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The effectiveness of play therapy in a school-based counseling program

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THE EFFECTIVENESS OF PLAY THERAPY IN A SCHOOL-BASED COUNSELING PROGRAM

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Aimee Marie O'Keefe

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ABSTRACT

This research project attempted to determine whether play therapy used to treat elementary and junior high school children in a School-Based Counseling program is effective. There is conflicting evidence in the literature as to the effectiveness of therapy with children, especially play therapy. This project used a qualitative design to evaluate play therapy used in a School-Based Counseling (SBC) program. Randomly selected case files from the 1998-1999 academic year were analyzed using questions considering demographic information for each child, the reason the child was referred to the program, the intervention used by the therapist, and the outcomes of therapy. The results of this project are inconclusive, but support the need for more research to be conducted in the area of play therapy.
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"Play therapy ingeniously undertakes the hard work of child psychotherapy in the appealing guise of play" (Webb, 1991). According to Web (1991), play therapy has been recognized since the 1920's when Anna Freud used play as a way to build relationships with her child clients. Other therapists followed her lead, using play in many ways (Webb, 1991). Play was used to interpret the child's feelings, as well as make assessments and diagnoses. Virginia Axline (1947) even describes play therapy as a "method of helping problem children help themselves". Webb (1991) suggests that although play therapists have different theoretical perspectives, and use different techniques, they all seem to agree that play is vital in the treatment of children.

Play is a necessary component in the lives of children. Children do not simply play because they have excess energy and nothing to do with their time (Landreth, 1982). Play is purposeful. Children use play to communicate with others, to express feelings and emotions, to explore relationships with peers and adults, and to cope with painful or confusing experiences (Fall, Balvanz,
Johnson & Nelson, 1999; Landreth, 1982; Singer, 1993; Webb, 1991). Play is a child's natural medium of self-expression (Axline, 1947). Play is also an important element of the development process (Russ, 1998). It helps children develop the skills they need to interact with others, communicate, and cope with difficult situations.

Children do not communicate with words the way adults do because their language skills are still developing (Fall, Balvanz, Johnson & Nelson, 1999; Lucco, 1991). Instead, children communicate through play. They interact with their peers in a way that is understood by the rest of the group. Some children, however, have not developed the skills necessary to take part in activities considered normal for their age group. Some of these children may have experienced some kind of trauma that has led them to close themselves off from others. Others may not have gotten socialization experiences from interacting with other children their age. Some of these children have such poor communication skills that they cannot compensate for this lack of skills through normal play. Peers and adults often penalize children with poor communication skills and social or behavioral problems. This can lead to feelings of frustration, anxiety and guilt, which are associated
with low self-esteem or a poor self-concept (Glenn & Smith).

When all of these things are considered, it can be seen that there is a need to ensure that children are given a chance to develop appropriate social skills, appropriate behavior, high self-esteem and a good self-concept. Play therapy can be an effective way of teaching these skills to children, particularly to those children who do not communicate effectively with adults. Play therapy can also be an effective way to help children process through a crisis. While intervening in a crisis situation, a therapist can administer play therapy in a way that encourages children to feel free to make mistakes without the fear of ridicule. The child can make contributions that they can be proud of, and make their own choices (Brown University, 1998). This self-determination given to children by their therapists empowers children and encourages them to continue to grow and develop while they are working through their pain.

It is important then, to take a closer look at play therapy and what it accomplishes. There have been inconsistent findings as to the effectiveness of various interventions in the school counseling setting, as well as
other clinical settings (Burnett, 1998; Fall, Balvanz, Johnson & Nelson, 1999). A 1985 study (Phillips, 1985) attempts to make sense of the little empirical evidence available that attempts to show that play therapy is effective. Phillips (1985) explains that all of the information up to that point regarding play therapy was based mostly on theoretical literature written by authors such as Axline (1947; 1964), Landreth (1982) and Moustakas (1959), with little empirical or scientific evidence to back it up. According to Phillips (1985), Virginia Axline’s books (1947, 1964), along with the writings of other experts in the field were based on clinical theories and experiences, not the results of experiments.

The information gained by the completion of this project attempts to add to the existing body of empirical evidence regarding the effectiveness of play therapy interventions with children. The project is qualitative and has been conducted according to the post-positivist paradigm. It is exploratory in nature. The study is small and attempts to show an association between play therapy and the improved social functioning of children. This study attempts to show that using play therapy to intervene with children that have experienced some type of dysfunction or
trauma can improve their behavior, social skills, or emotional problems.

