THE LONG-TERM EFFECTS OF PLAY THERAPY

DISSERTATION

Presented to the Graduate Council of the North Texas State University in Partial Fulfillment of the Requirements

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By

Michael R. Carns, B.S., M.A.
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The purpose of this study was to investigate and describe the long-term effects of play therapy on social contacts, self-esteem, school-related behavior patterns, level of academic functioning, attitude toward school, and family relations.

The subjects participating in this study were thirty children between the ages of thirteen and eighteen, who had been referred for counseling from schools in the North Texas area. Sixteen of the students in this study had received play therapy, while the remaining fourteen were evaluated as needing play therapy but declined treatment. Group I was comprised of those children who were evaluated as needing play therapy, were included in at least ten play therapy sessions, and had been out of play therapy for a minimum of one year and a maximum of six years. Group II was comprised of those children who were evaluated as needing play therapy, were included in at least ten play therapy sessions, and had been out of play therapy for a minimum of six years and a maximum of ten years. Group III was comprised of those children who were evaluated a minimum of one year and a maximum of six years previously and who were recommended for play therapy but did not participate. Group IV was comprised of
those children who were evaluated a minimum of six years and a maximum of ten years previously and who were recommended for play therapy but did not participate.

Measurements used to assess the results of this study were the Bonney-Fessenden Sociograph, Self-Esteem Inventory, Self-Esteem Behavior rating scale, Survey of Study Habits and Attitudes test, and the Family Environment Scale. The Mann Whitney U was used to analyze the data.

There were no significant differences between the group out of play therapy one to six years and the group out of play therapy six to ten years on social contact, self-esteem, school-related behavior patterns, or level of academic functioning. Statistically significant differences occurred at the .05 level of significance concerning the effects of time on home and family relations, with subjects in the six- to ten-year group perceiving more independence while parents in the one to six years group perceived more recreational activity occurring in the family. There were no significant differences between play therapy and non-play therapy children on social contact, self-esteem, school-related behavior patterns, or level of academic functioning. There were statistically significant differences at the .05 level of significance on home and family relations, with subjects one to six years out of play therapy perceiving more organization in their homes than their evaluation-only counterparts, while parents of the group one to six years out of play therapy
perceived significantly more cohesion than did parents in the evaluation-only comparison group. In the opposite direction, parents of the group one to six years since evaluation valued more goal-oriented behavior than did their play therapy counterparts. There were also statistically significant differences in the six- to ten-year category on home and family relations. Subjects in the category six to ten years out of play therapy perceived more independence in their homes, while their non-play therapy counterparts perceived more family recreational activity occurring. Between-group differences occurred on cohesion, expressiveness, and moral-religious emphasis, with non-play therapy subjects and parents disagreeing on these values significantly more than their play therapy counterparts.
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CHAPTER I
INTRODUCTION

Play therapy is the result of attempts in psychotherapy to provide children an avenue for emotional growth using play as the means of language and communication (25). Initial work in the area of play therapy tended to utilize concepts which had originally been developed for adult problems and then applied to child psychotherapy.

In their attempts to apply psychoanalytic theory to young children, Klein (33) and Freud (24) discovered that, unlike adults, children were either unable or unwilling to free-associate. Thus, due to characteristics present in many children, traditional verbal psychoanalysis appeared ineffective. Anna Freud (24) hypothesized that because children are still living with their parents, there is no transference neurosis among children in therapy. Also hindering child therapy was the inability of children to conceptualize Freudian concepts, and the involvement of children in emotional developmental stages which Freudians typically view in retrospect. To meet this challenge, play was instituted by both Klein (33) and Freud (24) in an effort to produce during therapy a positive emotional attachment between client and therapist, to reveal to the
child the power of the psychoanalyst, and to provide a method for making interpretations regarding the child's personality structure. Although play was a different method of accomplishing the goals of psychoanalytic therapy, the expected outcome of play therapy was an enhancement of the ego, just as would be the aim of adult psychoanalysis (26).

In the late 1930's, Taft (47), using Rankian theory, instituted changes in the aims and methods of psychotherapy with children. Emphasis was placed on using the play setting as a curative technique in its own right, eliminating from play therapy the analytic attempt to recover the past. A short time later, in the early 1940's, this emphasis on the "here and now" in play therapy was further advanced by Allen (2), who stressed the need for helping the child define himself as separate from the therapist. In the late 1940's, Axline (8) further defined this concept of exploration of self in the here and now. She stressed that play therapy is a self-exploratory experience in which the child learns about himself and how he relates to others. She notes that during play therapy, through the interactions with the therapist, the child comes to value both himself and others. In addition, the child learns a sense of freedom coupled with self-directed responsible behavior.

The basic concept underlying all forms of play therapy is that a child is better able to recreate and express both
his feelings and thoughts by means of concrete action than by means of verbalizations. The child's world is primarily a world of deeds, not words. "Play is the symbolization of the emotional activities of an individual" (28, p. 233). Play is important business of childhood, allowing children to develop at their own pace, exploring abilities through re-creation of their world both at home and school as they view it. Bernard (11) states that basic cultural skills such as male and female roles are learned through play, with play serving as a basic source of motivation to seek out and explore feelings about self and about self in relation to others.

According to Kubie (34), play and self expression through play are necessary elements for all children, since no child is free from emotional difficulty. Kubie believes that play fulfills an intermediate step which serves as a bridge between the limited verbal world of the child and the more structured language and communication patterns of adults. Through this medium of play, children may be able to free themselves from emotional difficulties. In apparent support of this theme, Frank (23) states that play is indicative of man's unique position in nature. Play, he says, helps the child to formulate for himself the symbolic human world in which he lives; and in so doing, the child strives for goals and values which give human living its uniqueness.
Apparently, then, various child guidance authorities view this form of therapy as a bridge between the child's thought processes and emotional experiences, thus fulfilling the role that conversation serves with adults in therapy. Play therapy is hypothesized to provide for the child an opportunity to learn about self, learning to face his world with increasing self-confidence, ordering the confusion and conflicts which brought him to play therapy, while also learning to relate to others and to himself in realistic, self-fulfilling ways. To date, however, these ideas have not been subjected to extensive empirical measurement.

In 1965, Lewis (37) described what he called "the intervention hypothesis." The underlying rationale of this hypothesis is that dealing with young people experiencing emotional difficulties will ultimately solve the mental health problems of our society. Effective intervention into emotional difficulties in children, he reasoned, should cause a noticeable reduction in the future incidence of emotional difficulties in these individuals as they mature. Apparently this goal has not as yet been realized. Outcome research has not shown conclusively that any form of child psychotherapy is effective in preventing later emotional difficulties in adults who have experienced child psychotherapy.

Six decades of child guidance do not seem to have reduced either the demand for mental health services to children, or the incidence of emotional
illness among adults . . . there seems to be no substitute for the long range, follow-up study as the procedure for investigating either therapy outcome or therapy process when the patients are children (10, p. 474).

Statement of the Problem

The problem with which this study was concerned was the long-term effects of play therapy on children experiencing school-related learning difficulties and emotional problems.

Purpose of the Study

The purpose of this study was to investigate and describe the long-term effects of play therapy on social contacts, self concept, school-related behavior patterns, level of academic functioning, attitude toward school, and family relations.

Research Questions

To carry out the purpose of this study, the following questions were explored:

1. What is the effect of the length of time following termination of play therapy on (a) social contact, (b) self-esteem, (c) school-related behavior patterns, (d) level of academic functioning, (e) attitude toward school, and (f) family relations?

2. How are the (a) social contacts, (b) self-esteem, (c) school-related behavior patterns, (d) levels of academic
functioning, (e) attitudes toward school, and (f) family relations of children who have experienced play therapy different from those of children who have been diagnosed as needing play therapy but not receiving it?

Definition of Terms

For the purposes of this study, the following definitions were used:

1. **Play therapy**, as practiced at a counseling center, is therapeutic play in a specially equipped play therapy room, for children usually between the ages of five and twelve.

Often, the child is provided with an opportunity to use the time period in the playroom as he chooses, with only a few broad limitations such as not harming himself or the therapist or destroying expensive or irreplaceable toys. At other times, depending on the philosophy of the therapist as well as the nature of the problem and verbal ability of the child, a more directive and interpretative approach might be employed. Joseph Solomon (46) might utilize such an approach, where the play media would simply serve as a structure to confront the child with his problem. In the understanding, caring, and permissive atmosphere of the play therapy situation, children "play out" their feelings much as adults "talk out" their problems. In play therapy, children can explore new ways of relating to themselves, to others, and to the immediate world. The attitudes and actions of the play therapist are easily predicted in the playroom, so
that the child knows what he can and cannot do. The basic approach to play therapy used at the center where this study was conducted emphasizes that the therapist be sensitive to what the child is feeling and expressing through his play and verbalizations, reflecting or interpreting these expressed emotional attitudes back to the child in such a way as to help the child more fully understand himself. As the child expresses both his negative and positive feelings and attitudes, he comes to view himself as neither completely good nor completely bad. When he is no longer preoccupied with the negative aspects of himself, he can invest more time and energy in positive psychological growth and maturity. Play therapy provides a means for the child to become more responsible for himself and more self-directed not only in the playroom but also at school, at home, and in his everyday life.

2. **Emotional expansiveness** is the score the individual received on the Bonney-Fessenden Sociograph (15). Emotional expansiveness is measured by the number of positive choices a student gives on a sociometric test. According to Bonney, emotional expansiveness "refers to the degree of social out-reaching, or of feelings of need for others, as shown by the number of choices given" (15). It is hypothesized that the choice of a large number of peers with whom the student would like to interact indicates that the student has
expectations that he is also worthy of being reciprocally chosen by a large number of others.

3. **Self-esteem** is the score the individual received on the Coopersmith **Self-Esteem Inventory** (Form B--ages nine to fifteen and Form C--ages fifteen and over) (19). Coopersmith specifies that

By self-esteem we refer to the evaluation which the individual makes and customarily maintains with regard to himself; it expresses an attitude of approval or disapproval and indicates the extent to which the individual believes himself to be capable, significant, successful, and worthy. In short, self-esteem is a personal judgement of worthiness that is expressed in the attitudes the individual holds toward himself. It is a subjective experience which the individual conveys to others by verbal reports and other overt expressive behavior (18, pp. 4-5).

4. **School-related behavior** is the score the individual received on the **Self-Esteem Behaviors** (19) rating form. Coopersmith states on the **Self-Esteem Behaviors** rating form, "On theoretical and empirical grounds, the behaviors were assumed to be an external manifestation of the person's prevailing self-appraisal" (18, p. 11). This instrument was completed by teachers on the basis of what they had observed of the subject's school-related behaviors and the perceptions they had of that student.

5. **Academic functioning** is the average of the school grades that the individual received for the semester most recently completed, compared with school grades received for the six weeks previous to the initial contact with the counseling center.
6. **Attitude toward school** is the score the individual received on the *Survey of Study Habits and Attitudes* (16). Brown and Holtzman state,

> It is an easily administered measure of study methods, motivation for studying, and certain attitudes toward scholastic activities which are important in the classroom. . . . The SSHA provides the student with a systematic, standardized way of indicating some of his feelings and practices regarding school work (16, p. 6).

7. **Home and family relations** is "a score obtained for each subscale of the *Family Environment Scale* by adding up the number of items on the scale which have been answered in the scored direction" (40, p. 9). Scores are obtained for each member of the family polled. The resulting scores measure perception of the identified value as perceived in the family by the parent and child.

Home and family relations, also a family incongruence score, is the differences in scores between family member pairs summed over the ten subscales of the *Family Environment Scale*. The resulting scores assess the extent to which pairs of family members agree or disagree about their family climate.

Some of the primary uses of the *Family Environment Scale* are to derive detailed descriptions of the social environments of the families and to compare parents' and children's perceptions (40). Home and family relations, then, is the parents' perceptions and children's perceptions of the
family environment, determined by comparison of the parents' and children's raw scores and discrepancy scores on the Family Environment Scale.

8. Playroom, as utilized at a counseling center, is a specially equipped room with toys intended to promote self-expression and self-exploratory behavior. Play equipment and materials utilized are Bobo punching toy; tempera paints in five colors; can of crayons; paper; colored chalk and chalkboard; play doll; doll house, open from the top with wooden furniture and set of family dolls to fit; small plastic animals; toy refrigerator and stove; pots and pans; ironing board and iron; assorted dolls, plastic baby bottle; doll bed; small plastic soldiers; gun and holster set; assorted hats; hand puppets; plastic ball and bat; log with real hammer and nails; Tinker Toys; toy telephone; and assorted trucks.

Background and Significance of the Study

Play therapy, in its various forms (8, 9, 14, 22, 41) appears to have gained wide acceptance as a procedure for dealing effectively with a variety of child related problems (5, 17, 32). Play therapy has aided in correction of poor reading performance (4, 5, 12, 13, 14, 48), correction of speech problems (21, 29, 31, 35, 45), decreased emotional and intellectual problems of the mentally retarded (3, 6,
and better social and emotional adjustment (1, 2, 7, 20, 42, 43, 44, 46).

The long-term effects of play therapy, however, have been exposed to limited research investigation. Dorfman draws the following conclusions from her review of play therapy research:

It is apparent from this summary of existing research that much remains to be done. One of the more pressing needs is for follow-up study of a large number of cases, at regular intervals. Instead of repeated follow-up studies of a relatively small number of cases, it might be more fruitful to restudy some cases after six months, others after one year, still others after two years, and so on (20, p. 273).

Eighteen years after the above statement was made by Dorfman, Ginott stated:

By definition, the aim of psychotherapy is to bring lasting personality improvement. Several studies have shown that play-therapy does produce desirable effects. However, it is unknown whether the effects are temporary or permanent. Follow-up studies are necessary in order to establish whether the benefits of therapy endure after the termination of treatment (27, p. 149).

A review of the literature related to play therapy from 1900 to the present revealed a total of only five studies which reported on the long-term effects of play therapy. The conclusions reached by Ginott in 1961 still appear to apply today:

On the basis of available research, it is impossible to know whether or not the beneficial outcomes of play-therapy are directly related to its practical procedures and theoretical rationales. . . . If psychotherapy is to achieve scientific
status, research minded practitioners must provide convincing proof of the worth of their methods (27, p. 154).

In order to provide more convincing proof of the worth of play therapy, more stringent research criteria apparently needs to be utilized. McNabb recommends that higher quality research "... in the field of play therapy would include defining behaviors and personality dimensionally specifically rather than globally; defining changes in behavior rather than in personality, and developing measures sensitive to specific behaviors" (39, p. 113). Authorities in the field appear to have determined some basic behavioral goals related to the psychological and emotional development of children in which play therapy seems to be helpful. The criteria includes social contacts with peers, self-concept, school behavior, school achievement, and relations with the family. Concerning the relationship of play therapy and social relations, Ginott (27) states that play therapy can be a means for providing a setting in which children discover and experiment with new and more satisfying ways of relating to peers. Through play therapy children learn societal standards and expectations and how to fulfill their needs in appropriate ways. According to Axline (8), the child comes to play therapy with a poor self-concept. The child entering therapy confines his search for higher self-concept to his inner world, where there is less struggle and more security, in effect turning his self-actualizing drive for
enhanced self-concept inward. During play therapy, this self-actualizing process is freed to be expressed outwardly, allowing for a convergence of outward behavior with self-concept which results in a more adaptive personality. In attempting to define this development of self-concept or self-esteem to which Axline refers, Coopersmith states,

the evaluation which the individual customarily maintains with regard to himself; it expresses an attitude of approval or disapproval, and indicates the extent to which the individual believes himself to be capable, significant, successful, and worthy. In short, self-esteem is a personal judgment of worthiness that is expressed in the attitude the individual holds toward himself (18, pp. 4-5).

