Household

The primary household where the child resided at the time therapy was rendered was also considered as a factor affecting the dynamics of play therapy. The subjects were divided into two groups based on single parent or dual parent household. As shown in Table 9, results suggested statistical significance between children residing in single parent households and use of toys in the hammer and puppet categories during play therapy sessions. According to Grubbs (1995), "nearly 90% of children born in 1991 will live with only one parent in childhood or adolescence (p,3). Also, research indicates that divorce may impact children even into adulthood (Whitehead, 1993). Single parent households are often stressful and chaotic. The custodial parent often has increased responsibilities both at work and home leading to many adjustments for both the parent and the child. Use of the hammer in play sessions offered children from single parent households the opportunity to feel powerful and in control of both self and their surroundings.

Puppets may have been used to address issues relating to family. A child may choose a puppet to represent the absent parent and address issues in the playroom they may not have the opportunity to in everyday life. Household was also analyzed with feelings expressed and themes played out during sessions and showed no statistical significance with either variable. However, a trend was noted with total number of limits set during play therapy sessions. These

children exhibited behavior in the play room that required intervention and limit setting by the therapist. As with hammer use, feeling or being out of control may have led to this behavior.

Presenting Problems

The presenting problem refers to the parent/guardian's primary reason for bringing the child in for play therapy services as noted on the Child/Adolescent Background Information Form (Appendix A). Because the presenting problem plays a part in determining the focus of therapy, this variable was investigated to examine its impact on the process of play therapy. Presenting problems were examined in the following categories: abuse (physical, emotional and sexual), adjustment to life issues, feelings of anger/irritability, feelings of anxiety/nervousness, attention problems, hyperactivity and parent/child relationship problems.

Abuse. The first presenting problem examined was abuse and included children who had experienced physical, sexual or emotional abuse or a combination of these experiences. A correlation was found between abuse and the toy categories crafts and money. Use of the crafts materials allowed for creativity and expression in drawing, painting, finger painting, gluing, watercolor or sculpting. According to Segal (1984) expressive art activities can elicit thoughts and feelings the individual may be unaware exist by stimulating all of the senses. He described the relationship between sensory experiences and emotional expression as allowing the brain to tap into stored memories and feelings thus bringing what was once denied into awareness. Repressed memories and feelings is something that is often experienced by children who have been abused. The use of crafts during play therapy sessions provided opportunities for abused children to become more aware of repressed feelings and facilitate healing.

Victims of abuse often express feelings of helplessness and lack of control. According to Landreth (1991) "the cash register provides for a quick feeling of control as the child

manipulates the keys and calls out numbers" (p.121). Therefore toys in this category may provide the opportunity for abused children to feel powerful and in control of themselves and their surroundings.

In addition to the cash register, subjects who experienced abuse may also have used the play money for other significant reasons. For example, a child may have taken all of the money to hide it or keep it. Money may represent security for children who have been neglected and in society money represents power and happiness. Abused children may have used the money to connect with feelings of strength and power.

Analysis also revealed a statistically significant relationship between children who have experienced abuse and expression of the feelings happy, confident and the theme power/control during play therapy sessions. In this study, children who have experienced abuse significantly expressed feeling happy, relieved, satisfied, pleased, delighted, excited, surprised, silly, confident, proud, strong, powerful, determined, and free during play therapy sessions. This is a wide range of emotions and may have been expressed at significant points during the therapeutic process. Because victims of abuse struggle with feelings of powerlessness it is understandable that the children in this study exhibited play behavior that manifested the power/control theme. The expression of feelings also confirms that in addition to playing out the theme of power/control, these children also expressed feelings of strong, powerful and determined. The correlation between children who experienced abuse and the toys in the money category indicates that the children also used these toys to play out the power/control theme. As this theme is played out and feelings are resolved, the child may have expressed more the feelings of happy, relief, confident and proud as a result of resolving painful issues and feeling more powerful and free in the playroom.

Anger. Also investigated were children presenting with feelings of anger/irritability. Significance was found between these children and the toy categories of dress up and games. These are not the conventional toys one would expect an angry child to use during play therapy sessions. Toys in the games category included bowling, ring toss, bat and a variety of balls. These games involved rolling or throwing of objects and bowling may result in a crashing noise and action. The noise and activity level experienced in play behavior with games may have been therapeutic for the child experiencing feelings of anger.

The dress up category included a wide variety of clothes, costumes and accessories including but not limited to: superhero capes, army uniform and police hats, etc. In addition, children may have used the sword or weapon and handcuffs in conjunction with the dress up category. However, it is possible that in some cases the therapists may have failed to document clearly. For example, one therapist noted by this category that the child dressed up as a policeman to play "cops and robbers". In this case, guns and handcuffs may have been used in conjunction with dress up. Another possibility is that many children do not get the opportunity to dress up at home. The presence of another unrelated intervening variable is also possible. In any case, these results emphasized that to limit the selection and availability of toys based on therapist expectations of which toys would be used for a specific purpose can limit the process of play therapy.