As it is the goal of all social workers to improve the social functioning of their clients, this project is especially useful. There are many questions as to the effectiveness of play therapy as a treatment intervention. By examining play therapy interventions, the researcher hopes to shed some light on the answers to these questions. The main goal of this project has been to determine whether play therapy in general is effective. However, there are other things, such as the types of play therapy interventions that school based counselors use with children, and what types of presenting problems play therapy is most effective in solving that were also explored.

LITERATURE REVIEW

"'Play Therapy' is a psychological therapy that utilizes developmental stages and toys, games, creativity, imagination and other common aspects of childhood expression, experience and skills as a way to help an individual resolve psychological issues that are not or cannot be resolved by more standard talking therapy." (CBT
Institute, 1995) This somewhat complicated definition of play therapy illustrates the complex considerations a clinician must make when using play therapy to treat children. Play therapy has been described as a non-threatening treatment modality that is especially effective with children who cannot or will not communicate verbally about the problem that caused them to seek treatment (Axline, 1947; Webb, 1991). Landreth (1993) states “The elementary school counselor uses play therapy with children because play is the child’s symbolic language of self-expression, and for children to play out their experiences is the most natural, dynamic, and self-healing process in which children can engage.”

Singer (1993) expresses the belief that play therapy with children is an essential part of the healing process. She presents several case examples of experiences that children have endured. Through these examples, Singer shows how working with these children using play therapy has improved their lives in significant ways. Webb (1991) suggests that children are especially susceptible to the effects of stressful or traumatic events because they do not yet have the coping skills necessary to handle the confusion of serious life events. Webb writes with the
assumption that a crisis can happen to anyone, even children, regardless of previous pathology or history of crisis. Webb places emphasis on the perception by the individual of the event leading to a crisis. This emphasis suggests that each individual will cope differently with an event, and that an incident may or may not lead to a crisis situation. Children, however, usually have not developed the coping skills necessary to handle crises. Play therapy can be used effectively in treatment with these children.

Play therapy utilizes the child's natural form of expression to process feelings and events related to the trauma from which he or she has suffered (Chethik, 1989; Webb, 1991). Play therapy also allows the child to remain somewhat removed from the traumatic events without denying that they have occurred. This allows the child to work through the issues of abuse at his or her own pace without creating more harm than good (Webb, 1991). Play therapy also allows for a continuing assessment of the child's situation and progress in treatment. Play Therapy considers the special issues related to children with regards to therapy.

As can be seen in the writings of Webb (1991), Singer (1993), and Gil (1991), as well as the works of many other
authors in the field, play therapy can be used for almost all problems that children experience. All of these authors present case examples showing children who suffer from such things as abuse, neglect, loss, medical crises, and behavior or adjustment problems. Some of these issues take long-term intensive therapy to improve, while others take only a few weeks of intervention before the child is able to work through the crisis.

An example where play therapy can be especially effective is in improving a child’s self-esteem. Several conditions have been suggested to make therapy with children as effective as it can possibly be in improving self-esteem. One of these suggestions is allowing children the freedom to make mistakes without the fear of being ridiculed or penalized. A second suggestion is to allow children to participate in activities that are important contributions of which they can be proud. A final suggestion is to give children the chance to make their own choices about their actions. According to a letter published by Brown University (1998), following these guidelines can help to improve the self-esteem of a child. This is only one of the goals of play therapy, but it is
easy to see how play therapy easily fits the conditions of these suggestions.

If children are allowed the sense of power that comes from directing their own activities, and that they cannot get by participating in activities directed entirely by adults, they may experience the benefits of a more positive self-concept (Unterspan, 1996). Axline (1947) would agree that this non-directed use of play therapy is especially beneficial. Axline advocates for a client-centered approach in her 1947 book. She expresses the belief that the child holds the capacity to change, and the way to accomplish that change, within himself. She suggests that active interaction by the clinician with a child through play therapy is necessary to allow that child to make the appropriate changes.

Play Therapy Interventions

There are many possible play therapy interventions that can be used to work with children. The agency at which this research project was conducted encourages the use of art, books, games, or any other technique the therapist can adapt to the therapy session.
Ordinary games can be used to reinforce positive behavior in children with classroom behavior problems. Schaefer and Reid (1986) ask their readers if there is any better way to teach children how to be civilized and well adjusted than to teach them how to participate in playing games. According to these authors, games can also be used to help a child learn to communicate or problem solve. It has been this researcher’s experience that games can also be used to build a relationship between the child and the therapist and create a relaxing and comfortable atmosphere for the child. A child becomes more comfortable with an adult who will play “Chutes and Ladders” with her than with an adult who sits across the room and asks questions about her feelings. Not only do children enjoy games, but games also give children a boost in physical, cognitive, emotional and social development (Schaefer & Reid, 1986).