Another major concern in play therapy is the need for improvement in school and family relations in the child's life. Rabinovitch (43) indicates that a large group of children ultimately end up in therapy due to their problems and difficulties associated with school. School-related failure and ensuing feelings of inferiority and inadequacy begin to affect the child both at school and at home, resulting in interpersonal pressures between the child and his parents and teachers which add further to his school failure and feelings of inadequacy. Thus, play therapists do apparently perceive some basic behavioral needs as being met in play therapy, and that play therapy is an acceptable mode of treatment (30).

The small number of studies related to long-range outcomes of play therapy, coupled with the conflicting and
contradictory results in those few studies, indicates a need for more data on the long range effects of play therapy. If the long-term impact of play therapy on these major concepts of child development identified by Ginott, Axline and Rabinovitch are to be adequately determined, additional follow-up studies such as the present study must be conducted. Whether the effects of play therapy are temporary or permanent has yet to be shown. Data related to the long-term effects of play therapy on behavioral constructs may help to standardize and quantify information on play therapy, should future play therapy researchers choose to investigate the same constructs.

Assumptions

When recommendation was made for play therapy by the evaluation team, an assumption was made that parental and family variables were responsible for the decision not to enroll children in play therapy. This group of subjects was designated evaluation only.

Limitations

This study was limited to children between the ages of thirteen and eighteen who were initially referred to a counseling center due to poor or inadequate adjustment to home, school, and society, who had been out of counseling at least one year, and who were currently attending school. Caution should be exercised in generalizing the results of
this study beyond this population. Also, recognized major limitations are the absence of pretest data controlling for history, maturation, and parental decisions influencing who did or did not receive play therapy. In addition, subjects were not compared on the basis of reason for referral, due to the fact that some children were referred for single reasons and others for multiple reasons.
CHAPTER BIBLIOGRAPHY


Opinions shared by several authorities in the field of play therapy suggest that play serves the purpose for children that speech serves for adults. Play is a means for expression of feelings, a way to explore interpersonal relations, and an avenue for developing insight into self. Through play children may be free, creative, and self-directive (1, 2, 6, 8, 10, 12, 13).

Ginott states, "Play therapy is the preferential treatment for many young children and should be used extensively in child guidance" (13, p. 16). Similar convictions from individuals holding widely varying philosophies and conducting play therapy in divergent ways have been expressed by Virginia Axline (2), J. C. Solomon (28), Melanie Klein (15), Anna Freud (11), D. M. Levy (18), and A. G. Woltman (30). However, there has been relatively little scientific investigation of play therapy as a viable counseling approach.

A wide variety of measurement criteria has been used to determine outcome effectiveness of play therapy. Also, characteristics and behaviors of children measured vary considerably from study to study, and results achieved are
contradictory and difficult to compare. Nevertheless, there do appear to be general categories within which therapy outcome studies naturally fall. The categories are outcome research in play therapy, play therapy follow-up studies, and child therapy follow-up studies not specifying treatment. Subsections of outcome research include (1) studies which have found play therapy helpful to children and (2) studies which reported subjective evidence that play therapy is helpful to children. Subsections of the play therapy follow-up studies include (1) studies based on researcher observation and (2) studies based on objective instrumentation.

Outcome Research in Play Therapy

Studies Which Have Found Play Therapy Helpful to Children

Seeman, Barry, and Ellinwood (26) investigated the effectiveness of play therapy in the treatment of aggression and withdrawal. The Tuddenham Reputation Test was administered to 150 children aged eight to nine years in an upper middle class school while their teachers completed the Radke-Yarrow Teacher Rating Scale. Using data from these instruments, the researchers were able to classify behavior into categories of high adjustment, aggression, and withdrawal. The sixteen children who rated lowest on composite adjustment scores of the two instruments were divided into two groups matched
for age, sex, and aggressive or withdrawn patterns of behavior as indicated by test results. Children in the experimental group attended weekly forty-five minute play therapy sessions for as long as the therapist felt they were needed. The average number of sessions attended was thirty-seven. Children were tested three times: before therapy, after seven months of treatment, and one year after the second testing. Results indicated that after therapy, children who were involved in a play therapy experience scored significantly higher on the test instruments than did their counterparts in the control group.

Levi and Ginott (16) compared the improvement rate of 314 children receiving play therapy with the remission rate of 300 children who went no further than the intake interview. Improvement was defined as the disappearance of presenting symptoms. A comparison between the improvement rate of the experimental group and the remission rate of the control group was considered to be a measure of the effectiveness of therapy. When parents of both experimental and control group children were contacted, parents reported 55 per cent of the children in play therapy to be improved and 45 per cent were unimproved at termination. Parents of untreated children contacted reported 20 per cent of their children improved.

In one of the few studies in play therapy which employed an adequately matched control group, Cox (8) investigated
the effects of play therapy on interpersonal relationships and individual adjustment of institutionalized children. Two groups of orphanage children, nine in each group, were matched individually for age, sex, residential placement, adjustment, and sociometric status. Criteria for evaluation of progress were Thematic Apperception Test scores and sociometric measures which were administered to both groups. Both groups were chosen so that they would be a representative sample from the orphanage population. The experimental group received ten weeks of play therapy, while the control group received none. Both groups were evaluated at the end of therapy and again fifteen weeks later. The findings were that the adjustment scores and peer ratings of about one-half of the children in the experimental group showed improvement with no significant improvement occurring within the control group.

Studies Which Reported Subjective Evidence that Play Therapy is Helpful to Children

Quattlebaum (23) attempted to determine if the self-concept of maladjusted fifth grade students could be improved through the use of play therapy or through individual counseling. Fifth grade teachers identified a group of maladjusted fifth grade pupils who were then randomly assigned to a no-treatment group, an individual counseling group, and a play therapy group. Weekly individual sessions were conducted by one counselor, and were either non-
directive counseling or non-directive play therapy, depending on which group the individual was in. Before initiation of treatment and at the conclusion of treatment the Rorschach Thematic Apperception Test and the Draw-A-Person Test were administered. The results indicated that even though overall statistically significant differences were not found between groups, individual children in both the play therapy and individual counseling groups did improve.

The effects of play therapy on interpersonal relationship, behavior patterns, use of intellectual capacities, and adjustment were examined by Herd (14). The twenty-seven subjects were six to eleven years old, of at least average intelligence, who were identified by their schools as having behavior problems. Diagnostic testing at a counseling clinic confirmed the need for counseling. The children were randomly placed in one of three groups: experimental, control, and placebo. The experimental group participated in ten weekly fifty-minute individual play therapy sessions, while the placebo group participated in fifty minutes of supervised play each week. The control group participated only in pre- and posttesting.

Pre- and posttesting included a personality test, a sociometric rating by the child's peers, a behavioral rating by the child's teacher, a maturity rating by the child's mother, and collection of the child's school grades. The
results indicated a significant change only on the variable of school grades. Little statistical evidence was found to support the hypothesis that positive behavior changes occur as a result of play therapy. However, letters from parents and teachers of experimental group subjects indicated positive behavior change. No other correspondence occurred.

A study by Pelham (20) compared the effectiveness of group and individual play therapy with kindergarten children who had been identified by their teachers as having socially immature classroom behavior. The study involved seventeen children in the experimental group. Nine of the children received group therapy, and eight received individual therapy. The control group consisted of eighteen children who were diagnosed as needing play therapy but did not receive it. Criteria for testing the hypotheses included the Missouri Children's Picture Series, the Children's Self-Social Constructs Tests, and the Behavior Problem Checklist. Each child in the experimental group received from six to eight forty-five-minute therapy sessions, all of which were conducted by the investigator. Few statistically significant differences in social maturity were found between the experimental and control groups. The experimental group developed more complex self-concepts, but decreased in maturity as measured by the Missouri Children's Picture Series. In addition children in the experimental group were seen by their
teachers as having improved significantly in classroom behavior. No differences were found between children who had received group therapy and those who had received individual play therapy. No significant changes were noted in the control group.

**Play Therapy Follow-Up Studies**

*Studies Based on Researchers' Observations*

The follow-up studies attempted thus far have yielded limited and contradictory data. In most cases, information was obtained through subjective information from one source rather than from standardized instruments which might be cross-checked and compared. In a descriptive study, Conn (7) discusses progress made during his play contact with a thirteen-year-old boy diagnosed as having castration fears. Based on personal observation, he indicated success in the therapy process at the conclusion of therapy and also in a follow-up conducted fifteen years later. However, Conn stated that the subject at the time of the follow-up was not married and was living with his parents, a point which the author did not explore except in passing reference, and one which may or may not represent pathology in the subject, relating to the original problem.

Axline (4), in a one-year follow-up study, investigated twenty-two of thirty-two original play therapy cases whom she viewed as successful. The therapist met the child in
an interview room and asked the question, "Do you remember me?" No other format was used. Those who could not be contacted personally were reached by mail. Axline concluded from her interview that the twenty-two children were still successfully adjusted a year after termination of treatment. However, in reviewing this study, the absence of pre-post assessment and a comparison control group, and failure to identify the specific behaviors modified by play therapy make it impossible to assess what changes occurred, and to what extent.

A five-year follow-up by Axline (3), using a format similar to his previously reported follow-up study, was conducted by interviewing play therapy subjects who had been experiencing reading difficulties. Since all of the original subjects were in the same classroom, the original therapist was introduced by the subjects' current teacher, and the children were asked if they recognized the visitor. No prearranged questioning structure was utilized. Of the group of twenty-two children interviewed, five were honor-roll students with straight A records, fifteen had attained reading skills adequate for their grade placement, and the remaining two were still experiencing significant reading problems. However, since no parablel data are available from a control group, and no attempt was made to indicate origin of the children's academic problems, the results of this play therapy study are inconclusive.
Studies Based on Objective Instrumentation

In one of the more pointed attempts at follow-up play therapy investigation, Pumfrey and Elliott (22) challenged the claim by Bills (5) that play therapy improved the reading attainment of socially maladjusted children with reading difficulties. The subjects in this study were twenty-eight boys, ranging in age from seven to nine, who were diagnosed as being intellectually dull normal, socially maladjusted, students with reading problems. Sixteen of the original twenty-eight subjects were randomly selected and placed in either the control or experimental group. The authors report no significant differences in mean scores between the experimental and control groups on the initial measures. The experimental group received nine weekly one-hour sessions of play therapy. The control group remained in their classes and neither the experimental nor the control groups received special help with reading. Post-testing and one-year follow-up testing were conducted.

The assessment immediately following treatment revealed that the more intelligent and emotionally adjusted children in the experimental group tended to improve in social adjustment, with apparent regression later. Other findings related to reading scores on the posttest and follow-up indicated no significant improvement in reading performance in either the experimental or control groups. This, the authors
conclude, is in direct contradiction with Bills (5), who found in his study that play therapy was successful in improving reading in socially maladjusted children with reading difficulties. They explain the discrepant results as follows: "His 'retarded' readers all had reading attainments commensurate with their chronological age, i.e., they were of above average intelligence, and this could account for the discrepancy between our results and his" (22, p. 160).

In their analysis of the results of this study, Pumfrey and Elliott concluded the long-term effects of play therapy are not lasting, due to

... a rather narrow range of differential treatments ... the approaches commonly used include non-evaluative reflection of the child's emotions, and an emphasis on the process of self-exploration and evaluation as the main sources of personality reorganization. ... In such a situation where treatment is relatively well-defined, it would seem to be important to insure that diagnostic procedures are used which will select those children most capable of benefiting from the treatment (22, p. 160).

On the basis of the limited number of sessions held in this study, it is difficult to determine if remaining in therapy would have produced more long-term results.

Child Therapy Follow-Up Studies
Not Specifying Treatment

Follow-up investigations have been conducted in which the clients at the time of treatment were play therapy age, although the authors do not specify the type of therapy
utilized. An example is the study conducted by Cunningham, Westerman, and Fischnoff (9), of children from a child guidance clinic five years after the final therapy contact. At the initiation of the study, all records were reviewed and a diagnostic label according to the Stanford Nomenclature of Disease was assigned each case. Four hundred twenty children in a wide range of diagnostic categories were then evaluated as to their progress at termination, based on therapist reports of client in session behavior. Standings at the close of therapy were ordered as improvement, little or no improvement, and regression of behavior. At the initiation of follow-up, rankings were: 59.7 per cent showed improvement, 36 per cent appeared to have little or no improvement, while less than 5 per cent were viewed as worse. Criteria for evaluation of the child five years later were based on an interview with the mother of the child. Information obtained concerned the subject's current adjustment as seen by the mother, how the child was getting along at home and at school, and whether the symptoms for which the child was originally referred remained, or new ones had developed. The results of the follow-up interview indicated that 63 per cent of the children were making satisfactory adjustment, 22 per cent were viewed as having partially satisfactory adjustment, with 14 per cent classified as being unsatisfactorily adjusted.
As reported by most of the mothers, the child's improvement was more frequently related to clinic treatment than maturation. Improvement sustained at the time the case was closed, as indicated by the therapist, was not always sustained five years later, and the current cases unimproved at the time of closing are currently getting along adequately. This argues against attributing the current adjustment exclusively to therapy. However, 60 per cent of the former patients are symptom-free and this percentage might well have been increased had treatment been more successful with the children showing education disabilities (9, p. 610).

This study involved the largest sample of subjects studied. Though the sample appears most impressive, difficulty is encountered in feeling confident of the results of the study, since no information is given as to type of treatment and success or failure of children in that type of therapy. In addition, ratings of status at initiation of the follow-up were based on therapist observations, while those ratings established at the conclusion of the study resulted from parent observations. The assumption appears to be, then, that the child's therapy behavior is consistent with his at home behavior, a hypothesis which apparently needs to be verified from several objective observers' viewing the child's behavior in both environments.

In another investigation in which the study did not specify treatment, Shirley, Baum, and Polsky (27) surveyed eighty-five child guidance clients, six to twelve years after termination of treatment. As in the study by Cunningham and others, the Shirley study utilized similar ratings of successful, improved, and unimproved, in labeling case
records. In the initial investigation of subject records preceding follow-up, thirty-five children were identified as successfully treated. At the conclusion of the follow-up 60 per cent were found to be adjusted, 23 per cent displayed some problems, and 17 per cent were labeled as maladjusted. When considering the fifty children characterized as successfully treated at the initiation of the investigation, 56 per cent remained unimproved, 20 per cent had improved, and 16 per cent were well adjusted. Thus, when treatment was successful, the chances were much better that the client would be well adjusted years later than when treatment was unsuccessful. However, in the analysis of their findings, the investigators conclude,

Of the children whose cases had been closed five years or longer, exactly half designated as unimproved by treatment had made progress toward adjustment during the five-year interval; and almost the same proportion of those who had been called successful had regressed. Time, it seems, benefits no more and no less than it deprives (27, p. 40).

The researchers also note from their findings that "as to type of treatment for the child, psychotherapy did not yield results that were more permanent than those of indirect treatment, but it seemed to have more latent effects" (27, p. 46). Thus, the issue of time and maturation or treatment as the more significant determiner of behavior appears to still be a mystery. It would also seem that since a similar structure to that of the Cunningham study
was utilized, the same questions concerning data sources may
be raised. Without objective observation of both the clinical
and home settings, it is difficult to compare and contrast
the ratings given in each.

Rexford, Schleifer, and Van Amerongen (24) conducted
a follow-up study of fifty-seven children who had been
referred to a child guidance clinic to alter anti-social
behavior patterns. Nine of the children were seen only for
diagnostic purposes and as such were treated as a control
group to determine the effectiveness of the treatment among
those who had undergone therapy. The follow-up which for
some in the treatment group came as late as seven years
following therapy, and for others as recently as two years after
therapy, indicated that anti-social behavior was curbed in
thirty-two of the forty-eight cases contacted. However, many
of those children were found to be below normal appropriate
levels of functioning in social relationships and intellectual
capacity in school, and demonstrated limited interest in
constructive recreational activities.

Of the sixteen considered unimproved, none were currently
engaged in delinquent activity. Two of those engaged in
serious delinquent acts had from the termination of therapy
to the follow-up regressed from the improved to the
unimproved group. Apparently then, therapy was helpful
in many cases in curbing overt acting-out of emotional disturb-
ance, but did not effectively eliminate the child's problems.