Anxiety. The presenting problem of feelings of anxiety/nervousness was also explored with toy use/play behavior, feelings and themes. Significance was found with easel/paints, crafts, dolls and constructive toys. The results of this study indicated that the use of expressive arts (crafts, painting) is an important variable in the play therapy process for children experiencing feelings of anxiety. Similar to the abuse correlation, crafts offered children experiencing anxiety

the opportunity to elicit thoughts and feelings that are often difficult to express verbally (Segal, 1984). It is also possible that the anxious child may have wanted to distance from the therapist. Because of the set up of the playrooms utilized in this study, using toys in the crafts category allowed the child to be across the room at a table facing away from the therapist. A wide range of toys was used by subjects in this category further emphasizing the importance of a variety of toy selections in the playroom for children with the same presenting problem.

Attention Problems. When attention problems was examined as the independent variable, significance was found with toys used during play therapy sessions. Sandbox, dress up and money were all found to be statistically significant. A child experiencing attention problems may feel out of control due to the inability to concentrate and focus for extended periods of time. Similar to the abuse correlation, toys in the money category helped these children gain a sense of control and mastery. Many children in this category were diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). Children with ADHD often experience low self-esteem and consider themselves to be "different" from their peers. People with money are often considered by children to be powerful and respected, therefore subjects in this category may have used toys in the money category to identify themselves with these characteristics.

Dress up allowed the child with attention problems the ability to "be" someone else for a little while. For example, the child may dress up and pretend to be a parent or teacher in order to work through relational difficulties. Also, a child can pretend to be a policeman or fireman who are often thought of as being powerful by children. Again, the possibility exists that the opportunity to dress up was not available to these children at home.

As shown in Table 18, a relationship was also found between children experiencing attention problems and the feelings in the following categories angry (angry, impatient, annoyed,

frustrated, mad, mean and jealous), hesitant (hesitant, timid, confused, nervous, embarrassed and ashamed) and curious (curious, interested and focused). It is understandable that children experiencing attention problems expressed anger, impatience, annoyance and frustration more often than other feelings during play therapy sessions. The inability to focus and concentrate for an extended length of time may result in perpetual impatience and frustration for children with attention problems. Also, these children may have been expressing and reacting to similar feelings directed at them by parents, teachers and other adults in their lives.

The results also indicated that children with attention problems expressed more hesitance, embarrassment and shame during play therapy sessions. Often, children with attention problems are in trouble for their lack of focus and concentration. They may experience an internal distractibility and eventually begin to question their thoughts and desires as well as become embarrassed or ashamed by their inability to follow directions. The analysis also showed that these children were curious, interested and focused during play therapy sessions. It is possible that attention to many different activities or exploratory behavior characteristic of children with attention problems was mistaken for expression of the aforementioned feelings by play therapists in the study.

Hyperactivity. Hyperactivity was also investigated for correlations with toys, feelings and themes. Statistical significance was discovered with the feeling category hesitant and the exploratory theme. Hyperactivity is defined as the inability to concentrate and focus for extended periods of time. Hyperactive children are often misunderstood. Constant movement and inability to sit still make it difficult to relate to and understand the hyperactive child. (Weiss & Hechtman, 1993). It is unclear from the data whether these subjects actually stayed with the exploratory

theme throughout the course of therapy or if manifestation of hyperactive behavior was mistaken for exploratory behavior by the therapists in the study.

Parent/Child Relationship. The final presenting issue, parent/child relationship problem was investigated as a variable. No correlations were found between toys/play behavior, feelings or themes, however significance occurred between children being seen for this issue and the total number of limits set during play therapy sessions. Many parents brought their children to therapy for this presenting issue because they have experienced difficulty getting their children to mind and follow directions. It is likely that these children were testing their parents and therefore they continue this behavior in the playroom with the therapist. No other presenting problem showed significance when examining limits as the dependent variable.

Time Lapse Study

For each session, the frequency of each toy category/play behavior, emotion, and theme was computed for each child across sessions. Because one of the objectives of play therapy is to help children express emotions, which ones were being expressed most often during play therapy sessions with children was examined. The following is a discussion of the most common emotions expressed during play therapy sessions with the children in this study.

The total number of times an emotion was noted on the Play Therapy Session Summary Form (Appendix B) was totaled and divided by the number of children who reached that session number. Any emotion more than one standard deviation above the mean was noted with statistically significant frequency.

As reported in Table 21, excited, pleased, focused, interested, proud, curious, frustrated and confident were the feelings expressed with significance over the course of play therapy by the children in this study.