The use of specially designed therapeutic games, such as the Talking, Feeling and Doing game, is also helpful. These types of games use scenarios and questions related to many of the issues for which many children get referred to counseling (Gardner, 1986). According to Gardner (1986) these games reframe painful or uncomfortable events into a positive interaction between the child and the therapist.
They also allow for a dialogue to take place between the child and the therapist in a way that is not intrusive or unwelcome. Gardner (1986) also suggests that the use of such games can encourage children to open up when they usually would not.

Bibliotherapy is also a good option to use when working with children (Rudman, Gagne & Bernstein, 1993). According to Rudman, Gagne and Bernstein (1993), a child can identify with a character the same age that is experiencing a similar problem, and will begin to understand that he is not alone in his feelings. These authors also suggest that books give the child a chance to dialogue with the therapist about the issue for which he is being treated using a vocabulary that both the therapist and the child can understand.

Art is seen as another very useful form of treatment. It is especially useful in the assessment of a child’s problem. Kaufman and Wohl (1992) explain how projective drawing tests, such as the House-Tree-Person (HTP) drawing or the Kinetic Family Drawing (KFD), can be used to determine how a child sees herself, or the environment around her. These authors explain that a child will project feelings and perceptions onto their drawing. They
explain that by discussing the details of the drawing with the child, a therapist can gain important insights into the child’s world.

Another projective play technique very similar to art therapy is the use of mutual storytelling. This technique, as explained by Gardner (1971), involves assessing the child through a storytelling process and then giving the child a more desirable approach to the situation through the telling of a second story by the therapist. In Gardner’s approach, the child is asked to tell a story about anything. The story should include a beginning, middle and end, and the story should have a moral or lesson. The therapist listens carefully to the story and responds with her own story. The therapist’s story also has a moral or lesson and should show the child another possible solution to the events of the original story.

The squiggle story game is a way that children’s drawings can be combined with the mutual story telling technique (Weiland, 1992). In the squiggle story game, the therapist and the child take turns creating drawings based on squiggles created by one or the other. After a series of drawings are created, the therapist tells a story that relates to the child’s issue. Weiland (1992) states that
insight gained by children does not always need to be expressed using adult language. He explains that games like the squiggle story game draw on the subconscious of both the child and the therapist, allowing the child to process through grief or trauma without the need for verbalization by the child or the therapist. This leads to a resolution of the issue in a way that benefits the child and does not further traumatize the child.

Another form of play therapy that utilizes the subconscious of the child is sand tray therapy (Dundas, 1990). According to Dundas (1990), there are universal symbols that are attached to objects used in sand tray therapy. These objects are used in a way that seems to be repeated by many children. These universal symbols are then given deeper meaning by each individual. As children work with the objects in the sand tray, they seem to follow a series of phases that mirror the events that are taking place in their life. As the child makes changes in the world he created in the sand-tray, he begins to feel empowered. The child is given control over the fantasy world and therefore feels he has more control in the real world (Dundas, 1990). All of this change takes place at a sub-conscious level and with little verbalization.
These interventions are just a few that can be used in play therapy. The creativity of the therapist can allow for many more innovative techniques to be used. The child may also suggest ways to work through issues by his actions or by what he says to the therapist. It is important that the clinician pay close attention to the cues the child gives in order to provide the most effective intervention.

Play Therapy Research

Phillips (1985) states that most of the information that exists in the literature regarding play therapy comes from theoretical writings of clinicians’ experience rather than empirical findings. Phillips (1985) further states that these theories are rarely tested, and that when they are, there is little evidence found to support them. He suggests that this may be the case because the majority of play therapy is conducted by clinicians whose priority is the well being of their clients. Research, therefore is seen as secondary to the clients’ needs. Most clinicians who use play therapy know that it works because of years of clinical experience, not from conducting research or scientific experimentation.
Phillips (1985) also suggests, “Play therapy in general suffers from a credibility problem” and “children’s play is taken only half-seriously.” Society does not recognize play as important and necessary. Most People view play therapy with a great deal of skepticism, not understanding how children can be helped with their serious problems just by playing with a therapist. The credibility of play therapy is not improved when many clinicians who use play therapy cannot articulate an explanation of the process that allows play therapy to work.

A 1998 article (Russ, 1998) cites a study that concludes that play results in improvement in child development. Russ (1998) also suggests that there is a positive relationship between play and coping skills. This suggests that children who play and play well are more able to develop coping strategies for many situations (Russ, 1998). This same article suggests that play is also related to adjustment. Russ claims “children who engage in make-believe play are better adjusted across different situations.” Normal development and adjustment are two key elements that allow children to interact with peer, teachers and their parents, as well as to function properly in school and at home.
The article by Russ (1998) also presents three guidelines for furthering research in the area of play. The first guideline calls for more laboratory research on play and problem solving. This includes identifying the many dimensions of play and conducting systematic experiments to determine the effectiveness of play interventions. The second guideline suggests refining specific play techniques. This includes differentiating between play techniques and facilitating play as and intervention. The third guideline calls for developing "intervention modules" focused on specific needs. These modules can be introduced to children at different times throughout treatment as the therapist sees appropriate.