In a later study by Witmer (29), a comparison was made between a group of fifty cases matched on certain variables to cases in the earlier Shirley and others study, from the same child guidance clinic. The matched variables were age at the time of referral, intelligence, sex, health rating, economic status, and type of referral source. As with the Shirley and others investigation, type of treatment was not specified. These fifty comparison cases comprised a diagnostic group seen eight to thirteen years previously, and were not subjected to treatment beyond the initial evaluation. Prior to the follow-up, records were reviewed to determine the type and extent of the problem presented in the initial interview. During the follow-up study, an outline similar to that in the Shirley study was followed in interviewing the parents. This information was then verified against information supplied by social agencies having knowledge concerning the present functioning of the client.

Follow-up of the diagnostic group showed 48 per cent with successful adjustment, 30 per cent improved but still somewhat maladjusted, and 22 per cent still unimproved. In comparing the Witmer and Shirley studies, the results indicate little difference between the later adjustment of successfully treated children and untreated children. Apparently, many of the maladjusted children outgrew their
problems, whether they were treated or not. In exploring their conclusions, the authors softened the implications of the results by adding the perspective,

This conclusion is subject to some modification, however, for it will be recalled that the diagnostic cases revealed somewhat more favorable original situations than did those in the successfully treated group . . . for although the figures suggest that children tend to outgrow their problems, they also show that this takes time and that there are many years in which maladjusted children who are not treated or are not able to respond to treatment remain in their unhappy state (29, p. 85).

Lehrman (17) conducted an analysis and follow-up of cases covering a one-year period at a child guidance clinic. Fifty-three of the 196 cases were of play therapy age. However, treatment received is not specific. As with previous investigations explored in this section, this study reviewed the cases of all children and used similar ratings to determine each child's status at termination of therapy. Ratings utilized were improved, partially improved, and unimproved. Of these fifty-three children, 34 per cent were viewed as improved, 21 per cent labeled partially improved, and 45 per cent were determined to be unimproved at the close of treatment. In comparing status at the close of treatment and a year later, an increase in successful adjustment and a decrease in failures was found. In a critique of these findings, Ginott notes, "How much of this improvement can be attributed to therapy, and how much to maturation or
to the effects of time, cannot be determined, because no parallel data are given for a control group" (17, p. 150).

In a separate part of the Lehrman study, the treated group was then compared for community adjustment, as opposed to an initial investigation of personal adjustment. The control group was composed of children who withdrew from treatment after an initial contact. Of the fifty-three children treated, 43 per cent were judged successful, 23 per cent partially successful, and 34 per cent unsuccessful in their community adjustment. Of the twenty-six children in the control group, 19 per cent were successful, 50 per cent partially successful, and 31 per cent unsuccessful in their community adjustment. These results reveal more complete successes in the treated group, a greater number of subjects experiencing success in the untreated group, and an equal distribution of failures in both groups.

Why the investigators chose a comparison group for one part of the investigation and not the other is unexplained. Due to the lack of controls in investigating personal adjustment at follow-up, Lehrman's results are difficult to view with confidence. When the two categories of successful adjustment and partial adjustment are combined as one category and unsuccessful adjustment as another, it would appear that the conclusions of this study are very similar to those of studies by Shirley and Witmer. Little difference exists between the treated children and untreated children
In one of the longest follow-up studies of play therapy age children (19), shy, withdrawn children seen sixteen to twenty-seven years previously were given interviews of one and one-half hour to two and one-half hours to determine their present emotional status. At the initiation of the study, records were searched by a social worker to select a group of children who had had a comprehensive social history taken, one or more psychological examinations including, a standard intelligence test, and a psychiatric interview. Children with a Stanford-Binet IQ of less than eighty were not included. All of those with unusual diagnoses were eliminated from the subject pool, as well as any subject with hysterical conditions which might contribute to emotionality of the subjects.

Three classification categories were then utilized to determine the final subject pool. They were external reactors--children identified as acting out their emotional difficulties, internal reactors--children showing predominantly shy, withdrawn behavior, and mixed reactors--those children having characteristics of both of the above groups. Only shy, withdrawn children, or internal reactors were included in this study. A total of thirty-four subjects, twenty-four boys and ten girls, were finally selected.

Results of the follow-up interviews were evaluated through four criteria. These included the person's own
concept of his adjustment; relationships of the subject with his immediate family or others close to him; superficial relationships or those outside his intimate relations; and the stability of employment as well as the satisfaction experienced in his present position. Based on these criteria, the individual was categorized according to the following definitions:

Satisfactory adjustment--those who are getting along adequately or better; those who are getting reasonable enjoyment, comfort, and fun out of living; Marginally adjusted--those who are not quite adequately adjusted but still not sick; those who are not fulfilling their potential, but still not needing treatment in their opinion or in ours; those who are just getting along, but without much positive enjoyment or fun out of living; Sick--those who are hospitalized or who have been hospitalized for mental or emotional disturbances; those who consider themselves sick enough to ask for help from some source or those who we think need help (19, p. 744).

On the basis of separate evaluations of excerpts of the interviews, the following results were obtained: twenty-two, or 64.7 per cent, of the subjects were classified as getting along well; eleven, or 33.3 per cent, were viewed as marginally adjusted; while one subject was diagnosed as sick (19).

In evaluating their study, the authors note,

There is a rather striking correlation between better adjustment and more outgoing, aggressive marital partners. In this respect they seem to have compensated for their shyness rather than to have attempted changing it.

There has been much emphasis in mental health education for teachers and others on bringing out the shy, withdrawn child. It is just possible that we might be somewhat overconcerned about these personality characteristics. The core histories suggest that
most of these people have been allowed to develop in their own way and in their own pace with generally satisfactory results (19, p. 753).

Multiple factors appear to be operating in the present adjustment of the individuals investigated. Although some of these were examined, no attempt was made to isolate or correlate the extent to which factors or interplay of factors influenced the present behavior patterns of these people. Such an inquiry may prove helpful to verify or negate long-term behavior patterns contributing to either adaptive or maladaptive behavior.

Summary

The literature reveals conflicting results and unclear investigation of this topic. Some studies indicate child psychotherapy produced long-term change (5, 8, 21), while others conclude that treatment was ineffectual (20, 29). In reviewing their findings, one group of researchers concluded,

This argues against attributing the current adjustment exclusively to therapy. However, 60 per cent of the former patients are symptom free and this percentage might well have been increased had treatment been more successful with the children showing education disabilities (9, p. 610).

Another investigation noted, "As to type of treatment for the child, psychotherapy did not tend to yield results that were more permanent than those of indirect treatment, but it seemed to have more latent effects" (27, p. 46).
This comment reflects the type of inconsistent statements found in several of the follow-up studies. In a review of studies involving child psychotherapy in general, Robins states,

The studies mentioned have varied greatly in the size of their samples of children to be followed, in the proportion of the original sample recovered at follow-up, and in the length of the follow-up interval . . . these variations make it difficult to present a coherent account of what we now know about the influence of childhood behavior and environment on adult life (25, p. 11).

The reported follow-up studies on play therapy have yielded inconsistent results, possibly due to the fact that data collection was based on subjective interviews of either the subjects alone or the subjects and their families. Limited objective instrumentation was utilized, and attempts have not been made to investigate similar behavioral concepts among studies, and how these concepts affect the emotional adjustment of children. It would appear that a general uncertainty concerning the long-term effects of play therapy and child psychotherapy on behavior change still remains.

The studies that have been undertaken on play therapy are difficult to compare, due to the diverse and oftentimes unrelated criteria utilized to evaluate play therapy intervention. It does not appear that any long-term play therapy study has been conducted which attempts to focus on a variety of specific behavioral criteria. The fact that there is
a need in play therapy for some type of consistent research approach is shown by a statement in a study by Herd:

There is at present an increasing interest in play therapy in the treatment of children. Its effectiveness, however, has been explained primarily on the basis of philosophical constructs. . . studies involving small samples report little long-term therapy and few follow-up studies. This has limited to a serious degree generalizations which can be drawn from the situations tested to other situations (14, pp. 8-9).
CHAPTER BIBLIOGRAPHY


CHAPTER III

METHODS AND PROCEDURES

This chapter presents in detail (1) the procedures involved in subject selection, (2) the instruments used, (3) the procedures involved in collecting the data, and (4) the statistical procedures employed in analyzing the data.

The Population

Principally, the counseling center serves those children located in the greater North Texas area. It is university-affiliated and is staffed by university faculty members and graduate students completing advanced degrees in reading, counseling, and speech.

School districts served cover a wide range of both settings and population. Students are referred to the counseling center from small rural school districts with enrollments of 800 to 1,500 and from moderately large urban districts with enrollments of 8,000 to 10,000. In general, the children enrolled in the counseling center are between the ages of five and fifteen and have average or above average intelligence, as measured by standardized intelligence tests. Children are typically referred for a combination of the following behavioral and performance characteristics.
1. Low reading ability--at least one year below grade level (grades 1-4), at least two years below (grades 5-12);  
2. Very poor scholastic performance in all areas;  
3. Underachieving;  
4. Chronic disturbance of other persons' achievement;  
5. Withdrawn;  
6. Very low self-esteem--poor self confidence;  
7. Past history of poor school adjustment;  
8. General lack of interest in school work;  
9. Poor attendance in school;  
10. Poor communication due to speech impairment;  
11. Poor communication due to hearing impairment;  
12. Hyperactivity;  
13. Easily distracted;  
14. Poor motor coordination;  
15. Impulsivity;  
16. Short attention span;  
17. Follows no logical pattern in behavior;  
18. Poor "stick-to-it-iveness";  
19. Wanders aimlessly about room apparently concerned with everyone's business;  
20. Seldom considers consequences of behavior;  
21. Rapid changes in mood and temperament;  
22. Performs inconsistently and with marked variability in the various school subjects;  
23. Excessive day dreaming;  
24. Excessive bullying, fighting and similar aggressive behavior;  
25. Recurring instances of theft;  
26. Cries easily and often;  
27. Malingering; and  

The majority of children referred to the counseling center receive diagnostic evaluation in the areas of reading, speech and counseling. The counseling evaluation procedure involves separated, structured, in-depth interviews with the parent and child. As would be expected over a ten-year period, the utilization of some diagnostic instruments was discontinued and more current instruments were incorporated into the diagnostic procedure. With the exception of the Developmental Test of Visual-Motor Integration, which has been used since
1971, the following instruments were utilized in an original or revised form during the ten-year span investigated in this study: the Wechsler Intelligence Scale for Children (WISC-R), Bender-Gestalt Visual-Motor Test, Developmental Test of Visual-Motor Integration, Sentence Completion Test, Informal Free Expression, House-Tree-Person, and School Apperception Method.

In addition to the above, three questionnaire forms are used by the counseling center to gather information on the child's home and school background. These forms consist of a parent information form for recording developmental and physical information and the parents' description of the problem; a teacher's observation form assessing the child's social, emotional, and academic adjustment at school; and a school assessment and referral form for recording the results of school tests in academic and physical areas, with a statement of the problem as perceived by school personnel. Following completion of diagnostic testing, a meeting of the reading, speech, and counseling staffs is held to discuss the strengths and weaknesses of the individual in the areas examined. Based on the three evaluations and the outcome of the staffing, children are enrolled in those therapies which best meet their developmental needs. In all cases of referral, the parents are given a complete appraisal of the child's strengths and weaknesses in reading, speech and social-emotional development. Remediation then proceeds
if the parent agrees with the evaluation finding, and if the parent can provide transportation for the child.

**Play Therapy Environment**

Play therapy sessions occurred in a fully equipped playroom at the counseling center. Play therapy subjects averaged twenty-four sessions per person, with sessions occurring once a week for forty-five to fifty minutes per session. Counselors involved with the subjects were doctoral students enrolled in a supervised counseling internship, or were paid graduate assistants.

**Description of the Instruments**

The purpose of this study was to investigate the long-term effects of play therapy on social contacts, self-esteem, school-related behavior patterns, level of academic functioning, attitude toward school, and family relations. A major concern, therefore, was the selection of instruments which would not only most accurately assess these behaviors but would also accommodate the concerns of time and ease of administration.

**The Bonney-Fessenden Sociograph (1)**

In conjunction with the above format, the Bonney-Fessenden Sociograph (1) was chosen for the collection of sociometric data in this study. Since many of the children referred for play therapy have limited peer interaction, it
seemed appropriate to measure the long-term effect of play therapy on the students' social outreaching and need for others. This instrument serves the purpose of simplifying the collection of sociometric data while assessing the individual's need for others (2). No other sociograph surveyed allowed for the possibility of assessing social awareness and social need without large numbers of other individuals also being involved in the assessment. All children was asked to indicate the names of children with whom they would like to work. They were then asked to name those children with whom they would choose to have fun. This procedure was used for all subjects, and the results served as a means of comparing subjects, and their amount of need for others.

The Coopersmith Self-Esteem Inventory (SEI) (4)
(Form B and C)

Measurements of self-esteem are widely used in attempts to show success or failure of a particular counseling approach. If play therapy is successful over an extended period of time, then play therapy subjects should be experiencing normal or average self-esteem.

The Self-Esteem Inventory is easily administered, and is easily readable (age nine to adult). In its original long form (Form A), the inventory is a fifty-eight-item self-concept scale designed to measure the individual's attitude toward himself, and is inclusive of the range from
age nine to adult. In standardizing the original form, the
test-retest reliability correlation from one sample of thirty
fifth-grade children over a three-year interval was .70.
Coopersmith (4) reports a convergent validity between Form
A of the SEI and the Soares Scales to be .63. He also found
convergent validities of .60 between Form A of the SEI and
a derived picture test, and .45 between Form A of the SEI
and the CPI Self-Acceptance Scale. On a measure of dis-
criminant validity, Coopersmith reports correlations of
.75 and .45 with the Edwards and the Marlowe-Crowne Social
Desirability Scales respectively. All coefficients were
reported as significant.

To cut down on administration time of the SEI, Form B
was developed by Coopersmith (4) in 1974. This form con-
sists of twenty-five items selected on the basis of a factor
analysis of the long form. No validity or reliability data
for Form B could be located in the literature, however.
Coopersmith (4) states that a correlation of .86 exists be-
tween the total scores on Forms A and B, indicating apparent-
ly that the reliability and validity of the original scale
also apply to Form B. Due to differences in adult and
child language development, Form C was developed by altering
the language of Form B. Form C, like Form B, consists of
twenty-five items. As with Form B, for the same reasons
as already stated, no validity or reliability data is
available on Form C. Coopersmith (4) does, however, report a correlation of .80 between the scores on Forms A and C. Although the language differs between forms, and questions are reordered, all three forms are identical in scoring procedure and answers. Scores on the SEI Forms B and C are multiplied by four to obtain a possible score of 100, which would be the total score in Form A. Coopersmith indicates that Forms B and C, over repeated samples including different ethnic and socio-economic groups, have yielded mean scores between seventy and eighty, which is the middle range of self-esteem on the Coopersmith scales, with scores below seventy and above eighty indicating low and high self-esteem, respectively.

The Self-Esteem Behaviors (SEB) (4) Rating Form

Outside observations give many indications as to whether or not the approach used in therapy is benefiting the subject. Teachers, therefore, can be a valuable source of information, as they have daily interaction over extended periods of time with children referred for play therapy.

The Self-Esteem Behaviors rating form was chosen because it is a shortened version of an earlier school-related behavior rating scale (4), and requires minimal time from teachers. The behaviors to be rated on the
original Behavior Rating Form (BRF) were identified through observation of child behavior both in and out of the classroom, as well as through interviews with teachers, principals, and clinical psychologists. Cross-rater reliability on the BRF, using teachers and principals as raters, was .73, on seventy-one subjects (4). The teacher ratings yielded a mean score of 68.4 and a standard deviation of 15.4. The mean score for the boys was 65.0, with a standard deviation of 16.2; and the mean score for the girls was 71.3, with a standard deviation of 13.6, which is significantly higher with less variability, than that of the boys. The test-retest reliability was .96 for one teacher after an eight-week interval.