The following emotions peaked during specific play therapy sessions: delight (session #1), interested (session #6), powerful (session #6), angry (session #6), curious (session #9), and confident (session #9). The results indicated a progression from exploratory feelings in response to the novelty of the experience to expression of stronger and perhaps more meaningful emotions such as anger and confidence as therapy progressed. The time lapse study of emotions was consistent with Hendricks' (1971) findings of increased aggression and anger in sessions 5-8 with the peak of anger expression in session 6. She found that curiosity was expressed in the first session, however, the results of this study found that curiosity peaked in session 9.

The average of the documented occurrence of toy use over the course of treatment was also examined. The following toy categories had notable peaks during specific play therapy sessions. Hammer (session #2,7), kitchen (session #7), crafts (session #10), dolls (session #7), money (session #6), medical (session #7), musical (session #11), and vehicles (session #7). These results also confirmed Hendricks' (1971) findings of the presence of creative play in sessions 9-12. Participants in this study showed a peak use of crafts in session 10 and musical instruments in session 11. Her study discovered relationship play increased in sessions 9-12, however, the findings of this investigation are slightly earlier around session 6-7. Toys often used by children for relationship play such as kitchen (session #7), money (session #6), and medical (session #7) were all found to fall into this time frame. Whether preparing a meal to share in the kitchen, playing store or playing doctor with therapist, these toys are often used by children to make contact and build a relationship with the therapist.

Session Dynamics

The final variables investigated were the overall session dynamics. A Likert scale 1-10 of each child's overall behavior and affect during every play therapy session were examined. Intervals were collapsed to allow for the coding of data on a scale of 1-5 as divided in section III C on the Play Therapy Session Summary Form (Appendix B). Analysis of the data revealed statistically significant movement from anxious/insecure to confident secure in session 11. There were 32 who completed at least 11 sessions of play therapy. Statistically significant movement from negative affect to appropriate affect occurred in session 12. There were also 32 subjects in sessions 12 and 13 where locus of control began moving from external to internal when children began to exhibit more self-control in play activities. Finally, play behavior moved from being inhibited and constricted to creative/expressive/spontaneous and free during sessions 11-13. The aforementioned findings of the time lapse study and sessions dynamics reaffirm Hendricks' (1971) statements that as play therapy progresses children express feelings more directly and there is a decrease in exploratory/noncommittal behavior during sessions. The relationship between session number and dynamics has provided information that is both interesting and compelling about the process of play therapy.

Conclusion and Implications

The results of this investigation offer an abundance of information for mental health professionals working with children. The breakdown of toys used by the children in this study presents a guide to the toys that are most used in the process of play therapy. Sandbox and easel/paints were used by 100% of the participants in this study during each play therapy session. These are two items that, because of space limitations and mess are often missing from offices of mental health professionals yet appear to be significant to the play therapy process. A smaller

container, such as a sand tray, and finger or water color paints may be used if space is an issue. However, this study indicates that these materials are essential when providing play therapy for children.

Toys in the weapon category were used by 94% of participants however many parents and therapists express concern over their presence in the playroom. The bobo, gun, knife, sword, rope and other toys like these are often questioned for necessity by parents as well as some mental health professionals who work with children. The belief is they are only used for aggression. This is not true and their use by children for other purposes should also be noted. For example, bobo can be used to hit, hug or balance or sit on. In some cases bobo is used for nurturing or mastery, not simply for aggression.

The same is true for toys in the weapon category. Often a child will give a gun to the therapist and "team up" against the bad guys indicating use of something that is traditionally considered to be an aggressive toy for relational purposes. Likewise, some children literally want to load and unload the dart weapon, shoot at a target, or make darts "stick" to something else in the playroom. These activities are about gaining mastery rather than expressing aggression.

It is evident by the consistent use of the majority of the categories of toys provided in the CFRC playrooms that the toys included in this study are important to the process of play therapy with children regardless of gender, age, ethnicity, family household, and presenting problem. The results suggest that these toys should be considered essential components in every playroom.

The patterns of toy use by children with a variety of presenting problems also provide important information to mental health professionals working with children. For example, when working with clients who have experienced abuse it is important to have toys that allow them to

address feelings of helplessness and play out the power/control theme. Money, cash register and other such items allow the abused child to feel in control. Crafts and expressive art materials are also crucial for the exploration and resolution of buried emotions.

Dolls and the doll family should be available to children of both genders during play therapy sessions. It is interesting that boys in this study showed significance with toys in the doll category. One possibility is that girls have the opportunity to use dolls, bottles and similar item in real life and therefore are not compelled to use them in the playroom. Often in society, boys are encouraged to "be tough" and play with toys considered gender appropriate. Like girls, boys also have an intrinsic need to nurture and to be nurtured. Since this need may be thwarted in society, it makes sense that boys would use toys in the doll category to help meet their innate need for nurturance during play therapy sessions.