Russ (1998) cites the 1985 article by Phillips, suggesting that these two authors agree that play therapy needs to be systematically researched in order to get a better understanding of the effectiveness of its many interventions. Both authors have seen a positive outcome with focused and specific play therapy interventions when they are used on such issues as behavior and adjustment. Both authors, however, call for more exploration of the subject of play therapy in order that more conclusions can be drawn. Further research is also needed to support the
clinical and anecdotal evidence that can be found in the literature.

The Role of Family

The support of other family members seems to be an important factor in the psychological treatment of children. Bratton, Ray, and Moffit (1998) have shown the importance of support from grandparents who are raising their grandchildren. Grandparents have always been viewed as a crucial support system to families. The active support of grandparents who are raising their grandchildren is seen as especially essential to the ability of children to cope with the permanent or temporary loss of their parents.

If support from grandparents who are raising their grandchildren is so important, it can be also assumed then that the interaction between parent and child is also important to the healing process. Urquiza and McNeil (1996) present an intervention strategy that involves the use of parent-child interaction. This intervention, based on social learning theory, teaches the parents and the child how to change the dysfunctional behaviors that lead to abuse. This intervention provides live coaching for both
child-directed interaction and parent-directed interaction. Through these two phases of treatment, the parents and the children are taught how to interact with each other during play. The activity is directed by both parent and child while allowing both parent and child to develop better skills and behaviors. By using this type of therapy for treatment, the therapist is improving the parent-child interaction in a way that makes the home environment a safer and more nurturing place for the child. Interventions in the home help to support the interventions taking place in the therapy sessions, making them more beneficial for all involved.

The Role of Culture

The issue of cultural differences as they relate to play therapy is also addressed in the literature. Juarez (1985) explains that it is necessary for clinicians working with minority children to examine their beliefs and feelings toward children from other cultural backgrounds. Juarez also asks clinicians to evaluate their attitudes toward issues of acculturation. A third area to which Juarez believes clinicians need to pay close attention is the assumptions made of Hispanic children. She explains
that this group is heterogeneous, and assumptions should not be made about an individual based on the knowledge that the child is Hispanic.

Martinez and Valdez (1992) explain that children of different cultural backgrounds may play differently. These authors suggest that play therapists have games, toys, dolls, music and books from many different cultures available to children in order to accommodate children from a variety of cultural backgrounds. These authors show through case examples that children who have been exposed to different experiences based on their cultural backgrounds will engage in play based on their backgrounds. A Hispanic child using a kitchen set may make burritos whereas an American child might make hamburgers.

The point of addressing cultural issues is to not make assumptions about any child. Clinicians should always be aware of possible differences and should be responsive to these differences. The therapist should acknowledge the differences of each child as a unique and essential part of who that child may be. Therapists should also respond positively to differences, reinforcing a positive self-concept. By doing these things the clinician aids the
child in the development process and achieves a goal of play therapy.

The Need for Research

Play therapy literature is filled with theory, suggestions and speculations. The literature falls short at empirical evidence. The fact that play therapy is effective is well accepted by many. However, there is little empirical evidence to support this. It is necessary then to conduct studies to evaluate play therapy and explore the many aspects of this often used intervention. Russ (1998) states "Play has an important role in child development and is a major intervention approach in child psychotherapy." Russ (1998) goes on to say that it is necessary to integrate current literature in play therapy with current literature on child development in order to develop effective interventions to be used with children. It is the aim of this research project to add to the existing literature, and maybe move a step closer to reaching the answers sought by so many researchers.

By examining and evaluating the play therapy techniques used in an existing school based counseling
program, the researcher hopes to find some empirical evidence to support the theories that guide play therapy.

Purpose of the Study

The main purpose of this study was to evaluate the effectiveness of several types of play therapy used by therapists in a School Based Counseling (SBC) program. The types of play therapy that were evaluated by this project include such techniques as projective art, therapeutic and non-therapeutic games, the use of books, and projective play with puppets or doll houses. By examining these techniques, the researcher hoped to get an understanding of children's responses to such interventions, as well as an indication of which interventions are most effective in treating specific types of problems.

The project is qualitative in design therefore, it was not expected that a true cause and effect relationship would be shown by this project. Instead it was hoped that a trend would be found in the data that might indicates how children respond to play therapy interventions.
Hypotheses

It was expected that the researcher would find the following:

1) Play therapy is more effective with children than discussion therapy and will result in a positive treatment outcome.