In his revision of the BRF, Coopersmith states that many of the original questions did not consistently differentiate on self-esteem behaviors. The five questions determined through the item analysis of the BRF that did maximally differentiate self-esteem behaviors are reactions to new situations, reactions to failure, excitability, confidence and assurance and overall assessment of esteem (4).

Each of these items now included in the SEB is rated on a five-point Likert rating scale, from "always" to "Never." The high self-esteem rating of five has been varied in position from right to left, to minimize superficial
responses. For this study the word "child" was changed to "student," and part of question three concerning a young child's reaction to a stranger was deleted to accomodate the grade levels seven to twelve being surveyed. For each subject, the total scores were multiplied by four, as recommended by Coopersmith (4), in order to derive a score equivalent to the BRF. According to Coopersmith, scores above eighty-three and below fifty-three indicate good adjustment and maladaptive adjustment, respectively, while scores falling between fifty-three and eighty-three indicate adequate school adjustment. The BRF examines reactions to new situations, reactions to failure, excitability, confidence and assurance, and overall self-esteem.

School Grades

School grades in this study provided a consistent measure over time. School grades give a measure, before play therapy contact and at follow-up, of how children are functioning in the school setting from which most referrals of young children occur.

Grades in English, mathematics, social studies, and science were used to assess the child's level of academic functioning in school because these subjects are required and therefore serve as a consistent comparison of academic progress. For this study, school assessments were converted to grade points, as follows: A to B = 3, B- to C- = 2, and
D+ and below = 1. Children who were first, second, and third graders at the time of initial contact with the counseling center had their school grades of "excellent," "satisfactory," and "needs improvement" converted to excellent = 3, satisfactory = 2, and needs improvement = 1, in order to compare them with letter grades they received later, and with those initially received by older students.

Since most of the referrals to the counseling center involve school difficulties, it would seem that successful play therapy experiences would help the child develop acceptable attitudes towards study in the school environment.

In examining the variety and range of attitude toward school instruments available, the Survey of Study Habits and Attitudes appears superior. It seems to be well suited for uncovering attitudinal and motivational school related difficulties (2). The Survey of Study Habits and Attitudes test appears to be well grounded, easy to understand, and an excellent source of study habits and study attitude information that can be very useful to the student and professionals involved with the student (2). Specifically, this instrument is a 100-item survey comprised of four basic scales: Delay Avoidance, Work Methods, Teacher Approval,
and Education Acceptance. Two subtotals may be derived from the four scales by combining Delay Avoidance and Work Methods, for a Study Habits Score, and Teacher Approval and Education Acceptance for a Study Attitude score. A total score measuring Study Orientation results from combining the two subscales Study Habits and Study Attitude.

Validation of the SSHA was carried out at two levels. First, the test was administered to 3,731 students in grades seven through twelve in ten school systems in central Texas, in which the authors report significant correlations between grade-point average and the total SSHA score ranging between .31 and .85, with a mean correlation of .55. A year later the SSHA was administered to subjects at the junior and senior high level in six states, where significant correlations of .46 to .55 were reported between grade-point average and total SSHA scores.

To determine reliability, the SSHA was administered on two separate occasions to 237 ninth graders, with a four-week interval between administrations. The test-retest reliability for the total score was .95.

High versus low scores on the SSHA were determined by consulting the appropriate percentile norms table in the scoring manual of the SSHA, in which raw scores may be directly converted to percentile ranks. Brown and Holtzman (4) suggest that scores above the fiftieth percentile are
indicative of appropriate school adjustment, while scores below the fiftieth percentile indicate poor or maladaptive school adjustment.

The Family Environment Scale (FES) (Form S) (6)

None of the long-term follow-up investigations attempted to gather family data based on an objective standardized instrument. Thus, an instrument was selected which measures family attitudes and values.

The FES has been utilized to assess differences between counseled and non-counseled families. Significant differences were found indicating more conflict, less cohesion and less expressiveness in counseled than non-counseled families. This instrument appears well suited to assess any differences between play-therapy and evaluation-only families (7). The FES is a forty-item instrument measuring three different family dimensions encompassing ten subscales. The first three sub-scales, Cohesion, Expressiveness, and Conflict, focus on interpersonal relations among family members, assessing the degree to which family members feel they belong to and are proud of their family, and the extent to which the family member perceives that there is open communication or conflict within the family.

The second group of subscales, Independence, Achievement Orientation, Intellectual Cultural Orientation, and
Moral-Religious Emphasis, represents the directions of personal growth perceived in the family by its members. Specifically, they measure family member perception of the emphasis on family member autonomy, emphasis on academic and competitive concerns, variety of intellectual and cultural activities engaged in by the family, and emphasis on ethical and religious issues and values.

The final two subscales, Organization and Control, represent the dimension of basic organizational structure of the family. These subscales are designed to gather information concerning the importance of family rules and responsibilities and the extent to which family members dictate to or direct one another (6).

To standardize the long form (Form R) of the FES, forty-one three-member families, fifty-six four-member families, fifty-nine five-member families, forty-three six-member families, and thirty-two families of seven members or more, from lower, middle, and upper socioeconomic strata, were polled. Subtest internal consistency ranged from .79, on Moral Religious Emphasis, to .64, on Independence. The test-retest reliability, with an eight-week interval between testings yielded a high of .86 for Cohesion and a low of .68 for Independence, which the author reports as acceptable. The author indicates average subscale intercorrelations of .20, revealing that the subscales measure distinct though somewhat related aspects of family social environments (6).
The first forty items on the regular ninety-item Form R are the short form items for each subscale instead of nine in Form R. The purpose in developing Form S of the FES was to allow rapid assessment.

Two scores may be obtained on the FES. The subscale score is obtained by adding up the number of items on the subscale which have been answered in the scored direction. An average score is then calculated for each subject and parent, and these scores can then be compared with the subscale scores of the normative sample. This score indicates parents' and children's perceptions of their families. The second score, the incongruence score, is the difference between family member pairs for each of the ten subscale scores of the FES. These differences are summed over the ten subscales, with a resulting score which assesses the extent to which the pair of family members disagree about their family environment (6). Normative mean differences and standard deviations are supplied for each subtest of Form S (6). The FES was administered to mothers because they appeared to have sufficient time available for participation in the study.

Collection of the Data

Data for this investigation were gathered and plans executed according to the following sequence:
1. Every folder in the record file at the counseling center was examined in order to compile a list of possible subjects.

2. From the pool, four groups were constructed. One group (Group I) was comprised of those children who were evaluated as needing therapy, were included in at least ten play therapy sessions and had been out of play therapy for a minimum of one year and a maximum of six years. A second group (Group II) was comprised of those children who were evaluated as needing play therapy, were included in at least ten play therapy sessions, and had been out of play therapy for a minimum of six years and a maximum of ten years. A third group (Group III) was comprised of those children who were evaluated a minimum of one year and a maximum of six years previously, and were recommended for play therapy but did not participate. A fourth group (Group IV) was comprised of those children who were evaluated a minimum of six years and a maximum of ten years previously, and were recommended for play therapy but did not participate. Any potential subject enrolled in speech or reading therapy was excluded.

3. Subjects were contacted by consulting local and area telephone directories, last known school attended, area post offices, and the area County Electrical Cooperative.

4. Letters with stamped self-addressed return envelopes asking parents to supply their new address and telephone
numbers were sent to the last known address of families still not located. (See Appendix A.)

5. Home visits were made in which an initial parent interview was conducted, a brief explanation of the study (see Appendix B) was given, and written permission (see Appendix C) for the child to participate was obtained.

6. Test instruments for the parents were then administered.

7. In a separate home visit, test instruments were then administered to the subjects themselves.

8. Following the completion of all home visits, school districts in which subjects were currently enrolled were contacted and supplied with a brief description of the study, including the purpose and procedures for gathering school related behaviors. (See Appendix D.)

9. Signed parent permission forms were supplied to school administrators and permission to gather data from teachers was requested.

10. Data from teachers and school grades were collected.

11. Data was then compiled and submitted to the North Texas State University Computing Center for analysis.

Subjects

An original pool of eighty-two subjects was compiled from the record files at the counseling center. Through the process of attempting to contact these eighty-two subjects
and their families, forty-one families could not be located, and eleven families declined to be involved in the study. No attempt was made during the collection of the data to balance the groups either numerically or through common characteristics; the intent instead was to utilize whoever would agree to participate from the original pool. The result was a sample of thirty individuals, twenty-four boys and six girls, currently between the ages of thirteen and eighteen. Groups I, III, and IV contained seven subjects each, while Group II contained nine subjects. Groups I and IV contained six boys and one girl each, while Group II contained seven boys and two girls and Group III contained five boys and two girls.

In order to show the extent of characteristic similarities and differences between groups, Table I has the ranges and means for age, intelligence scores, and academic grades in all comparison groups.

**TABLE I**

**RANGES AND MEANS OF AGE, I.Q., AND ACADEMIC GRADES IN GROUPS I, II, III, AND IV**

<table>
<thead>
<tr>
<th>Group</th>
<th>Age Range</th>
<th>Mean Ages</th>
<th>I.Q. Range</th>
<th>I.Q. Means</th>
<th>Academic Grade Range</th>
<th>Mean Academic Grades</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group I</td>
<td>13.9-16.3</td>
<td>14.8</td>
<td>97-140</td>
<td>110</td>
<td>1.00-3.00</td>
<td>1.71</td>
</tr>
<tr>
<td>Group II</td>
<td>15.4-18.2</td>
<td>17.2</td>
<td>83-108</td>
<td>101</td>
<td>1.25-3.00</td>
<td>1.91</td>
</tr>
<tr>
<td>Group III</td>
<td>13.8-18.3</td>
<td>15.5</td>
<td>83-110</td>
<td>91</td>
<td>1.25-2.25</td>
<td>1.75</td>
</tr>
<tr>
<td>Group IV</td>
<td>13.1-18.2</td>
<td>15.9</td>
<td>88-99</td>
<td>92</td>
<td>1.25-3.00</td>
<td>1.75</td>
</tr>
</tbody>
</table>
Table I shows a mean for intelligence scores for Group I (out of play therapy one to six years) which is somewhat higher than the comparison group, while Group II (out of play therapy six to ten years) is considerably older than their Group IV (evaluation only, six to ten years previously) counterparts.

There was no significant difference between groups on grade-point average and age at the time of diagnostic evaluation, as determined by the Mann-Whitney U Test. There was a difference between Groups I and III on intelligence scores, but not between any of the other groups.

In an attempt to control for contamination of the data, verification that the student had not been in counseling, special reading, or speech therapy following contact with the counseling center was obtained from the parents during the home visit.

Analysis of Data

The data collected in this study were treated statistically at the North Texas State University Computer Center. The Mann-Whitney U, and means and standard deviations computed to evaluate subject data with normative data on test instruments, were used to compare the play therapy and evaluation groups on the criteria used for this study. Significance of differences between the play therapy and evaluation groups on the two questions asked in this study, and the criteria within each of the two questions, were
tested at the .05 level of significance. Following this, data were then compared, using numbers of subjects attaining given scores on test instruments. The intent of this was to look at scoring patterns which the statistical analysis might not accurately represent.
CHAPTER BIBLIOGRAPHY


CHAPTER IV

ANALYSIS OF RESULTS

The purpose of this chapter is to present and analyze the findings of this investigation as they relate to each research question. Analysis of the results utilized the Mann-Whitney U test. The .05 level of significance was accepted as the basis upon which significant differences between comparison groups were determined. A U value equal to zero represents the greatest possible difference between two samples, with the U value increasing as samples become more alike. The U value is obtained by using the sample sizes being compared and table of U values for the selected level of significance of the investigation. Groups I and II, which were compared in this study, had sample sizes of seven and nine, respectively. The U value at the .05 level of significance was fifteen or less. Comparison Groups I and II, with samples of seven each, required a U value of eleven or less to be statistically significant, and comparison Groups II and IV, with sample sizes of nine and seven, respectively, required a U value of fifteen or less to be statistically significant.

In the presentation of tables, Group I included those children who had at least ten play therapy sessions at the
counseling center more than one year and less than six years previously. Group II included subjects with at least ten play therapy sessions more than six and less than ten years previously. Group III was comprised of those subjects who had no play therapy sessions but were evaluated one to six years previously as needing play therapy. Group IV was comprised of those subjects who had no play therapy sessions but were evaluated six to ten years previously as needing play therapy.

To facilitate continuity in the study, the research questions are restated in their original form as a way of introducing the presentation of the obtained results. The focus of each table is on one of the six criteria of (a) social contact, (b) self-esteem, (c) school-related behavior problems, (d) level of academic functioning, (e) attitude toward school, and (f) family relations.

Research question one (a): What is the effect of length of time following termination of play therapy on social contact? The means, standard deviations, and Mann-Whitney U test score obtained on the work criterion of the Bonney-Fessenden Sociograph administered to subjects in Groups I and II are presented in Table II (p. 67).

The means and standard deviations in Table II revealed that both play therapy groups were similar on the work criterion. The U value of 29 was above the significant U
value of 15 necessary to show a significant difference at the .05 level between groups, on the work criterion of the Bonney-Fessenden Sociograph.

The means, standard deviations, and Mann-Whitney U Test score obtained on the play criterion of the Bonney-Fessenden Sociograph administered to subjects in Groups I and II are presented in Table III.

<table>
<thead>
<tr>
<th>Group</th>
<th>Means</th>
<th>Standard Deviations</th>
<th>N</th>
<th>Mann-Whitney U</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>3.57</td>
<td>2.89</td>
<td>7</td>
<td>29.00</td>
</tr>
<tr>
<td>II</td>
<td>3.44</td>
<td>2.88</td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>

TABLE II
MEANS, STANDARD DEVIATIONS AND MANN-WHITNEY U SCORE FOR GROUPS I AND II ON THE WORK CRITERION OF THE BONNEY-FESSENDEN SOCIOGRAPH

<table>
<thead>
<tr>
<th>Group</th>
<th>Means</th>
<th>Standard Deviations</th>
<th>N</th>
<th>Mann-Whitney U</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>4.14</td>
<td>2.34</td>
<td>7</td>
<td>26.50</td>
</tr>
<tr>
<td>II</td>
<td>4.00</td>
<td>3.28</td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>

TABLE III
MEANS, STANDARD DEVIATIONS AND MANN-WHITNEY U SCORE FOR GROUPS I AND II ON THE PLAY CRITERION OF THE BONNEY-FESSENDEN SOCIOGRAPH
As shown by the data in Table III, subjects in both play therapy groups made similar numbers of choices on the play criterion. The U value of 26.50 was above the significant U value of 15 necessary to show a significant difference at the .05 level between groups, on the play criterion of the Bonney-Fessenden Sociograph.

In order to show a more complete picture the work and play criteria scores for subjects in Groups I and II were combined. The means, standard deviations and Mann-Whitney U score are presented in Table IV.

**TABLE IV**

**MEANS, STANDARD DEVIATIONS AND MANN-WHITNEY U SCORE FOR GROUPS I AND II FOR TOTAL SCORES ON THE BONNEY-FESSENDEN SOCIOGRAPH**

<table>
<thead>
<tr>
<th>Group</th>
<th>Means</th>
<th>Standard Deviations</th>
<th>N</th>
<th>Mann-Whitney U</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>7.72</td>
<td>5.23</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>7.44</td>
<td>6.16</td>
<td>9</td>
<td>27.00</td>
</tr>
</tbody>
</table>

The results of the total scores on the Bonney-Fessenden Sociograph indicated that both groups appear similar in their needs for others. The U value of 27 was above the significant U value of 15 necessary to show a significant difference at the .05 level, between play therapy groups. It appears, from a review of the data related to question one (a), that
elapsed time since play therapy contact has no appreciable
differential effect on the emotional need for others.