A wide variety of toys are also recommended for playrooms accommodating children of various ages. Because of the developmental discrepancy between children of different ages, toys must be available to meet the needs of various age groups. Younger children need toys that are simple to manipulate and do not cause frustration. Toys from the vehicles category including cars, planes and a riding car are recommended for younger children. Sometimes older children feel that certain toys are "for babies". Toys in the game and craft categories work well for older children. It is important to offer a variety of toys from the categories investigated in this study so that children of all ages feel comfortable in the playroom.

Information was also gained about time and the process of play therapy. At the onset of therapy, participants in this study expressed surprise, and delight probably due to the novelty of the playroom and play therapy experience. As therapy progressed, children increased in expression of interest, powerfulness and anger. Peak toy use during this period (session 6-7)

included hammer, kitchen, dolls, medical and vehicles. After some resolution (session 9 and later), children felt more free, expressed increased curiosity and confidence while using more creative toys such as crafts and musical instruments. The impact of resolution was evidenced by the shift in overall session dynamics from maladaptive/non-coping behavior to adaptive/coping behavior. This shift was noted between sessions 11-13.

The peak sessions for shift in dynamics (feeling content, confident, internal locus of control and creativity) are from sessions 11-13 yet the average number of sessions children usually complete is much less indicating many parents discontinue treatment before it has a chance to be effective. One implication is that mental health professionals need to do a better job of explaining the play therapy process to parents. Often parents will terminate therapy as soon as improvement is seen in the child's behavior. Educating parents that play therapy is actually a process that takes time for lasting effects may allow for true resolution of issues and appropriate termination experiences. Completion of the play therapy process increases the likelihood of a positive outcome and lasting effects.

The fact that significant changes are seen in later sessions also has implications for managed care companies who often limit the number of sessions available to mental health professionals working with children. Many managed care companies believe that children's problems can be resolved in fewer sessions than indicated in this study. It is often difficult to get approval to see children once their initial sessions have been utilized. This study indicates that resolution and progress begins in approximately in session 9 and positive movement continues through session 13 and beyond. Session 6 seems to fall in the beginning of the working phase of therapy. To discontinue treatment at this time does not allow for proper resolution of issues by children participating in play therapy. Allowing mental health professionals to work with

children until resolution is achieved may decrease the likelihood of children having to reenter therapy for the same presenting problem at a later time. In the long run, allowing children to resolve problems and participate in appropriate termination may save managed care companies both time and money.

Recommendations

Based on the results of this study, the following recommendations are offered:

1. Conduct a replication of this study using a larger sample size.
2. In the replication study, balance subjects for ethnicity.
3. Train all play therapists on use of the play therapy session summary form for greater consistency in documentation.
4. In the replication study, have raters watch videotapes of the play therapy sessions to ensure the accuracy in documentation by play therapists of toys used and feelings expressed during sessions.
5. In the replication study, analyze the toys and feelings individually rather than in categories.
6. Make activity room categories mirror categories of play therapy rooms and conduct a similar study investigating session dynamics of preadolescent children.
7. The authors of the Play Therapy Session Summary may reevaluate the toy and feeling sections of the form for appropriateness of categorization.

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APPENDIX A

CHILD/ADOLESCENT BACKGROUND INFORMATION FORM

CFRC_____
CDHC_____
BIOFBK_____
SC_____

University of North Texas
Department of Counseling, Development & Higher Education
Counseling Program Clinical Services

Child/Adolescent Background Information *(use for all minors)*

Welcome to the Child and Family Resource Clinic. Please answer all information as completely as possible. If applicable, both mother and father should complete together. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. Your child's counselor will discuss your responses with you after he/she has reviewed the form.

*Child's Name:*_____ *Date of First Visit* _____
Last First MI
Completed by: _____ *Relationship to Child:* _____

Home Phone: _____ (***May call***: Yes No ***May Leave Message***: Yes No)
Work Phone: _____ (***May call***: Yes No ***May Leave Message***: Yes No)
Best Time and Place to call: _____
Child's Address: _____
Street City State Zip

Child's Gender: Male__ Female__ *Date of Birth*___/___/___ *Age*____ *SS#*_____

Child's Ethnicity:
Africa American___ Bi-racial___ Hispanic/Latin___
Asian___ Caucasian___ Native American___ Other _____

Child's primary language: English ___ Spanish ___ Other _____
Language spoken at home (parent's language) _____

Child's Legal Guardian (Managing Conservator)*:* _____
(If the child is not living with both natural parents, both adoptive parents, or only living parent, the clinic requires a photocopy of the legal document stating custody arrangements, consisting of the cover page, page specifying conservator(s), and signature page). (The photocopy should be stapled to this form.)