2) There is an inverse relationship between the number of referral items marked and the outcome of treatment. The more referral items marked, the less likely there will be a positive outcome in treatment. This is due mostly to the time limits in treatment designated by the SBC program.

3) Behavior modification and games will work better with behavior problems such as disruptive classroom behavior and oppositional/defiant behavior than any of the other interventions, resulting in a positive treatment outcome.

4) Projective play, art and play dough will work better with emotional problems, such as sadness/depression and anxiety than any of the other interventions, resulting in a positive treatment outcome.
METHODS
Sample Selection and Data Collection

Data were collected from a community family counseling agency. This agency provides local junior high and elementary schools with a School Based Counseling (SBC) program. Access to this agency was obtained through the researcher's position as a therapist in the School Based Counseling program. The therapists working in the SBC program are master's level interns who receive weekly clinical supervision. The interns are also trained in writing treatment notes and reports and complete all of the case files that were evaluated for this study.

Files from the 1998-1999 academic year were randomly selected and evaluated using the survey questions listed in Appendix I. Every fifth file was examined until one hundred (100) files were reviewed. Data were only collected by the researcher. She evaluated each case file by answering all questions listed in the data collection survey.
Instrument Development

Data were collected using the survey questions developed by the researcher (see Appendix B). These questions were developed based on the information that is available in every case file used in the SBC program. Each file contains a referral, an intake form, session notes from each session, a case disposition report and a closing summary. The questions developed for this project were derived from the information contained in each of these reports.

Protection of Human Subjects

There has been no contact with participants for this project. All data was collected from existing files. All of the children who participated in the SBC program during the 1998-1999 academic year are no longer eligible to participate in the program. This ensures that no contact will be made with the students. No names are used in this project, and confidentiality has been protected by the researcher at all times. Informed consent to collect data
was obtained by the community family counseling agency (see Appendix C).

RESULTS

This qualitative project examined the use of play therapy interventions in a School-Based Counseling (SBC) program. Data were evaluated by examining frequencies, means and other descriptive statistics. A t-test was performed in order to test the hypothesis that the more referral items marked, the less likely there will be a positive outcome in treatment. The following results were obtained.

The sample consisted of one hundred (100) case files, including children from kindergarten to eighth grade. The children ranged in age from four to fourteen years of age, with the average age being about nine years old. The children came from a variety of ethnic backgrounds with the majority being either Latino/Hispanic (39%) or Caucasian (32%). 8% of the sample were African American children, 1% were Asian/Pacific Islander children. The rest of the children were of mixed or unknown ethnic descent. More than half of the children (61%) were male.
The initial referral form, or request for services, included the following problem areas: problems with classroom behavior, sadness/depression, anxiety, oppositional/defiant behavior, elimination disorders, and health complaints. There was also a place on the referral form for the person referring the child to include a description of any problem not included on the list. Reasons listed on the referrals that fit into this "other" category included things such as, separation or divorce, domestic violence, loss of a family member, and hospitalization or surgery. In almost every case, the initial referral included items in more than one problem area. The number of referral items marked ranged from none to 26, with the mean of 5.7.

The areas that were marked the most often on these referrals were classroom behavior and oppositional/defiant behavior. 48% of the cases included classroom behavior as a referral reason, while 41% of the cases had oppositional/defiant behavior marked as a referral item. Sadness/depression was marked as a referral reason in 30% of the cases. Anxiety was marked in 16% of the cases, "other" was marked in 10% of the cases, and health complaints were marked in 6% of the cases. Elimination
disorders were not given as a reason for referral in any of the cases reviewed.

There was also an opportunity for the parents or guardians of the child to give the presenting problem in their own words during the intake. The presenting problems reported by parents or guardians were divided into the same categories as the reasons for referral. Presenting problems as given by parents or guardians also included more than one problem area in most cases. Because teachers, principals and other school staff made up a large number of the people who referred children to the program, the reasons the parents gave as presenting problems differed somewhat from the reasons listed on the initial referral form (see Table 1).

"Other" became the most often cited presenting problem. 47% of the cases included some reason in the "other" category as the presenting problem. Only 19% of the cases included classroom behavior as a presenting problem. 22% included oppositional/defiant behavior as a presenting problem. Sadness/depression was given as a presenting problem in 11% of the cases, and anxiety was given in 3% of the cases. Elimination disorders was given as a presenting problem one time, while health complaints
were not mentioned by parents or guardians as a presenting problem.