Research question one (b): What is the effect of
length of time following termination of play therapy on
self-esteem? The means, standard deviations, and Mann-
Whitney U test score obtained on the Self-Esteem Inventory
administered to subjects in Groups I and II are presented
in Table V.

**TABLE V**

MEANS, STANDARD DEVIATIONS AND MANN-WHITNEY U SCORE
FOR GROUPS I AND II ON THE SELF-ESTEEM INVENTORY

<table>
<thead>
<tr>
<th>Group</th>
<th>Means</th>
<th>Standard Deviations</th>
<th>N</th>
<th>Mann-Whitney U</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>60.00</td>
<td>15.66</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>66.22</td>
<td>23.07</td>
<td>9</td>
<td>30.50</td>
</tr>
</tbody>
</table>

The means of the attained scores for play therapy groups
were below the seventy to eighty range for average self-
esteem reported by Coopersmith in his standardization of
Forms B and C of the Self-Esteem Inventory (2).

The standardization sample had standard deviations be-
tween eleven and thirteen, which were somewhat divergent
from Group I and highly divergent from Group II. Those sub-
jects who were out of play therapy longer had a somewhat
higher average self-esteem, with a greater scatter of scores
than those subjects who received play therapy more recently. Differences may be attributable to maturation, since subjects in the group six to ten years out of play therapy (Group II) were an average of three years older.

Since the standard deviation on this test instrument is eleven to thirteen points, test results would place members of both play therapy groups as potentially scoring within the medium range of self-esteem. This fact was still not as encouraging as it might be, however, because Coopersmith (2) reports that in most of his samples the curve is skewed in the direction of high self-esteem. Therefore, as a whole, the individuals in the play therapy groups appeared to perceive themselves as somewhat less adequate in self-esteem than a normal distribution of individuals might. The $U$ value of 30.50 was above the significant $U$ value of 15 necessary to show a significant difference at the .05 level between comparison groups on research question one (b).

Research question one (c): What is the effect of the length of time following termination of play therapy on school-related behavior patterns? The means, standard deviations, and Mann-Whitney $U$ test score obtained on the Self-Esteem Behaviors rating form administered to subjects in Groups I and II are presented in Table VI (p. 71).

Play therapy group means of 63.71 and 73.55 respectively are within the moderate range of school adjustment as
TABLE VI

MEANS, STANDARD DEVIATIONS AND MANN-WHITNEY U SCORE FOR GROUPS I AND II ON THE SELF-ESTEEM BEHAVIORS RATING FORM

<table>
<thead>
<tr>
<th>Group</th>
<th>Means</th>
<th>Standard Deviations</th>
<th>N</th>
<th>Mann-Whitney U</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>63.71</td>
<td>15.42</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>73.55</td>
<td>12.28</td>
<td>9</td>
<td>15.50</td>
</tr>
</tbody>
</table>

indicated by Coopersmith (2). The U value of 15.50 was slightly above the significant U value of 15 necessary to show significant difference at the .05 level, between comparison groups, on research question one (c).

It appears from a review of the data related to question one (c), that elapsed time since play therapy contact has no appreciable differential effect on school-related behavior patterns. Means shown in Table VI indicate that both groups were seen by their teachers at the time of this follow-up investigation as being in the average range of school adjustment. Since Group II subjects were significantly older at follow-up, some difference on scores on the SEB may have been due to maturation.

Research question one (d): What is the effect of the length of time following termination of play therapy on level of academic functioning? Averaged individual grades and group means on school grades at evaluation and follow-up for subjects in Groups I and II are presented in Table VII.
### Table VII

**Averaged Individual Grades and Group Means for Groups I and II on School Grades at Evaluation and Follow-Up**

<table>
<thead>
<tr>
<th></th>
<th>Group I Evaluation</th>
<th>Group I Follow-Up</th>
<th>Group II Evaluation</th>
<th>Group II Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.00</td>
<td>1.00</td>
<td>1.24</td>
<td>2.25</td>
<td></td>
</tr>
<tr>
<td>1.25</td>
<td>2.50</td>
<td>1.50</td>
<td>2.50</td>
<td></td>
</tr>
<tr>
<td>3.00</td>
<td>3.00</td>
<td>3.00</td>
<td>2.25</td>
<td></td>
</tr>
<tr>
<td>1.50</td>
<td>1.00</td>
<td>1.75</td>
<td>1.75</td>
<td></td>
</tr>
<tr>
<td>1.00</td>
<td>1.00</td>
<td>2.00</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>2.00</td>
<td>1.75</td>
<td>1.75</td>
<td>3.00</td>
<td></td>
</tr>
<tr>
<td>1.25</td>
<td>2.00</td>
<td>2.00</td>
<td>2.75</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>-</td>
<td>2.50</td>
<td>1.50</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>-</td>
<td>1.50</td>
<td>2.50</td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>1.71</td>
<td>1.75</td>
<td>1.91</td>
<td>2.17</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>.68</td>
<td>.80</td>
<td>.54</td>
<td>.63</td>
</tr>
</tbody>
</table>

Averaged individual grades at evaluation and follow-up show an initial difference between groups. With time this difference widened, with the group six to ten years out of play therapy (Group II) achieving a consistently higher upward trend in grades than their counterparts one to six years out of play therapy (Group I).
The means, standard deviations, and Mann-Whitney U test score obtained on the differences in school grades at evaluation and follow-up of subjects in Groups I and II are presented in Table VIII.

**TABLE VIII**

MEANS, STANDARD DEVIATIONS AND MANN-WHITNEY U SCORE OF DIFFERENCES IN SCHOOL GRADES AT EVALUATION AND FOLLOW-UP FOR GROUPS I AND II

<table>
<thead>
<tr>
<th>Group</th>
<th>Means</th>
<th>Standard Deviations</th>
<th>N</th>
<th>Mann-Whitney U</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>0.04</td>
<td>0.74</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>0.25</td>
<td>0.58</td>
<td>9</td>
<td>21.50</td>
</tr>
</tbody>
</table>

The mean difference for the groups one to six years out of play therapy in Table VIII indicated almost identical school grades preceding therapy and at follow-up, with the standard deviation showing a scatter of less than one grade point. The group six to ten years out of play therapy showed a similar mean standard deviation, with average scores at follow-up about one-fourth grade higher than they were preceding treatment. Although the six-to-ten-year group (Group II) exhibited a larger increase in grade-point average than the one-to-six-year group (Group I), findings were non-significant. The U value of 21.50 was above the significant U value of 15 necessary to show significant differences at
the .05 level between comparison groups on research question one (d).

Research question one (e): What is the effect of length of time following termination of play therapy on attitude toward school? The percentile rank, means, standard deviations, and Mann-Whitney U Test score obtained on the *Survey of Study Habits and Attitudes* administered to subjects in Groups I and II are presented in Table IX.

**TABLE IX**

PERCENTILE RANK, MEANS, STANDARD DEVIATIONS AND MANN-WHITNEY U SCORE ON THE *SURVEY OF STUDY HABITS AND ATTITUDES* FOR GROUPS I AND II

<table>
<thead>
<tr>
<th>Group</th>
<th>Percentile Rank</th>
<th>Means</th>
<th>Standard Deviations</th>
<th>Mann-Whitney U</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>20</td>
<td>20.29</td>
<td>8.26</td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>25</td>
<td>22.89</td>
<td>8.22</td>
<td>26.50</td>
</tr>
</tbody>
</table>

Subjects in both play therapy groups scored at the twentieth percentile, in comparison with the SSHA normative group of students aged thirteen to eighteen. According to Brown and Holtzman (1), scores above the fiftieth percentile are related to appropriate school adjustment, while scores below the fiftieth percentile indicate poor or maladaptive school adjustment. In addition, the eight-point standard deviation in Table IX indicates a limited scatter in scores, revealing
a consistent grouping at the lower end of the SSHA scale. The U value of 26.50 was above the significant U value of 15 necessary to show significant difference at the .05 level between comparison groups. Apparently from a review of the data related to question one (3), elapsed time since play therapy contact has no appreciable differential effect on attitude toward school.

Research question one (f): What is the effect of length of time following termination of play therapy on family relations? The means and standard deviations obtained on the Family Environment Scale administered to children and parents for Groups I and II are presented in Table X. In addition, the difference between means is presented in Table X in order to show the degree to which children and their parents differed in their responses on ten subscales of the FES (Table X, p. 76).

Table X shows child and parent scores by group and differences between mean child-parent scores by group, on the ten subscales of the Family Environment Scale for both play therapy groups.

In considering differences between mean scores, a difference of .80 or more was considered a marked variation between comparison groups. There was a difference of 1.40 and .82 between subjects on variable four (independence), and variable ten (control), respectively. Subjects out of play therapy for six to ten years (Group II) had somewhat higher
TABLE X

GROUP MEANS FOR CHILDREN, PARENTS AND DIFFERENCES BETWEEN MEANS FOR GROUPS I AND II ON THE FAMILY ENVIRONMENT SCALE

<table>
<thead>
<tr>
<th>Subscales</th>
<th>Group I</th>
<th>Group II</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C Mean</td>
<td>P Mean</td>
<td>Difference Between Means</td>
<td>C Mean</td>
</tr>
<tr>
<td>Cohesion</td>
<td>3.28</td>
<td>3.43</td>
<td>.15</td>
<td>3.67</td>
</tr>
<tr>
<td>Expressiveness</td>
<td>3.14</td>
<td>3.43</td>
<td>.29</td>
<td>3.11</td>
</tr>
<tr>
<td>Conflict</td>
<td>2.14</td>
<td>2.29</td>
<td>.15</td>
<td>2.11</td>
</tr>
<tr>
<td>Independence</td>
<td>2.71</td>
<td>3.29</td>
<td>.58</td>
<td>4.11</td>
</tr>
<tr>
<td>Achievement Orientation</td>
<td>2.71</td>
<td>2.71</td>
<td>0</td>
<td>2.67</td>
</tr>
<tr>
<td>Intellectual Cultural Orientation</td>
<td>1.86</td>
<td>2.00</td>
<td>.14</td>
<td>2.22</td>
</tr>
<tr>
<td>Active Recreational Orientation</td>
<td>2.57</td>
<td>3.14</td>
<td>.57</td>
<td>1.89</td>
</tr>
<tr>
<td>Moral Religious Emphasis</td>
<td>3.00</td>
<td>2.57</td>
<td>.43</td>
<td>2.56</td>
</tr>
<tr>
<td>Organization</td>
<td>3.43</td>
<td>2.57</td>
<td>.86</td>
<td>2.67</td>
</tr>
<tr>
<td>Control</td>
<td>2.71</td>
<td>2.43</td>
<td>.28</td>
<td>1.89</td>
</tr>
</tbody>
</table>

independence, scores while subjects out of play therapy for one to six years (Group I) had somewhat higher control scores. These scores are non-significant, however. There was a difference of .81 between parents on variable seven (active-recreational orientation), with parents in the group one to six years out of
play therapy (Group I) scoring higher on family recreational activity than the group six to ten years out of play therapy (Group II). There was a difference of .86 within groups, between children and parents, on variable nine (organization) in which children in the group one to six years out of play therapy (Group I) had higher scores on the organization subscale than did their parents. No differences between groups are apparent when viewing the differences between parent and child means. All above reported means are non-significant.

The Mann-Whitney U scores between subjects of Groups I and II, parents of Groups I and II, child and parent of each group, and child-parent differences between groups on the Family Environment Scale are presented in Table XI (p. 78).

Comparison of groups in Table XI revealed some statistically significant results. Subjects in the group six to ten years out of play therapy (Group II) perceived more independence than did their counterparts one to six years out of play therapy (Group IV). At the same time, parents in the one-to-six-year group perceived more recreational activity occurring in the family.

A method of evaluating the overall differences in scoring patterns between subjects and parents concerns the discrepancy score obtained from the Family Environment Scale
### TABLE XI

MANN-WHITNEY U TEST SCORES BETWEEN SUBJECTS OF GROUPS I AND II, PARENTS OF GROUPS I AND II, CHILD AND PARENTS OF EACH GROUP AND CHILD/PARENT DIFFERENCES BETWEEN GROUPS FOR THE FAMILY ENVIRONMENT SCALE

<table>
<thead>
<tr>
<th>Subscales</th>
<th>Group I Subjects U Score</th>
<th>Group II Parents U Score</th>
<th>C &amp; P Group I U Score</th>
<th>C &amp; P Group II U Score</th>
<th>C/P Differences Groups I &amp; II U Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohesion</td>
<td>24.50</td>
<td>24.00</td>
<td>24.00</td>
<td>39.00</td>
<td>25.50</td>
</tr>
<tr>
<td>Expressiveness</td>
<td>29.50</td>
<td>24.00</td>
<td>23.50</td>
<td>35.00</td>
<td>19.50</td>
</tr>
<tr>
<td>Conflict</td>
<td>31.50</td>
<td>26.50</td>
<td>20.50</td>
<td>39.50</td>
<td>23.50</td>
</tr>
<tr>
<td>Independence</td>
<td>9.50*</td>
<td>23.00</td>
<td>16.50</td>
<td>33.00</td>
<td>30.50</td>
</tr>
<tr>
<td>Achievement Orientation</td>
<td>31.00</td>
<td>22.50</td>
<td>23.50</td>
<td>32.50</td>
<td>15.50</td>
</tr>
<tr>
<td>Intellectual-Cultural Orientation</td>
<td>25.00</td>
<td>30.00</td>
<td>20.50</td>
<td>36.00</td>
<td>24.50</td>
</tr>
<tr>
<td>Active-Recreational Orientation</td>
<td>20.50</td>
<td>14.00*</td>
<td>16.00</td>
<td>31.00</td>
<td>21.50</td>
</tr>
<tr>
<td>Moral-Religious Emphasis</td>
<td>25.00</td>
<td>28.00</td>
<td>19.50</td>
<td>35.50</td>
<td>29.00</td>
</tr>
<tr>
<td>Organization</td>
<td>19.50</td>
<td>28.50</td>
<td>16.50</td>
<td>38.50</td>
<td>32.00</td>
</tr>
<tr>
<td>Control</td>
<td>17.00</td>
<td>24.00</td>
<td>21.50</td>
<td>38.00</td>
<td>31.00</td>
</tr>
</tbody>
</table>

* p .05

The discrepancy score is the difference between the total raw scores of parents and children. It may be utilized as a standard of comparison for general agreement or disagreement.
The means, standard deviations, and Mann-Whitney U test score obtained on the discrepancy score of the Family-Environment Scale administered to subjects in Groups I and II are presented in Table XII.

**TABLE XII**

MEANS, STANDARD DEVIATIONS AND MANN-WHITNEY U SCORES FOR GROUPS I AND II ON THE AMOUNT OF AGREEMENT BETWEEN SUBJECT AND PARENT ON THE FAMILY ENVIRONMENT SCALE

<table>
<thead>
<tr>
<th>Group</th>
<th>Means</th>
<th>Deviations</th>
<th>Mann-Whitney U Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>10.85</td>
<td>3.23</td>
<td>24.00</td>
</tr>
<tr>
<td>II</td>
<td>12.22</td>
<td>3.76</td>
<td></td>
</tr>
</tbody>
</table>

Subjects and parents in this study were compared with the normative sample used to standardize the FES. Former play therapy subjects indicated less disagreement with their parents on what occurs or what values are emphasized in their family, when compared with the normative sample discrepancy mean score of 14.65. In addition, highly similar scoring patterns, as shown by the standard deviations for both play therapy groups, occurred. The U value of 24 was above the significant U value of 15 necessary to show significant difference between comparison groups on research question one (f).
The remaining tables in this section represent each of the five variables as they relate to question two. Discussion of the data focuses on comparing results between Groups I (one to six years out of play therapy) and III (one to six years since evaluation), and between Groups II (six to ten years out of play therapy) and IV (six to ten years since evaluation).

Research question two (a): How are the social contacts of children who have experienced play therapy different from those of children who have been diagnosed as needing play therapy but not receiving it? The means, standard deviations, and Mann-Whitney U test scores obtained on the work criterion of the Bonney-Fessenden Sociograph, administered to all subjects, are presented in Table XIII.