In case of emergency, contact: _____
Name: Last, First Relationship Phone

Is your child presently receiving counseling elsewhere? Yes No
(If yes, do not complete this form until you have talked with your counselor)

Family members receiving services at this clinic Yes No (Name/Dates of service) _____
_____

Is your child currently on probation? Yes No *School Child attends:* _____
Current School Address & Phone _____
*Grade Level (*now): _____ *Has your child ever been retained? Yes No If yes, what grade* _____
*Current Teacher(s): 1)*_____ *2)*_____ *3)*_____
Current School Counselor: _____

Is your child receiving special education or other services? Yes No
*(explain)*_____

Has your child ever seen a mental health professional (psychiatrist, psychologist, or a counselor)? Yes No **(If so, we will need your permission in order to communicate with that individual or agency)**

Previous Mental Health Professional/Agency_____
Name Address
Phone_____ Dates of Service_____(beginning - ending)

Has your child been hospitalized for mental health concerns? Yes No
If yes: When _____ Where_____

How were you referred to our clinic? (Check those that apply):

Counselor/Psychologist/Psychiatrist__		School personnel__
Court__	Minister___	Self__
DPRS__	Newspaper Ad__	UNT Community__
Flyer__	Physician__	Yellow Pages__
Friend or Co-Worker__	Relative___	Other_____

Are you seeking services because your child is a victim of a crime? Yes No
Did it result in legal action? Yes No *(If Yes, explain)*_____

Person responsible for financial arrangements with our clinic: _____
Name: Last, First

Are you applying for sliding scale payments? Yes No
Gross Household Annual Income and Child Support Received

___Less than $15,000	___20,001 - 22,000	___26,001 - 28,000	___34,001 - 39,000
___15,001 - 18,000	___22,001 - 24,000	___28,001 - 31,000	___39,001 – 40,000
___18,001 - 20,000	___24,001 - 26,000	___31,001 - 34,000	

How many family members currently reside in your home? _____

*** INFORMATION ON CHILD'S MOTHER ***

Mother's Name: _____
Last First MI

I am: __ *biological mother* ___*stepmother* ___*adopted mother* *Other*_____
Address: _____
Street City State Zip

Home Phone: _____ *Work Phone:* _____
(May call: Yes No Leave Message: Yes No) (May call: Yes No Leave Message: Yes No)

Date of Birth: _____ *Occupation:* _____
Employer _____ *How Long:* _____

Last Year of education completed:

8th grade or below _____	Trade School ___	Master's Degree ___
High School ___	Some College ___	Ph. D. Degree ____
GED ___	College Graduate ___	

History of learning, emotional, or behavioral problems: Yes No
(If yes, please explain) _____

History of alcohol/drug/substance abuse: Yes No
(If yes, please explain) _____

History of family violence: Yes No
(If yes please explain) _____

History of criminal activity: Yes No
(If yes, please explain) _____

Current living arrangements:

Family of origin___	Relatives___	Single___
Married___	Roommate(s)___	Single parent w/children___
Married w/children___	Significant other___	Other_____

Marital Status (indicate all that apply and duration of each, ex. 1965-1985):
Never married ___

Married 1_____	Separated 1_____	Divorced 1_____	Widowed 1_____
Married 2_____	Separated 2_____	Divorced 2_____	Widowed 2_____
Married 3_____	Separated 3_____	Divorced 3_____	Widowed 3_____

*** INFORMATION ON CHILD'S FATHER ***

Father's Name: _____
Last *First* *M.*
I am __ *biological father* ___*stepfather* ___*adopted father* *other* _____

Address: _____
Street City State Zip

Home Phone: _____ *Work Phone:* _____
(May call: Yes No Leave Message: Yes No) (May call: Yes No Leave Message: Yes No)

Date of Birth: _____ *Occupation:* _____
Employer: _____ *How long:* _____

Last Year of education completed:

8th grade or below _____	Trade School ___	Master's Degree ___
High School ___	Some College ___	Ph. D. Degree ____
GED ___	College Graduate ___	

History of learning, emotional, or behavioral problems: Yes No
(If yes, please explain) _____

History of alcohol/drug/substance abuse: Yes No
(If yes, please explain) _____

History of family violence: Yes No
(If yes please explain) _____

History of criminal activity: Yes No
(If yes, please explain) _____

Current living arrangements:

Family of origin___	Relatives___	Single___
Married___	Roommate(s)___	Single parent w/children___
Married w/children___	Significant other___	Other_____

Marital Status (indicate all that apply and duration of each, ex. 1965-1985): Never married_____
Married 1_____ Separated 1_____ Divorced 1_____ Widowed 1_____
Married 2_____ Separated 2_____ Divorced 2_____ Widowed 2_____
Married 3_____ Separated 3_____ Divorced 3_____ Widowed 3_____

*** GENERAL INFORMATION ***

Child's current household:
Adoptive parents ___
Blended family (both spouses with children) ___
Father only ___
Foster family ___
Institution___
Mother only ___
Natural Father and Stepmother ___
Natural Mother and Stepfather ___
Natural Parents ___
Relatives ___
Other_____

List by Household your child's current family, beginning with the oldest member and include the child:
Primary Household (anyone who currently lives with child)
How long in this current living situation: _____

Name	Age	Gender	Relationship to you (include step, half, etc.)