Each case included a treatment plan in which the therapist gave the goals of treatment. These goals were also divided into the same categories as the referral items and the presenting problems. The "other" category was used most often to describe the goals of treatment. This category includes specific goals such as, "discuss feelings related to parents' divorce", and "provide child with alternative ways to express anger". "Other" was given as goal of treatment in 68% of the cases. Improve classroom behavior was a treatment goal that was given in 27% of the cases. Decrease oppositional/defiant behavior was listed as a treatment goal in 11% of the cases. Decrease sadness/depression and decrease anxiety were each given as treatment goals in 8% of the cases. Decrease enuresis/encopresis and decrease health complaint were not listed as goals of treatment in any of the cases reviewed.

During data collection, a variety of interventions were found to be used by the therapists. These interventions were grouped into eleven categories. These categories were: art, games, discussion, worksheets, read book, behavior modification, role play, free play, play
dough, relaxation and projective play. In most cases, a number of interventions were combined by the therapist in each session. The number of times an intervention was used in each case was recorded. Art, games and discussion were found to be the most frequently used interventions. All of the categories of interventions were used at least once or twice in most cases.

Any time discussion was used as an intervention, it was used in combination with other techniques. This made it difficult for the researcher to test the hypothesis that play therapy is more effective with children than discussion therapy and will result in a positive treatment outcome. Discussion was used in 93% of the cases. Only five cases did not use discussion, and there were two cases where the intervention used was not specified. In 58 cases where discussion was used, there was also a positive outcome in treatment. In 34 cases where discussion was used, there was also a negative outcome in treatment (see Table 2).

Games and behavior modification were combined with other treatments and used for many types of presenting problems. Games/behavior modification was used in 80% of the cases. In 18 cases, there was no games/behavior
modification used, and there were two cases where the intervention was not specified. In 51 cases where Games/behavior modification were used, there was also a positive outcome in treatment. In 28 cases where Games/behavior modification were used, there was also a negative outcome in treatment (see Table 3).

Art and projective play were also combined with other treatments and used for many types of presenting problems. Art/projective play was used in 86% of the cases. In 12 cases, there was no art/projective play used, and there were two cases where the intervention was not specified. In 56 cases where art/projective play were used, there was also a positive outcome in treatment. In 28 cases where art/projective play were used, there was also a negative outcome in treatment (see Table 4).

61% of all files examined reported positive treatment outcomes. A positive treatment outcome means that the therapist reported that the goals described at the beginning of treatment were met by the last session. The number of sessions ranged from 0 to 16, with the average number of sessions being 10. This is consistent with the agency's policy of seeing clients for a total of eight to twelve sessions.
A t-test was used to test the hypothesis, there is an inverse relationship between the number of referral items marked and the outcome of treatment. The more referral items marked, the less likely there will be a positive outcome in treatment. The result of this test was not significant. Positive treatment results were associated with a mean of 5.16 referral items marked. Negative treatment results were associated with a mean of 6.39 referral items marked. These two averages are very similar, showing that there is little difference in the relationship between positive treatment results and the number of referral items marked, and negative treatment results and the number of referral items marked.

DISCUSSION

The results show that the interventions used by therapists in the School Based Counseling (SBC) program are often combined. Many of the interventions are also used only once or twice per case. This makes determining the effectiveness of certain types of interventions very difficult. There was no way to tell if any intervention worked better than any other, or whether any intervention
worked best with any specific type of presenting problem. This suggests that there is a need to develop a way to compare the different types of interventions used in therapy with children.

However, it may be that using a combination of play therapy interventions is the best way to produce a positive outcome in treatment. By combining interventions, the therapist has more flexibility and a greater ability to respond to what the child brings into the session. Axline (1947; 1964) would suggest that the child choose the type of play used during each session. This may result in either a variety of types of play used by the child, or a specific type of play used over and over by the child.

It is difficult to tell whether the time limit placed on treatment by the agency had any effect on the outcome of treatment. The agency policy states that the therapist may see a child for a maximum of eight to twelve sessions, unless there are special circumstances that may lead to more sessions. It was assumed by the researcher that this would limit the types of problems with which the therapist could effectively work during treatment. There was nothing in the results to support this assumption. It is unclear
whether short-term play therapy is more effective with some kinds of problems than with others.

Also, the researcher believed that the more referral items that were marked on the initial referral, the less likely the therapist could address all of the child's issues, and therefore there would be a negative outcome to treatment. The t-test used to test this hypothesis was not significant, so it might be assumed that the number of referral items marked is not a factor in treatment outcome. These results, however, may have been influenced by the way in which the data were collected. It seems that the therapists who participated in the SBC program were able to either focus on just a couple of the areas, or the therapist was able to combine some interventions to address several problem areas at once. It would be helpful to take a closer look at this in future research.