**TABLE XIII**

MEANS, STANDARD DEVIATIONS AND MANN-WHITNEY U SCORES ON THE WORK CRITERION OF THE BONNEY-FESSENDEN SOCIOGRAPH FOR COMPARING GROUPS I WITH III AND II WITH IV

<table>
<thead>
<tr>
<th>Group</th>
<th>Means</th>
<th>Standard Deviations</th>
<th>N</th>
<th>Mann-Whitney U</th>
</tr>
</thead>
<tbody>
<tr>
<td>I and III</td>
<td>3.57</td>
<td>2.89</td>
<td>7</td>
<td>24.50</td>
</tr>
<tr>
<td>II and IV</td>
<td>3.44</td>
<td>2.88</td>
<td>9</td>
<td>24.50</td>
</tr>
<tr>
<td></td>
<td>2.43</td>
<td>1.62</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>
Table XIII shows that means and standard deviations were highly similar for Groups I and III on the work criterion of the Bonney-Fessenden Sociograph. Means and standard deviations for Groups II and IV, though non-significant, show nearly a one-person difference in choices between groups. The U value of 24.50 was above the significant U value of 11 and 15 necessary to show a significant difference at the .05 level of significance between play therapy and non-play therapy groups on the work criterion of the Bonney-Fessenden Sociograph.

The means, standard deviations, and Mann-Whitney U scores obtained on the play criterion of the Bonney-Fessenden Sociograph, administered to all subjects, are presented in Table XIV.

### TABLE XIV

**Means, Standard Deviations and Mann-Whitney U Scores from Play Criterion of the Bonney-Fessenden Sociograph for Comparing Groups I with III and II with IV**

<table>
<thead>
<tr>
<th>Group</th>
<th>Means</th>
<th>Standard Deviations</th>
<th>N</th>
<th>Mann-Whitney U</th>
</tr>
</thead>
<tbody>
<tr>
<td>I and III</td>
<td>4.14</td>
<td>2.34</td>
<td>7</td>
<td>24.00</td>
</tr>
<tr>
<td>III</td>
<td>3.71</td>
<td>2.21</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>II and IV</td>
<td>4.00</td>
<td>3.28</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>2.57</td>
<td>1.81</td>
<td>7</td>
<td>24.50</td>
</tr>
</tbody>
</table>
A review of the data related to question two (a), concerning the play criterion, indicates some non-significant differences between Groups II and IV. However, it appears that no appreciable differential effect on social outreaching for non-performance relationships occurred between subjects who had experienced play therapy and subjects who had only been evaluated. The U values of 24.00 and 24.50 were above the significant U values of 11 and 15 necessary to show a significant difference at the .05 level of significance between comparison groups, on the play criterion of the Bonney-Fessenden Sociograph.

The means, standard deviations, and Mann-Whitney U test scores obtained from the total scores of the Bonney-Fessenden Sociograph, administered to all subjects, are presented in Table XV.

**TABLE XV**

**MEANS, STANDARD DEVIATIONS AND MANN-WHITNEY U SCORES FROM TOTAL SCORES OF THE BONNEY-FESSENDEN SOCIOGRAPH FOR COMPARING GROUPS I WITH III AND II WITH IV**

<table>
<thead>
<tr>
<th>Group</th>
<th>Means</th>
<th>Standard Deviations</th>
<th>N</th>
<th>Mann-Whitney U</th>
</tr>
</thead>
<tbody>
<tr>
<td>I and III</td>
<td>7.72</td>
<td>5.23</td>
<td>7</td>
<td>21.00</td>
</tr>
<tr>
<td>II and IV</td>
<td>6.85</td>
<td>4.32</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7.44</td>
<td>6.16</td>
<td>9</td>
<td>25.00</td>
</tr>
<tr>
<td></td>
<td>5.00</td>
<td>3.43</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>
No significant statistical differences occurred when comparing the responses of the one-to-six- and six-to-ten-year play-therapy groups with the one-to-six and six-to-ten-year-evaluation-only groups on the emotional need for others. Groups II (play therapy six to ten years) and IV (evaluation only six to ten years) had means and standard deviations which appeared divergent from one another on both questions of the Bonney-Fessenden Sociograph. The means and standard deviations shown in Table XV are, however, non-significant. The U values of 21 and 25 were above the significant U values of 11 and 15 necessary to show a significant difference at the .05 level of significance between comparison groups on question two (a).

Research question two (b): How is the self-esteem of children who have experienced play therapy different from that of children who have been diagnosed as needing play therapy but not receiving it? The means, standard deviations, and Mann-Whitney U test scores obtained on the Self-Esteem Inventory, administered to all subjects, are presented in Table XVI (p. 84).

The means of the scores obtained for Groups I and III on the Self-Esteem Inventory are below the seventy to eighty range reported by Coopersmith (2) for average self-esteem. However, the Group IV mean score was in the average range of self-esteem and the Group II mean score was
TABLE XVI
MEANS, STANDARD DEVIATIONS, AND MANN-WHITNEY U SCORES ON THE SELF-ESTEEM INVENTORY FOR COMPARING GROUPS I WITH III AND II WITH IV

<table>
<thead>
<tr>
<th>Group</th>
<th>Means</th>
<th>Standard Deviations</th>
<th>N</th>
<th>Mann-Whitney U</th>
</tr>
</thead>
<tbody>
<tr>
<td>I and III</td>
<td>60.00</td>
<td>15.66</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>II and IV</td>
<td>66.22</td>
<td>23.07</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>II and IV</td>
<td>76.00</td>
<td>21.42</td>
<td>7</td>
<td>23.50</td>
</tr>
<tr>
<td>II and IV</td>
<td>76.00</td>
<td>21.42</td>
<td>7</td>
<td>25.50</td>
</tr>
</tbody>
</table>

less than four points below the average range. The U values of 23.50 and 25.50 were above the significant U values of 11 and 15 necessary to show a significant difference at the .05 level of significance between comparison groups on question two (b).

Research question two (c): How are the school-related behavior patterns of children who have experienced play therapy different from children who have been diagnosed as needing play therapy but not receiving it? The means, standard deviations, and Mann-Whitney U test scores obtained on the Self-Esteem Behaviors rating form, administered to all subjects, are presented in Table XVII (p. 85).

The means of the scores obtained on the Self-Esteem Behaviors rating form show all comparison groups scoring in
TABLE XVII
MEANS, STANDARD DEVIATIONS AND MANN-WHITNEY U SCORES
ON THE SELF-ESTEEM BEHAVIORS RATING FORM FOR
COMPARING GROUPS I WITH III AND II WITH IV

<table>
<thead>
<tr>
<th>Group</th>
<th>Means</th>
<th>Standard Deviations</th>
<th>N</th>
<th>Mann-Whitney U</th>
</tr>
</thead>
<tbody>
<tr>
<td>I and III</td>
<td>63.71</td>
<td>15.42</td>
<td>7</td>
<td>23.50</td>
</tr>
<tr>
<td>II and IV</td>
<td>73.55</td>
<td>12.05</td>
<td>9</td>
<td>26.00</td>
</tr>
<tr>
<td></td>
<td>65.71</td>
<td>16.79</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

the average range of school-related adjustment (2), with somewhat higher mean scores for Group II as compared to Group IV. The U values of 23.50 and 26 were above the significant U values of 11 and 15 necessary to show a significant difference at the .05 level of significance between comparison groups on question two (c).

Research question two (d): How are the levels of academic functioning of children who have experienced play therapy different from children who have been diagnosed as needing play therapy but not receiving it? The individual averaged grades and group means for all subjects on school grades at evaluation and follow-up are presented in Table XVIII (p. 86).

At evaluation comparison Groups I and III were similar, with Group III achieving greater gains in grades at follow-up.
### TABLE XVIII

**INDIVIDUAL AVERAGED GRADES AND GROUP MEANS FOR GROUPS I AND III, AND II AND IV ON SCHOOL GRADES AT EVALUATION AND FOLLOW-UP**

<table>
<thead>
<tr>
<th></th>
<th>Group I</th>
<th>Group III</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Evaluation</td>
<td>Follow-Up</td>
<td>Evaluation</td>
<td>Follow-Up</td>
</tr>
<tr>
<td>2.00</td>
<td>1.00</td>
<td></td>
<td>1.25</td>
<td>2.25</td>
</tr>
<tr>
<td>1.25</td>
<td>2.50</td>
<td></td>
<td>2.25</td>
<td>1.25</td>
</tr>
<tr>
<td>3.00</td>
<td>3.00</td>
<td></td>
<td>2.25</td>
<td>2.75</td>
</tr>
<tr>
<td>1.50</td>
<td>1.00</td>
<td></td>
<td>1.75</td>
<td>2.00</td>
</tr>
<tr>
<td>1.00</td>
<td>1.00</td>
<td></td>
<td>1.25</td>
<td>1.25</td>
</tr>
<tr>
<td>2.00</td>
<td>1.75</td>
<td></td>
<td>2.00</td>
<td>1.25</td>
</tr>
<tr>
<td>1.25</td>
<td>2.00</td>
<td></td>
<td>1.50</td>
<td>2.75</td>
</tr>
<tr>
<td>Mean</td>
<td>1.71</td>
<td>1.75</td>
<td>1.75</td>
<td>1.92</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>.68</td>
<td>.80</td>
<td>.43</td>
<td>.68</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Group II</th>
<th>Group IV</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Evaluation</td>
<td>Follow-Up</td>
<td>Evaluation</td>
<td>Follow-Up</td>
</tr>
<tr>
<td>1.25</td>
<td>2.25</td>
<td></td>
<td>1.50</td>
<td>2.25</td>
</tr>
<tr>
<td>1.50</td>
<td>2.90</td>
<td></td>
<td>1.75</td>
<td>1.25</td>
</tr>
<tr>
<td>3.00</td>
<td>2.25</td>
<td></td>
<td>3.00</td>
<td>2.00</td>
</tr>
<tr>
<td>1.75</td>
<td>1.75</td>
<td></td>
<td>1.25</td>
<td>1.00</td>
</tr>
<tr>
<td>2.00</td>
<td>1.00</td>
<td></td>
<td>1.50</td>
<td>3.00</td>
</tr>
<tr>
<td>1.75</td>
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<tr>
<td>2.00</td>
<td>2.75</td>
<td></td>
<td>1.50</td>
<td>2.75</td>
</tr>
<tr>
<td>2.50</td>
<td>1.00</td>
<td></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1.50</td>
<td>2.50</td>
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<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mean</td>
<td>1.91</td>
<td>2.16</td>
<td>1.75</td>
<td>2.00</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>.54</td>
<td>.63</td>
<td>.57</td>
<td>.73</td>
</tr>
</tbody>
</table>
Group II had a somewhat higher mean grade point at evaluation than Group IV.

The means, standard deviations, and Mann-Whitney U test scores obtained on the differences in school grades at evaluation and follow-up of all subjects are presented in Table XIX.

TABLE XIX
MEANS, STANDARD DEVIATIONS AND MANN-WHITNEY U Scores
OF DIFFERENCES IN SCHOOL GRADES AT EVALUATION AND FOLLOW-UP FOR GROUPS I AND III AND II AND IV

<table>
<thead>
<tr>
<th>Group</th>
<th>Means</th>
<th>Standard Deviations</th>
<th>N</th>
<th>Mann-Whitney U</th>
</tr>
</thead>
<tbody>
<tr>
<td>I and III</td>
<td>0.04</td>
<td>0.74</td>
<td>7</td>
<td>21.00</td>
</tr>
<tr>
<td>II and IV</td>
<td>0.25</td>
<td>0.65</td>
<td>9</td>
<td>28.00</td>
</tr>
</tbody>
</table>

As shown by the mean differences, Groups I and III achieved similar patterns of school grades, both preceding evaluation and at follow-up. Differences between means at evaluation and follow-up for Groups II and IV were identical. The U values of 21 and 28 were above the significant U values of 11 and 15 necessary to show a significant difference at the .05 level of significance between comparison groups on question two (d).
Research question two (e): How are the attitudes toward school of children who have experienced play therapy different from children who have been diagnosed as needing play therapy but not receiving it? The percentile rank, means, standard deviations, and Mann-Whitney U test scores obtained on the Survey of Study Habits and Attitudes, administered to all subjects, are presented in Table XX.

<table>
<thead>
<tr>
<th>Group</th>
<th>Percentile Rank</th>
<th>Means</th>
<th>Standard Deviations</th>
<th>N</th>
<th>Mann-Whitney U</th>
</tr>
</thead>
<tbody>
<tr>
<td>I and III</td>
<td>20</td>
<td>20.29</td>
<td>8.26</td>
<td>7</td>
<td>20.50</td>
</tr>
<tr>
<td></td>
<td>25</td>
<td>22.14</td>
<td>8.61</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>II and IV</td>
<td>25</td>
<td>22.89</td>
<td>8.22</td>
<td>9</td>
<td>29.50</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>21.71</td>
<td>9.36</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

Brown and Holtzman (1) state that scores above the fiftieth percentile are related to appropriate school adjustment, while scores below the fiftieth percentile indicate poor or maladaptive school adjustment. All group means were at or near the twentieth percentile in comparison to normative data reported by Brown and Holtzman. It appears, then, that
play therapy subjects at follow-up were doing no better than their counterparts who had only been evaluated. The U values of 20.50 and 29.50 were above the significant U values of 11 and 15 necessary to show a significant difference at the .05 level of significance between comparison groups on question two (e).

Research question two (f): How are the family relations of children who have experienced play therapy different from those of children who have been diagnosed as needing play therapy but not receiving it? The means and standard deviations obtained on the Family Environment Scale, administered to children and parents, are presented in Table XXI (p. 90). In addition, in Table XII (p. 93), differences between means are presented to show the degree to which children and their parents differed in their responses on ten subscales of the FES.

In considering differences between mean scores, a difference of .80 or more was considered a marked variation. Table XXI shows child and parent group scores and differences between mean child-parent scores for all ten subscales of the Family Environment Scale. There was a difference of 1.14 between subjects in Groups I and III on variable nine (organization). Subjects in Group I (play therapy) had somewhat higher scores on organization than did subjects in Group III (non-play therapy). Between subjects in Groups II and IV, there was a difference of 1.11, 1.40, and 1.02 on variable four (independence), variable seven (active
<table>
<thead>
<tr>
<th>Subscale</th>
<th>Group I</th>
<th></th>
<th></th>
<th>Group III</th>
<th></th>
<th></th>
<th>Group II</th>
<th></th>
<th></th>
<th>Group IV</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>C Mean</td>
<td>P Mean</td>
<td>Diff.</td>
<td>C Mean</td>
<td>P Mean</td>
<td>Diff.</td>
<td>C Mean</td>
<td>P Mean</td>
<td>Diff.</td>
<td>C Mean</td>
<td>P Mean</td>
<td>Diff.</td>
</tr>
<tr>
<td>Cohesion</td>
<td>3.28</td>
<td>3.42</td>
<td>.15</td>
<td>2.71</td>
<td>2.57</td>
<td>.14</td>
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<td>.28</td>
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<td>2.85</td>
<td>.14</td>
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<td>.22</td>
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<td>.28</td>
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<td>.42</td>
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<td>2.14</td>
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</table>
recreational orientation) and variable eight (moral-religious emphasis) respectively. Subjects in Group II (play therapy) had higher scores on independence than did their counterparts in Group IV (non-play therapy), while Group IV subjects had higher scores on active-recreational orientation and moral-religious emphasis in their homes than did Group II subjects. There was a difference of .85, 1.00, and 1.14 on parent responses between Groups I and III on variable one (cohesion), variable three (conflict), and variable five (achievement-orientation) respectively. Group I parents had higher scores on the subscale cohesion, while Group III parents had higher scores on conflict and achievement orientation than did Group I parents. There was a difference of .86 between children and parents of Group I on variable nine (organization), with children scoring higher on the organization subscale than their parents. There was a difference of 1.43 between children and parents of Group III on variable three (conflict), with parents scoring higher on the conflict subscale than did their children. Comparisons of within-group responses for Group IV indicated a difference of .86 on variable six (intellectual-cultural orientation), with parents scoring higher on the subscale representing intellectual cultural activity in the home than their children. Between-group comparisons for Groups I and III of child-parent mean differences show a difference of 1.28 and .86 on variables three (conflict) and nine (organization), respectively, with
Group III showing more mean differences than Group I between child and parent on conflict, while Group I had more mean differences than Group III on organization in the home.