Child lives in: House_____ Apartment _____ Duplex _____ Other_____

Second Household (non-custodial or extended family - if applicable)

Name	Age	Gender	Relationship to you (include step, half, etc.)

Currently involved in a custody dispute: No Yes (If yes, explain) _____
_____

If divorced, circle the number which best describes your relationship with your ex-spouse.

Hostile		Frustrating		Friendly
1	2	3	4	5

How often does client see non-custodial parent? _____

**** CHILD'S HEALTH ****

Child's Primary Care Physician: _____
Name Phone

_____
Address

Has your child ever seen a psychiatrist? Yes No
Is child currently seeing a psychiatrist? Yes No (If yes, list name, address and phone):

_____
Name Phone

_____
Address

*Date of LAST complete physical*_____
Physical Disability: Yes No (If yes, explain) _____
Chronic Illness: Yes No (If yes, explain) _____
Terminal Illness: Yes No (If yes, explain)_____

Check the following items for a diagnosis or medication that your child is now receiving or has received:

Diagnosis	**Current**	**Past**	**Date of Diagnosis**	**Name of medication**	**Dosage**
Depression	_____	_____	_____	_____	_____
ADHD	_____	_____	_____	_____	_____
ADD	_____	_____	_____	_____	_____
Conduct Disorder	_____	_____	_____	_____	_____
Learning Disability	_____	_____	_____	_____	_____
Anxiety/ Nervousness	_____	_____	_____	_____	_____
Panic Attack	_____	_____	_____	_____	_____
Manic-Depression (Bipolar)	_____	_____	_____	_____	_____
Schizophrenia	_____	_____	_____	_____	_____
Oppositional Defiant Disorder	_____	_____	_____	_____	_____
Mood/Anger	_____	_____	_____	_____	_____
Tics	_____	_____	_____	_____	_____
Insomnia/ Sleeplessness	_____	_____	_____	_____	_____
Obsessive/ Compulsive	_____	_____	_____	_____	_____
Addictions	_____	_____	_____	_____	_____
Convulsions	_____	_____	_____	_____	_____
Post-Traumatic Stress Disorder	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

(If you do not know the name and dosage of current medication, please bring the medication to your next session)

If your child has been diagnosed, who gave the diagnosis?
Counselor/Psychologist___ Family Physician___ Psychiatrist___ School___ Other_____
Name: _____ Phone #: _____

What other medication is your child currently taking?

Medication	Dosage	Taken for what reason?
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT CONCERNS *

Indicate severity of up to 10 items that currently apply to your child. (1-mild; 2-moderate; 3-severe)
Circle the item that you see as the most significant issue)

___Abuse (physical, emotional, sexual)
___Adjustment to life changes (changing schools, parents divorcing, moving, getting married or divorced, aging, etc.)
___Bed wetting daytime wetting, soiling or related problems
___Career Decisions
___Disturbing memories (past abuse, neglect or other traumatic experience)
___Drug or alcohol use (both legal and illegal drugs)
___Eating problem (purging, bingeing, overeating, hoarding, severely restricting diet)
___Family or Stepfamily relationship problems
___Feeling angry or irritable
___Feeling anxious (nervous, clingy, fearful, worried, panicky, obsessive-compulsive, lacking trust, etc.)
___Feeling guilty or shameful
___Feeling sadness or depression NOT related to grief
___Feeling sadness or depression related to grief
___Gang related concerns (explain)_____
___Health concerns (physical complaints and/or medical problems)
___Illegal behaviors (runaway, stealing, fire setting, truancy, etc.)
___Learning/Academic difficulties
___Non-family relationship problems (teachers, peers, etc.)
___Parent-Child relationship (discipline, adoption, single parent, etc.)
___Personal Growth (no specific problem)
___Religious or Spiritual concerns
___Sexual concerns (excessive masturbation, inappropriate acting out)
___Sexual identity concern
___Sleep problem (nightmares, sleeping too much or too little, etc.)
___Speech problem (not talking, stuttering, etc.)
___Suicidal Ideation (thoughts of death, wanting to die)
___Unusual behavior (bizarre actions, speech, compulsive behavior, tics, motor behavior problems, etc.)
___Unusual experiences (loss of periods of time, sensing unreal things, etc.)
___Other (explain)_____

Remember to circle the most significant issue.