The role of family in the outcome of play therapy treatment is unknown. Some authors suggest that the support of family members is essential in the treatment process (Bratton, Ray, & Moffit, 1998; Urquiza & McNeil, 1996). This study has shown that there is a difference in how the school staff perceives the child’s problem and how the parents of the child perceive the problem. It seems
that teachers see the problems of these children mostly as disruptive classroom behavior. They refer the child to the SBC program in order for these problems to be fixed. The parents or guardians of the child, on the other hand, have more information about the child’s life. They may have better insight as to why the child is experiencing difficulty in school. This would make the parents or guardians of the child a valuable asset to the therapist throughout the treatment process.

The impact of ethnicity, or the child’s culture on the outcome of play therapy is also unknown. Some authors suggest that specific cultural traditions and rituals be considered when using play therapy as a treatment with children (Juarez, 1985; Martinez & Valdez, 1992). It may be useful for the therapist to develop specific play interventions that rely on the cultural experiences and language of the child. This project took place in an agency that serves a high number of ethnic minorities. Because of this, it could be especially important for this and similar agencies to know what the impact of culture on treatment may be.

It was expected that the findings of this study would be limited. Generalizations should not be made based on
this study because the sample is fairly small. Also, because the data was retrieved from existing files, the researcher was very limited as to the kind of information she could obtain. There was no way to control for intervening variables. There was no way to know whether any other intervention the child may have received at the same time as the play therapy intervention could have had an effect on the outcome of treatment. Interventions introduced at home by the child’s parents, disciplinary actions in the classroom given by the child’s teacher or by the principal, as well as many other factors could all have an effect on the outcome of treatment.

Methodological Limitations

The validity and reliability of the data collection survey are unknown because it was developed by the researcher for this specific project. The weakness of using this type of a survey is that it is limited to the information presented in the case files. There is no way to evaluate any other variables that may effect the outcomes of play therapy. This method also relies on the accurate and complete documentation of the therapists who
participate in the SBC program. All of the therapists in the SBC program are interns, and although they are trained in writing case note, they may not have developed the skills they need to properly document the events of the treatment.

The strength of using this survey is that the researcher was able to focus on the information she was interested in for the purposes of the project. The researcher was also a participant of the SBC program and understands the processes and procedures that take place during treatment. The researcher also had the benefit of consulting with some of the interns from the 1998-1999 academic year, as well as with current interns participating in the program. These interns were helpful in deciphering notations, or in making suggestions of factors the researcher may want to evaluate in the process of collecting data.

Interns working in the SBC program, however, lead to another limitation. Many of the interns who participate in the program have very little experience writing treatment notes. This may lead to incomplete session notes or notes that are not specific. This factor may have had an effect on the outcome of the project. Notes written by interns
may have been difficult to read or misunderstood by the researcher.

Also, interns are in a position where they are trying many types of interventions for the first time. The interns may not know how to use the intervention effectively, or they may not understand how to interpret what the outcome of the intervention is. These possibilities may also be factors in the outcome of this project.

Implications for Social Work

The literature on play therapy repeatedly claims that more research needs to be conducted to establish that play therapy actually affects change in clients (Philips, 1985; Russ, 1998). This project was an attempt at getting one step closer to the answers sought by many in the field of social work. Play therapy is used over and over in many different settings. It is accepted as an intervention that works. The research tends to support this, but with little empirical evidence. It is therefore important that social workers take a closer look at play therapy.
The implications of using play therapy in treatment with children can be seen in many areas. There are diverse cultural factors that should be addressed by the therapist (Juarez, 1985; Martinez & Valdez, 1992). There is also a need for the therapist to assess and consider the role of family in the child's life (Bratton, Ray, & Moffit, 1998; Urquiza & McNeil, 1996). The way in which the child operates within the family system could mean the difference between a successful treatment outcome and an unsuccessful treatment outcome.

CONCLUSION

Play therapy is an accepted mode of treating children with an array of problems in a multitude of settings. Play therapy seems to work, but there is very little research to support this. What little research there is seems to be inconclusive, calling the reader to further research the problem and add to the existing body of knowledge. It was the goal of this researcher to add to this body of knowledge and further the argument that play therapy is indeed a viable treatment option in working with children.
This project was small, and therefore very limited in its ability to make a strong statement as to whether or not play therapy is effective in School Based Counseling (SBC) programs. Because more than half of the cases examined during this study resulted in a positive treatment outcome, it is fair to say that the procedures and interventions used by the SBC program can be effective with this population.