Comparison of Groups II and IV shows no apparent differences between groups. All above reported means are non-significant.

The Mann-Whitney U scores between subjects of Group I and III and II and IV, parents of Groups I and III and II and IV, are presented in Table XXII. In addition children and parents within each group, and child-parent differences between groups on the FES are presented in Table XXII (p. 93).

Concerning research question two, and the differences between play therapy and non-play therapy children on the ten subscales of the FES, there were statistically significant differences, with subjects one to six years out of play therapy perceiving more organization in their homes than their evaluation-only counterparts, while parents in the group one to six years out of play therapy perceived significantly more cohesion than did parents in the evaluation-only comparison group. In the opposite direction, parents of the group one to six years since evaluation valued more goal-oriented behavior than did their play therapy counterparts. There were also statistically significant differences in the six-to-ten-year category on home and family relations. Subjects in the category six to ten years out of play therapy perceived more independence in their homes, while their non-play-therapy counterparts perceived more family recreational
TABLE XXII

MANN-WHITNEY U TEST SCORES BETWEEN SUBJECTS OF GROUPS I AND III AND II AND IV, PARENTS OF GROUPS I AND III AND II AND IV, CHILD AND PARENT OF EACH GROUP, AND CHILD/PARENT DIFFERENCES BETWEEN GROUPS ON THE FAMILY ENVIRONMENT SCALE

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Subjects I &amp; III U scores</th>
<th>Subjects II &amp; IV U scores</th>
<th>Parents I &amp; III U scores</th>
<th>Parents II &amp; IV U scores</th>
<th>C &amp; P Group I U scores</th>
<th>C &amp; P Group II U scores</th>
<th>C &amp; P Group III U scores</th>
<th>C &amp; P Group IV U scores</th>
<th>C/P diff. I &amp; III U scores</th>
<th>C/P diff. II &amp; IV U scores</th>
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<td>20.00</td>
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<td>12.00*</td>
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<tr>
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<td>27.00</td>
<td>15.50</td>
<td>26.50</td>
<td>23.50</td>
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<td>8.00*</td>
<td>19.50</td>
</tr>
<tr>
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<td>13.50</td>
<td>31.00</td>
<td>20.50</td>
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<td>12.00</td>
<td>19.50</td>
<td>19.50</td>
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</tr>
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<td>8.00*</td>
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</tr>
<tr>
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<td>10.00*</td>
<td>18.50</td>
<td>26.50</td>
<td>16.00</td>
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<td>13.50</td>
<td>24.00</td>
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<tr>
<td>Moral Religious Emphasis</td>
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<td>19.50</td>
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<td>23.00</td>
<td>19.50</td>
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<td>10.50*</td>
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<tr>
<td>Organization</td>
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<td>20.50</td>
<td>28.50</td>
<td>16.50</td>
<td>38.50</td>
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<td>24.00</td>
<td>24.00</td>
<td>14.50</td>
<td>24.00</td>
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</table>

*p .05
activity occurring. Between-group differences occurred on cohesion, expressiveness, and moral-religious emphasis, with non-play therapy subjects and parents disagreeing on these values significantly more than their play therapy counterparts.

The following table concerns the discrepancy score which results from the scores obtained on the Family Environment Scale. The discrepancy score is the difference between the total raw scores of parent and child. It may be utilized as a standard of comparison for general agreement or disagreement. The means, standard deviations, and Mann-Whitney U scores for Groups I and III and II and IV on the amount of agreement between subjects and parent on the Family Environment Scale are presented in Table XXIII.

**TABLE XXIII**

MEANS, STANDARD DEVIATIONS AND MANN-WHITNEY U SCORES FOR GROUPS I AND III AND II AND IV ON THE AMOUNT OF AGREEMENT BETWEEN SUBJECT AND PARENT ON THE FAMILY ENVIRONMENT SCALE

<table>
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<tr>
<th>Group</th>
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<th>Mann-Whitney U</th>
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<tr>
<td>II and IV</td>
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<td></td>
<td>12.22</td>
<td>3.76</td>
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<tr>
<td></td>
<td>8.71</td>
<td>4.27</td>
<td></td>
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</table>
When compared with the normative sample mean of 14.65, all subjects had less disagreement on what occurs or what values are emphasized in their families than did the normative sample. These data agree with data in Table XX, in which there were few differences between child and parent group means on the ten subscales of the FES. The U values of 19.50 and 16 were above the significant U values of 11 and 15 necessary to show significant differences at the .05 level of significance between comparison groups, on research question two (f).
CHAPTER BIBLIOGRAPHY


CHAPTER V

SUMMARY

The literature contains references from authorities in play therapy, representing a variety of theoretical approaches, who have concluded that play therapy is a powerful tool in the process of facilitating behavior change (1, 6, 9, 11, 25). However, a search of the literature revealed little long-term research to support these conclusions. Results were varied with some of the studies reviewed showing long-term behavioral change (2, 6), while others concluded that treatment was ineffectual (21). In most cases, research conclusions were based on subjective data, with little or no supportive empirical data. In addition, the differences in methods of collecting data, as well as diverse criteria for analysis of behavior change, make it difficult to draw any consistent conclusions concerning long-term effects of play therapy. This diversity appears to be a major problem at the present time in play therapy research. Both outcome research and follow-up research have tended to focus on global changes in the individual rather than attending to specific benefits of therapy. The purpose of this study was to investigate and describe the long-term effects
of play therapy on social contacts, self-esteem, school-related behavior patterns, level of academic functioning and attitude toward school and family relations.

The subjects participating in this study were thirty children between the ages of thirteen and eighteen, who had been referred to the counseling center from public and private schools in the surrounding North Texas area. Sixteen of the students in this study had received only play therapy while the remaining fourteen were evaluated as needing play therapy but did not receive treatment. All subjects were in the normal range of intelligence as measured by a standardized intelligence test. Group I was composed of those children who were evaluated as needing play therapy, were included in at least ten play therapy sessions, and had been out of play therapy for a minimum of one year and a maximum of six years. Group II was composed of those children who were evaluated as needing play therapy, were included in at least ten play therapy sessions, and had been out of play therapy for a minimum of six years and a maximum of ten years. Group III was composed of those children who were evaluated a minimum of one year and a maximum of six years previously, were recommended for play therapy, but did not participate. Group IV was composed of those children who were evaluated a minimum of six years and a maximum of ten years previously, were recommended
for play therapy but did not participate. Any potential subject enrolled in speech or reading therapy was excluded.

The variables evaluated were emotional expansiveness as measured by the Bonney-Fessenden Sociograph, self-esteem as measured by the Self-Esteem Inventory, school-related behavior as measured by the Self-Esteem Behavior rating scale, academic achievement as measured by school grades, attitude toward school as measured by the Survey of Study Habits and Attitudes Test, and family members'agreement on what occurs and what is important in their family as measured by the Family Environment Scale.

The Mann-Whitney U test was used to analyze the data obtained in relation to research questions one and two. In addition, means and standard deviations were calculated to determine the extent to which comparison groups deviated from or were similar to normative data of instruments utilized in the study. Since the use of statistical analysis sometimes obscures individual variation, individual scoring patterns of subjects were considered when deviations from the statistical data were found.

Results

To carry out the purpose of this study, the following questions were explored: (1) What is the effect of the length of time following termination of play therapy on (a) social contact, (b) self-esteem, (c) school-related behavior
patterns, (d) level of academic functioning, (e) attitude toward school, and (f) family relations? and (2) How are the (a) social contacts, (b) self-esteem, (c) school-related behavior patterns, (d) levels of academic functioning, (e) attitude toward school, and (f) family relations of children who have experienced play therapy different from children who have been diagnosed as needing play therapy but not receiving it?

There were no statistically significant differences between subjects out of play therapy one to six years and subjects out of play therapy for six to ten years on (a) social contact, (b) self-esteem, (c) school-related behavior patterns, and (d) academic functioning. There were statistically significant differences at the .05 level on question one (f), with subjects who had been out of play therapy for six to ten years (Group II) perceiving their home environments as having more emphasis on independence and autonomy than subjects who had been out of play therapy for from one to six years (Group I). Parents in Group I perceived more family recreational activity occurring than did parents in Group II.

There were no statistically significant differences between play therapy and non-play-therapy subjects on (a) social contact, (b) self-esteem, (c) school-related behavior patterns, and (d) level of academic functioning. There were statistically significant differences at the .05 level on
question two (f), with subjects who had been out of play therapy for one to six years (Group I) perceiving more organization in their homes than their evaluation-only counterparts. Parents of the subjects who had been out of play therapy for one to six years (Group I) perceived significantly more cohesion in the family than did parents in the evaluation-only (Group III) comparison groups. In the opposite direction, parents of the group who had been out of play therapy from one to six years since evaluation perceived achievement or goal-oriented behavior in their families more than their play therapy counterparts.

There were also statistically significant differences at the .05 level on question two (f) in the six-to-ten-year category. Subjects who had been out of play therapy for six to ten years (Group II) perceived more independence in their homes, while their non-play-therapy counterparts (Group IV) perceived more family recreational activity occurring.

Between-group differences were the differences between parents' and subjects' scores within groups, with their resulting differences compared across groups. The result showed subjects in the group one to six years since evaluation with subjects and parents disagreeing on the extent of expressiveness in their homes more than their play therapy counterparts and their parents. In addition, between-group difference occurred for Group II (play therapy) and IV (non-play therapy), in which subjects and parents in the non-play
therapy group disagreed more as to the extent of cohesion and moral-religious emphasis in the home than their play therapy counterparts and their parents.

Discussion

In discussing the results of this investigation, it should be noted that some characteristic differences between groups may have influenced the data. These included differences in intelligence scores between Group I and III, as well as significant differences in age between Group I and II. However, the age difference is to be expected, since Group II subjects had been out of play therapy for a longer period of time.

The impact of elapsed time since participation in play therapy on the measured variables in this study resulted in few statistically significant findings. There were statistically significant differences on the effects of time on home and family relations, with subjects in the group six to ten years out of play therapy perceiving more independence and autonomy in the family. Parents of the group one to six years out of play therapy perceived more recreational activity as occurring in the family.

The above findings, coupled with nearly statistically significant results, mean scores, and individual scoring patterns, indicate a chronological trend toward improvement of
play therapy subjects on some measured variables, when compared with subjects who had been out of play therapy for a shorter period of time. Maturation, however, may be a factor contributing to any differences found.

Although no statistically significant differences were obtained between play therapy groups on the amount of grade point change from induction to follow-up, the individual patterns of grade change appear to indicate differences, as can be seen in Table XXIV.

<table>
<thead>
<tr>
<th>TABLE XXIV</th>
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<tr>
<td>A COMPARISON OF THE NUMBERS OF SUBJECTS AND THE AMOUNT OF GRADE POINT CHANGE MADE FROM INITIAL GRADES EARNED AT TIME OF EVALUATION AND GRADES OBTAINED AT FOLLOW-UP FOR GROUPS I AND II</td>
</tr>
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<table>
<thead>
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<th>Group</th>
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</tr>
<tr>
<td>Group II</td>
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</table>

The group that had been out of play therapy longer had more individuals who had a grade average improvement of 1.00 or better. Individuals in Group II improved their grades by approximately one-fourth grade point and had more acceptable school-related behavior adjustment, as indicated by mean scores and a nearly significant U value on the Self-Esteem Behavior rating scale (as rated by teachers). Like Group I,
they were well below the average on attitude toward school as measured by the Survey of Study Habits and Attitudes (a self rating). There appears to be a contradiction between the teachers' perception of acceptable school behavior and subjects' attitude to and perceptions of school behavior and functions. It may be characteristic for children, with time, to demonstrate more appropriate school-related behavior but not to admit to nor take responsibility for any behavioral changes. Although no long-term play therapy investigation in the literature studies this relationship, this sort of pattern was noted in process play therapy studies (14, 26) in which the children, though improving in their behavior in the later stages of therapy, still tended verbally to attempt to shift responsibility for their behavioral choices to the counselor.

Perhaps the greatest growth takes place after the person is no longer under the supporting influence of the therapist. Meeks (19) indicates that timing and developmental stages seem to be major factors in producing changes after termination of therapy. He states that often the child is experiencing school failures due to traumatic experiences at earlier stages of development, and his fear of failure and rejection inhibits the learning of new tasks. The child's learning potential increases in therapy but is not fully actualized, due to his dependency on the therapist.
He further hypothesizes that only after termination of treatment, when this dependency is ended, can the child reach his full potential. Support for this position can be found in a study by Cunningham and others (8), who in a follow-up study found an increase from the termination of therapy in the improved group in current adjustment as seen by the mother, how the child was getting along at school, and whether the symptoms for which the child was originally referred were improved.

It seems somewhat surprising that higher self-esteem scores did not occur with a rise in grades and more appropriate school-related behavior. There is some evidence in the literature, however, which indicates that although ability and academic performance are significantly associated with feelings of worth, they are not the major and overwhelming influence on the development of self-esteem (7).

As was noted earlier, the few statistically significant findings that did occur related to the effect of time on play therapy involved home and family relations. Statistically significant differences and mean scores revealed that subjects one to six years out of play therapy (Group I) perceived their home environments as controlled and organized, while their parents indicated an emphasis on family recreational activity. The subjects six to ten years out of play therapy
perceived their home environments as independent, with their parents valuing goal-oriented behavior.

In general, these results may reflect the age differences between Groups I and II. There seemed to be a greater feeling of control and family involvement in the younger subjects (Group I) and their families, which might be expected if parental restraints and limits tend to be tighter in younger age adolescents. While the early adolescent subjects in Group I were still highly emotionally involved in family activities, the older subjects (Group II) appeared to be establishing themselves as independent from their families.

The improved school adjustment and grade point changes of the subjects longer out of play therapy may have been due to several factors, such as the ability to delay gratification, which begins to occur in later adolescence, thus leading to more goal-oriented behavior. Tied to this may be a growing awareness of oncoming adult responsibilities and the need to set and strive for career goals. Several studies on adolescent and preadolescent behavior appear to confirm this trend toward more responsible behavior (5, 10, 17). Therefore, parental expectations and maturational factors might well motivate increases in grades and more appropriate classroom demeanor in the older subjects in Group II, although in many instances poor classroom behavior initiated in lower grades, increases in later adolescence. Finally, present emphasis
in today's schools on career awareness and a need for higher education to meet those career goals may be a factor significantly contributing to late adolescent achievement and behavior in school.

As with the results in research question one, concerning elapsed time out of therapy, few statistically significant findings occurred when play therapy and non-play therapy groups were compared. The statistically significant results occurred in the area of home and family relations, with subjects who had been out of play therapy for one to six years (Group I) perceiving more organization in their homes than their evaluation-only counterparts. Parents of subjects who had been out of play therapy for one to six years (Group I) perceived significantly more cohesion than did parents in the evaluation-only (Group III) comparison groups. In the opposite direction, parents of the group one to six years since evaluation perceived more goal-oriented behavior than did their play therapy counterparts.