When did you first become concerned about this issue? _____

How have you attempted before now to deal with this issue? _____
_____

Other treatment your child has received to address any of the concerns indicated above: None___
Couples Counseling___ Group counseling___ Individual counseling___
Family counseling___ Hospitalization___ Other _____

What do you enjoy most about this child? _____

What do you find most difficult about this child? _____

*Anything else you think we need to know*_____

What is the one thing I need to know to help your child today? _____

* FAMILY HISTORY/EXPERIENCES *

(For each of the following items that apply, write in your child's approximate age at the time it occurred):

Raised by:
Adoptive parent(s)___ Institution___ Relatives___
Foster parents___ Natural parents___ Single natural parent___
Grandparents___ Natural and step-parent___ Other_____

Stressors in the Family

Chronic illness of family member___ Death of significant person___ Domestic Violence____
Family member absent (explain)_____
Family member's disability/major accident/illness___
Family member emotional problems (explain)_____
Family member suicide (explain)_____
Financial problems___ Moved a lot___ Parents arguing frequently___ Parents divorced___
Other _____

History of your child having learning, emotional, behavioral problems: Yes No
(If yes, please explain) _____

History of your child having alcohol/drug/substance abuse: Yes No
(If yes, please explain) _____

History of family violence: Yes No
(If yes, please explain) _____

History of criminal activity in the family: Yes No
(If yes, please explain) _____

Has your child been abused (check all that apply): Physically___ Emotionally___ Sexually___

Has your child been neglected (check all that apply): Physically___ Emotionally___

School Problems (check all that apply):
Academic problems___ Discipline problems___ Severely teased___ Unpopular___
Other _____

Early Language/Speech Problems (explain)_____

History of emotional concerns include:

Appetite change ___	Heard voices___	Suicidal thoughts___
Emotional problems___	Loss of energy or fatigue___	Suicide attempts___
Gained weight ___	Lost weight___	Other _____

History of behavior problems includes: (check all that apply):

Accident-prone___	Aggressive Behavior (explain)_____		
Alcohol/drug use___	Attention problems___	Frequent arguments___	Hyperactive___
Impulsive___	Loner___	Misbehaved a lot___	Ran away___
Taken advantage of___	Temper outbursts___	Trouble with the law___	Other_____

History of anxiety symptoms includes: (indicate all that apply):

Irritable ___	Obsessive worrying ___	Physical symptoms (below) ___
Keyed up, on edge ___	Phobias ___	Other _____

History of health/physical problems includes: (check all that apply):

Asthma___	Disability___	Nervous stomach ___
Bedwetting___	Dizziness ___	Neurological problems/exam___
Bone/joint/muscle ___	Headache (kind) ___	PMS ___
Chest pain ___	Heart Palpitations___	Serious overeating/undereating__
Chronic illness___	Hospitalization___	Shortness of breath without exertion ___
Developmental delay(s)___	Major accident___	Sleep problem___
Diarrhea ___	Major illness___	Surgeries___
Other_____		

History of trauma/stressor includes: (check all that apply):

Child separated from parent (how long and when)_____

Death of a pet___	Death of a significant person___	Incarcerated family member___
Medical___	Natural Disaster___	Sexual Assault___
Victim of trauma (unusual, terrifying experience)___		Other_____

History of interpersonal problems includes: (check all that apply):

Aggressive behavior (explain)_____

Bullied___	Taken advantage of___
Frequent arguments___	Temper outbursts__
Loner___	Other_____

Family Atmosphere (circle the number that best describes how you view your child's current family atmosphere)

Very lenient	1	2	3	4	5	Very strict
Very non-religious	1	2	3	4	5	Very religious
Chaotic	1	2	3	4	5	Highly structured
Few expectations	1	2	3	4	5	High expectations
Inconsistent	1	2	3	4	5	Consistent

Family Support System (such as church, friends, relatives, school)

Hardly any support	1	2	3	4	5	Considerable support

Your child's current use of Computer, VCR, and Television (circle the number of hours that best describes use):

Computer (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

TV/VCR (circle approximate hours spent each week)

0-2 3-5 6-8 9-11 12+

APPENDIX B

PLAY THERAPY SESSION SUMMARY FORM

University of North Texas - Department of Counseling, Development and Higher Education
Counseling Program Clinical Services

Date__/___/__ Session #__ **PLAY THERAPY SESSION SUMMARY** Code # _____

Clinic/Rm #: _____ **Page 1 of 2 --- continued on back ---** *Signature required*

Child/Age_____/_____Counselor_____

Theory _____ Specific Interventions Used (***if any***)

I. SUBJECTIVE: *Underline all feelings, including capitalized words, expressed directly or through a toy (write toy above feeling). Circle predominate feeling(s).*

HAPPY: relieved, satisfied, pleased, delighted, excited, surprised, silly

SAD: disappointed, hopeless, pessimistic, discouraged, lonely

ANGRY: impatient, annoyed, frustrated, mad, mean, jealous

AFRAID: vulnerable, helpless, distrustful, anxious, fearful, scared, terrified

CONFIDENT: proud, strong, powerful, determined, free

HESITANT: timid, confused, nervous, embarrassed, ashamed

CURIOUS: interested, focused

FLAT: contained, ambiguous, restricted

II. OBJECTIVE:

A. TOYS/PLAY BEHAVIOR *Circle specific toys used (not category), give brief description of play. In blank, indicate meaningful/sustained play with "✶", indicate play disruption as "PD", and indicate therapist initiated activity as "TH" (Use your own code system for info important to you - ex:1st time or discontinued use of toy).*