There were also statistically significant differences in the six-to-ten-year category on home and family relations. Subjects who had been out of play therapy six to ten years (Group II) perceived more independence in their homes, while their non-play therapy counterparts (Group IV) perceived more family recreational activity occurring.
Between-group differences, which were comparisons of parents' and subjects' raw score differences compared across groups, showed variance on cohesion, expressiveness, and moral-religious emphasis, with non-play-therapy subjects and parents disagreeing on these values significantly more than their play therapy counterparts and their parents. The data indicate a trend toward more organization and control in Group I (play therapy) families, with Group III (non-play therapy) families focusing on goal-oriented behavior. In addition to the above, an analysis of the differences between parents and children showed more disagreement occurring in Group III (non-play therapy) over the extent of conflict and expressiveness in the family. In the six-to-ten-year category, between-groups differences show Group IV (non-play therapy) families with more disagreement on cohesion and moral-religious emphasis, while emphasizing family social activities more than their play therapy counterparts. It appears, then, that non-play-therapy families have more disagreement between parents and subjects on values in the home, and place more emphasis on goal-oriented or achievement-oriented behavior than do play therapy families.

Other trends noted on variables investigated in question two in this study occurred in social outreaching or need for others, self-esteem, school-related behavior, and academic achievement. Overall, no statistically significant
differences were noted between comparison groups on social outreaching, as measured by a sociometric scale. However, some mean scores and overall individual scoring patterns showed play therapy subjects with more social outreaching than their non-play therapy counterparts. Table XXV (p. 110) shows individual scoring patterns and choices on question one (work criterion) and question two (play criterion) of the Bonney-Fessenden Sociograph.

There were consistently more choices made by the play therapy group than were made by the non-play therapy group on both questions of the social expansiveness scale. This finding is in agreement with those of Seeman and others (23), in which social adjustment at follow-up was significantly higher for play therapy subjects.

Reported means on the Self-Esteem Inventory show that Group IV non-play-therapy subjects were in the moderate range of self-esteem, as defined by Coopersmith (7), while the remaining three groups were in the low range of self-esteem. These results closely parallel those of Quattlebaum (22), who found no statistically significant differences on self-concept between play therapy and non-play-therapy subjects.

Scores obtained on the Self-Esteem Behavior rating form place all four comparison groups in the middle or adequate range of school-related behavior, relating to appropriate
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<th></th>
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<td>Question II</td>
<td>3 2 3 1 - 1</td>
<td>3 1 1 1 - 1 2</td>
<td>- 1 1 2 1</td>
<td>1 2 1 - 2</td>
<td>5 3 4 2 - 1 3</td>
<td>5 - 2 1 4 1</td>
</tr>
<tr>
<td>Total</td>
<td>29</td>
<td>36</td>
<td>26</td>
<td>18</td>
<td>65</td>
<td>44</td>
</tr>
</tbody>
</table>
classroom behavior. Individual scoring patterns on the SEB measuring school related behavior are shown in Table XXVI.

**TABLE XXVI**

| Number of Subjects Who Received High, Moderate or Low Scores on the Self-Esteem Behaviors Rating Form |
|---|---|---|
| Group | High | Medium | Low |
| Group I | 1 | 4 | 2 |
| Group II | 4 | 4 | 1 |
| Group III | 0 | 5 | 2 |
| Group IV | 2 | 3 | 2 |
| Play Therapy | 5 | 8 | 3 |
| Evaluation | 2 | 8 | 4 |

When the four groups were placed in two major categories of play therapy and evaluation, a slight difference appeared between the two categories, showing that more of the play therapy Group II subjects scored in the high column, representing good school-related behavior patterns.

The individual scoring patterns for changes in grade point averages revealed a trend similar to the self-esteem findings. Table XXVI shows the number of subjects and the amount of grade point change from initial grades earned at the time of evaluation to grades obtained at follow-up.
TABLE XXVII

FREQUENCY COUNT OF THE AMOUNT OF GRADE POINT CHANGE MADE FROM INITIAL GRADES EARNED AT TIME OF EVALUATION AND GRADES OBTAINED AT FOLLOW-UP

<table>
<thead>
<tr>
<th>Grade Point Change</th>
<th>Group I</th>
<th>Group II</th>
<th>Group III</th>
<th>Group IV</th>
<th>Play Therapy</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>-1.0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>-.75</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
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<td>-.50</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>-.25</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
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<td>0</td>
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<td>.75</td>
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<td>1</td>
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<tr>
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<td>0</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

The data in Table XXVII show that subjects who had received play therapy six to ten years previously (Group II) attained more positive grade point changes than subjects in the other three groups. A grade improvement of 1.00 or better for six play therapy subjects, as compared to three non-play therapy subjects, appears to show a significant increase in grade average for play therapy subjects. This difference may reflect a longitudinal trend between play
therapy and non-play therapy subjects. The trend may indicate latent effects of the therapy process.

Since Group I did not achieve similar increases on school-related behavior or academic achievement it may be that age was a factor, with goal-oriented behavior, in later adolescence leading to more motivation toward academic achievement and more acceptable classroom behavior, as seen by teachers. It may also be that these improvements were due to the need to please parents and other adult figures in their lives. Jersild writes that "The child's view of himself never exactly reflects other people's picture of him, but it is certainly greatly influenced by others" (18, p. 172). Thus, a person's outward behavior may reflect this influence.

Although some differences were noted between play therapy and non-play-therapy groups in grades and teachers' observations of subject behavior, no trends or differences were found when the subjects were polled about their attitude toward school. Apparently, what the subjects felt toward their earlier poor school adjustment was not as readily modified or forgotten as was the ability to demonstrate observable behavior change.

Since a major objective of play therapy is to help children express and deal with their emotions, the degree and kind of emotions expressed by the children are important
to examine. Subjects in this study apparently had poor or moderate feelings about themselves and poor attitudes toward school. Moustakas (20) studied the effects of play therapy on the frequency and intensity of the negative attitudes of nine well adjusted and nine disturbed children. His study concluded that through the play therapy process, negativism decreased for the disturbed group. Negative expression, both verbal and non-verbal, toward other individuals and toward the surrounding environment, decreased, while overall expression of positive attitude increased. Thus, when considering the poor attitudes exhibited by all subjects toward their school environment, the findings of this study appear to be in contrast to those of Moustakas. When considering self-esteem and school-related behavior together, authorities in child guidance have drawn a parallel between self-esteem and attitude toward school. Shumsky describes the self-picture of a child in school who copes with his present circumstances in a way that builds effectively for the future.

He behaves as one who believes in his capacity for taking an active part in shaping his own "life chances." He proceeds as one who can effect a change in his life situation. He is assertive rather than passive in his approach to intellectual tasks. His way of coping bespeaks an undercurrent of self-reliance and optimism (24, p. 189).

Several studies have indicated support of the hypothesis that students who do not achieve well at school have a less
favorable view of themselves than do successful pupils (4, 7, 13, 16).

In summary, the fact that there were not many statistically significant contrastive findings between play therapy and non-play-therapy subjects in this study may have been due to several factors. First, the instruments utilized in this study may not have been sensitive enough to differentiate between subjects; this has been a point of concern in at least one play therapy study, where parents' and teachers' observations of the child's behavior indicated a shift toward improvement, although instruments utilized showed no change (17). In addition, when interviewing mothers of subjects, the general impression was one of emotional over-investment in their children. It would seem to require an unusually strong and independent child to follow a self-exploratory direction in such home environments. Jersild states of this relationship that the child "... is trying to cope with figures more powerful than himself. If he tries to protect himself from disapproval by being a good child, he may be driven into a state of self-surrender, curbing his impulse to become a person in his own right" (18, p. 178). It may be, then, that some adjustment in the total therapeutic approach may be helpful in facilitating a more objective posture on the part of mothers in daily interaction with their children.
Axline (1) suggests putting both the child and the parents in the playroom setting, because it allows the child the medium of expression that he knows. It further allows him to begin verbalizing within the family in a comfortable setting. Fuch (12) believes that it becomes a learning experience for a mother when she really begins to watch her child's play and learns to listen to what her child is saying. Not only is the mother able to assist the child in problem solving, she is also able to develop observational skills for herself.

According to Axline (1), at the end of successful therapy the child is taking responsibility for his own feelings and behavior. Ownership of feelings and behavior may be an important factor in the present investigation, since the majority of subjects were referred for play therapy due to irresponsible behavior demonstrated at school. The fact that limited improvement in school-related behavior as seen by teachers was occurring in play therapy subjects in this follow-up study may indicate a need for (a) measures which can be applied at termination of therapy to determine if the child has achieved responsibility for himself, (b) perhaps reinvolve ment in therapy when parents see regression from positive behavior that the play therapy process may have succeeded in only temporarily instilling, and (c) more involvement with home and school environments while the child is in counseling.
Findings

The purpose of this study was to investigate and describe the long-term effects of play therapy on social contacts, self-esteem, school-related behavior patterns, level of academic functioning, and attitude toward school and family relations. Some means and individual scoring patterns, as well as significant differences found on several subscales of the Family Environment Scale, indicate some possible differences between comparison groups.

The following findings are presented as a result of the statistical analysis and interpretation of the data related to this study. Caution should be exercised in generalizing to other play therapy populations.

On question one:

1. The length of time following play therapy contact does not appear to have an appreciable effect on social-contact.

2. The length of time following play therapy contact does not appear to have an appreciable effect on self-esteem.

3. The length of time following play therapy contact does not appear to have an appreciable effect on school-related behavior. However, individual scoring patterns show more subjects in the group six to ten years out of play therapy with higher school-related behavior patterns than subjects in the group one to six years out of play therapy.
4. The length of time following play therapy contact does not appear to have an appreciable effect on the level of academic functioning. However, individual scoring patterns show more subjects in the group six to ten years out of play therapy (Group II) with a 1.00 or better grade average improvement than subjects one to six years out of play therapy (Group I).

5. The length of time following play therapy contact does not appear to have an appreciable effect on attitude toward school.

6. It cannot be determined whether the length of time following play therapy contact had any effect on the child in relation to the family. However, statistically significant results show subjects six to ten years out of play therapy (Group II) perceiving more independence in their families, while parents of subjects one to six years out of play therapy (Group I) perceived more family recreational activity in the home. In addition, between-group differences indicated a nearly significant difference in that Group II showed more disagreement on achievement orientation than occurred in Group I.

The length of time following play therapy had minimal impact on the general amount of agreement or disagreement between subject and parent on perceived values within the family. However, mean scores indicated less disagreement than occurred in a comparative normative sample.
On question two:

7. Play therapy does not appear to have an effect on social contact. However, mean scores and individual scoring patterns indicated that play therapy subjects had considerably more social outreaching than their evaluation-only counterparts.

8. Play therapy does not appear to have an effect on self-esteem.

9. Play therapy does not appear to have an effect on school-related behavior. Individual scoring patterns showed more subjects in the group six to ten years out of play therapy scoring in the higher column, representing good school-related behaviors, than were found among the evaluation subjects.

10. Play therapy does not appear to have an effect on level of academic functioning. However, individual scoring patterns show more subjects in the group six to ten years out of play therapy achieving a 1.00 or better increase in their grade-point average than in the group of their non-play therapy counterparts.

11. Play therapy had no positive or negative impact on attitude toward school.

12. It cannot be determined whether play therapy had any effect on the child in relation to the family. There were statistically significant differences, with subjects one to six years out of play therapy perceiving more organization in their homes than their evaluation-only counterparts,
while parents in the group one to six years out of play therapy perceived significantly more cohesion than did parents in the evaluation-only comparison group. In the opposite direction, parents of the group one to six years since evaluation valued goal-oriented behavior more highly than did their play therapy counterparts. There were also statistically significant differences in the category six to ten years on home and family relations. Subjects in the category six to ten years out of play therapy perceived more independence in their homes, while their non-play-therapy counterparts perceived more family recreational activity occurring. Between-group differences occurred in cohesion, expressiveness, and moral-religious emphasis, with non-play-therapy subjects and parents disagreeing on these values significantly more than their play therapy counterparts.

Play therapy had minimal impact on the general amount of agreement or disagreement between subjects and parents about perceived values within the home. However, mean scores indicated less disagreement than occurred in a comparative, normative sample.

Conclusions

As a result of the findings of this study the following conclusions were drawn.

1. Home relations are a significant area to be examined in further play therapy research.
2. A definite conclusion is difficult to draw, when considering the effects of time on play therapy subjects. There were some trends favoring the older play therapy subjects; however, maturation may have influenced these outcomes.

3. It seems important to note that means and individual scoring patterns indicate that play therapy has an impact on some aspects of school-related functioning, although a definite conclusion cannot be drawn.

Recommendations

In view of the results of this investigation, the following recommendations are made:

1. This study should be replicated in order to further investigate basic behavioral changes as a result of play therapy.

2. Future follow-up studies should aim toward a much larger subject sample, in order to provide a larger basis for comparison, or should focus on smaller in-depth case studies.

3. Further follow-up studies should include data relating to the research variables recorded at the initiation of treatment or evaluation, at termination of therapy, and at follow-up. This procedure would better insure evaluation of progress with the passage of time.

4. Future follow-up studies should include an evaluation of personality variables and family relations with the
sample population including both parents and children, to determine what variables between experimental subjects and control subjects are associated with remaining in or leaving play therapy.

5. A study is needed to investigate the impact of school and home environments on children involved in play therapy.

6. Future follow-up studies should compare groups on the basis of the reason for referral.

7. Future follow-up studies should utilize creative criterion measures.

8. Future studies measuring attitude toward school should not use the Survey of Study Habits and Attitudes test, due to the length of administration time required.
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APPENDIX A

Dear Mr. and Mrs. ______________________:

I am currently engaged in gathering information concerning children who have been seen in the past at the Pupil Appraisal Center at North Texas State University. Our records show that __________________ was seen during 19___ by us. By returning the enclosed self-addressed envelope and information listed below, you will be most helpful.

Sincerely,

Michael R. Carns
Graduate Assistant
Pupil Appraisal Center
North Texas State University

Mr. and Mrs. ______________________
Address ______________________
______________________________
Telephone ____________________
APPENDIX B

PARENT INTERVIEW

I would like to ask you some questions concerning your son/daughter who was referred to the Pupil Appraisal Center.

All information gathered will be confidential and no names will be used in reporting the results of this study. There are no right or wrong answers to these questions so please feel free to react with whatever information you see as being helpful.

1. How would you describe __________ when you first brought him/her to the Pupil Appraisal Center? (What was he/she like?)

2. How would you describe __________ now? (What is he/she like now?) (attitudes, behavior, etc.)

3. What would you say is most different about him/her now?

4. Please describe your concerns about __________ when you made initial contact with the Pupil Appraisal Center. (What was bothering you most or what was the problem?)

5. Is that (No. 4) still a concern or still causing him/her trouble?

6. In general, describe his/her relationship with children and adults.
7. Could you give me some examples of things you and _________ frequently enjoy together?

8. Could you give me some examples of when you have been especially proud of _________?

9. How would you compare _________ to other children his age in terms of self reliance and independence?

10. Do you think _________ considers himself/herself generally better, worse, or about average in respect to his/her friends. What does he/she do to lead you to feel that way?

11. In general would you say _________ relates most easily with people who are older, younger or his/her own age. What about him/her leads you to believe that?
APPENDIX C

I __________________________ give my permission for the collection of information concerning ____________________.

I understand this information is to remain confidential and will be used for no other reason than has been explained to me.

Signed __________________________

Date __________________________
This study is being undertaken to investigate the long-term effects of play therapy on school behavior as well as home and family related behavior. To date the body of knowledge concerning this subject has been extremely limited.

Individuals from which data is to be elicited are children and their families who received counseling at the Pupil Appraisal Center of North Texas State University. These were children referred by parents, teachers, and counselors between September of 1967 and September of 1976.

Procedures will include a home visit, in which signed parent permission for collection of school related data will be obtained. Information being requested from the school will be the subject's grades from the six weeks period prior to initial contact with the Pupil Appraisal Center as well as the grades of the child's most recently completed semester. In addition, it is requested that two of the student's current teachers of required subject areas be asked to complete the Self-Esteem Behaviors Form, designed to assess the teacher's perception of the child's school related behavior. It is anticipated that this will require approximately ten minutes of the teacher's time.

Should your school be interested in the results of the data analysis, this information will be gladly supplied.

Thank you for your interest.

Michael R. Carns
Doctoral Student
Counseling and Student Personnel Services
North Texas State University
Denton, Texas
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