___hammer/log/woodworking

___sandbox/water/sink

___theater/puppets

___kitchen/cooking/food

___easel/paint/chalkboard

___bean bag/pillows/sheet/blanket

___bop bag/foam bats/etc

___dress up: clothes/fabrics/shoes/jewelry/hats/masks/wand

___crafts/clay/markers/etc.

___doll house/doll family/bottle/pacifier/baby

___cash register/money/phone

___camera/flashlight

___medical kit/bandages

___musical instruments

___games/bowling/ring toss/balls/etc.

___cars/trucks/bus/emergency vehicles/planes/boats/riding car

___animals: domestic/zoo/alligator/dinosaurs/shark/snake

___soldiers/guns/knife/sword/handcuffs/rope

___constructive toys/blocks/barricade

___sandtray/miniatures

B. SIGNIFICANT VERBALIZATION: CH=Child initiated TH=Therapist initiated

C. LIMITS SET: *Write limit set beside the RATIONALE (ex: threw sand on floor) & in the blank, indicate # of times limit set. If consequence and/or ultimate limit was set in response to broken limit, describe process.*

___Protect Child (Physical & Emotional Safety):

___Protect Therapist and/or MaintainTherapist Acceptance/Relationship:

___Protect Room/Toys:

___Structuring:

___Reality Testing:

Developed by Bratton & Homeyer (updated 7/2002) **Play Therapist Signature (with credentials)** **Date**

III. ASSESSMENT: General Impressions/Clinical Understanding

A. DYNAMICS OF SESSION: *Rate Child's Overall Play Behavior*

Child's Activity Level (low)	1	2	3	4	5	6	7	8	9	10	Child's Activity Level (high)
Intensity of Play (low)	1	2	3	4	5	6	7	8	9	10	Intensity of Play (high)
Inclusion of therapist (low)	1	2	3	4	5	6	7	8	9	10	Inclusion of Therapist (high)
Destructive	1	2	3	4	5	6	7	8	9	10	Constructive
Messy/Chaotic/Disorganized	1	2	3	4	5	6	7	8	9	10	Neat/Orderly

B. PLAY THEMES: *Underline all that apply, including capitalized words, & describe how theme was played out (toys used, etc). Circle predominate theme(s).*

EXPLORATORY: (not a true play theme - rather the way child gets comfortable & familiar with playroom)

RELATIONSHIP: connecting/trust/approval seeking/manipulative/collaborative/testing limits

POWER/CONTROL:

HELPLESS/INADEQUATE:

AGGRESSION/REVENGE:

SAFETY/SECURITY:

MASTERY: deconstructing/constructive/competency/integration/resolution

NURTURING: self-care/reparative/healing

DEATH/LOSS/GRIEVING:

SEXUALIZED:

OTHER:

C. OVERALL, CHILD'S BEHAVIOR / AFFECT WAS:

MALADAPTIVE / NON-COPING										**ADAPTIVE / COPING**
Sad/depressed/angry/fearful	1	2	3	4	5	6	7	8	9	10	Content/satisfied (Appropriate Affect)
Anxious/insecure	1	2	3	4	5	6	7	8	9	10	Confident/secure
Dependent/clingy/needy	1	2	3	4	5	6	7	8	9	10	Autonomous/Independent
Immature/regressed/hypermature	1	2	3	4	5	6	7	8	9	10	Age appropriate
Low frustration tolerance	1	2	3	4	5	6	7	8	9	10	High frustration tolerance
External locus of control	1	2	3	4	5	6	7	8	9	10	Internal locus of control (self-controlled)
Impulsive/easily distracted	1	2	3	4	5	6	7	8	9	10	Purposeful/focused
Inhibited/Constricted	1	2	3	4	5	6	7	8	9	10	Creative/Expressive/Spontaneous/Free
Isolated/Detached	1	2	3	4	5	6	7	8	9	10	Connected/Sense of Belonging

D. CONCEPTUALIZATION OF CLIENT AND CLIENT'S PROGRESS BASED ON THEORETICAL ORIENTATION:

IV. PLANS / RECOMMENDATIONS: *check all that apply*

___Parent Consult
___Family Session
___Sibling(s) 1X
___Friend 1X
___Filial therapy

___Therapy for parent(s)
___Recommend Parent Resources:
___Other Plans / Recommendations:

___Medication Evaluation
___Psychological Testing
___School Consult
___Classroom Observation
___Professional Consult: Psychiatrist, Pediatrician, Attorney
___Request Records:

_____/_____
Play Therapist Signature (with credentials) **Date**