The researcher hopes that there will be further research conducted in the area of play therapy so that the most beneficial treatments can be used with children. Children deserve to be given the best chance they can get to develop into healthy and productive adults. The use of effective interventions at critical times in children’s lives can help to make this happen.
Table 1: Referral Reason and Presenting Problems

<table>
<thead>
<tr>
<th>Problem Areas</th>
<th>On Initial Referral</th>
<th>Reported at Intake by Parent/Guardian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classroom Behavior</td>
<td>48</td>
<td>19</td>
</tr>
<tr>
<td>Sadness/Depression</td>
<td>30</td>
<td>11</td>
</tr>
<tr>
<td>Anxiety</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>Elimination Disorders</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Oppositional/Defiant Behavior</td>
<td>41</td>
<td>22</td>
</tr>
<tr>
<td>Health Complaints</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
<td>47</td>
</tr>
</tbody>
</table>

This table shows the number of times each of the problem areas was given as either a reason for referral by the person who referred the child to the SBC program, or as a presenting problem by the parent or guardian of the child.

Table 2: The Outcome of Treatment and the Use of Discussion

<table>
<thead>
<tr>
<th></th>
<th>Discussion</th>
<th>No Discussion</th>
<th>Not Specified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Outcome</td>
<td>58</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Negative Outcome</td>
<td>34</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Outcome Missing</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 3: The Outcome of Treatment and the Use of Games/Behavior Modification

<table>
<thead>
<tr>
<th></th>
<th>Games/Behavior Modification</th>
<th>No Games/Behavior Modification</th>
<th>Not Specified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Outcome</td>
<td>51</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Negative Outcome</td>
<td>28</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Outcome Missing</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
Table 4: The Outcome of Treatment and the Use of Art/Projective Play

<table>
<thead>
<tr>
<th></th>
<th>Art/Projective Play</th>
<th>No Art/Projective Play</th>
<th>Not Specified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Outcome</td>
<td>56</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Negative Outcome</td>
<td>28</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Outcome Missing</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
APPENDIX B: Data Collection Survey

The Effectiveness of Play Therapy in a School Based Counseling Program: Data Collection Survey

Case # ______

1. Age ______

2. Grade ______

3. Gender 1) male 2) female

4. Ethnicity 1) Asian/Pacific Islander 2) African American 3) Latino/Hispanic 4) Middle Eastern 5) Caucasian 6) Other 7) Unknown

5. What are the reasons for referral to the program?
   1) problems with classroom behavior (possible ADD or ADHD)
   2) sadness or depression
   3) anxiety
   4) elimination disorders
   5) oppositional or defiant behavior
   6) health complaints
   7) other

6. How many referral items were marked? ______

7. Who made the referral? 1) teacher 2) parent 3) principal 4) other

8. What do the parents report as the presenting problem?
   1) problems with classroom behavior (possible ADD or ADHD)
   2) sadness or depression
   3) anxiety
   4) elimination disorders
   5) oppositional or defiant behavior
   6) health complaints
   7) other
9. What is the duration of the presenting problem in months? ______ 
   -or- If the parents report that the child has always experienced this problem check here □

10. What were the therapist's treatment goals? (as listed on care plan) 
   1) improve/modify classroom behavior 
   2) decrease sadness or depression 
   3) decrease anxiety 
   4) decrease/eliminate enuresis or encopresis 
   5) decrease oppositional or defiant behavior 
   6) decrease health complaints 
   7) other

11. What intervention did the therapist use most often? (as listed in session information)

12. According to closing summary, were the goals of treatment met? 1) yes 2) no

13. Was there a crisis intervention? 1) yes 2) no

14. Was the child suicidal? 1) yes 2) no

15. Was the child homicidal? 1) yes 2) no

16. Did the child have any prior psychological treatment? 1) yes 2) no

17. Was the child on any medication for this or any other psychological problem? 1) yes 2) no

18. What was the therapist's degree/intended degree? 1) MSW 2) MFT

19. How many sessions did the therapist have with the child? ______
20. What treatment modality was used? 1) individual 2) group

21. What was the reason for discontinuing services?
   1) Case closed, no further intervention
   2) Case closed, referred to community agency
   3) Case closed due to lack of attendance
   4) Case closed against recommendation of the therapist
   5) other
APPENDIX C: Informed Consent / Debriefing Statement

The Effectiveness of Play Therapy in a School Based Counseling Program

This study has been designed to examine play therapy interventions used in a school based counseling program in order to determine the effectiveness of such interventions. This study is being conducted by Aimee O'Keefe, a student in the Masters of Social Work program at California State University, San Bernardino under the supervision of Jette Warka. This study has been approved by the Institutional Review Board of California State University, San Bernardino. The university requires consent before this agency can participate in this or any other research study.

In this study, case files from the 1998-1999 academic year will be examined. A survey will be used to collect specific information from each file. The survey will contain questions regarding general demographic information of each child, the reason the child was referred to the therapist, and the interventions the therapist used to treat the child. In order to ensure confidentiality, no names will be used in this study. The findings will be
reported as a group only. No identifying information will be used, and no individuals will be mentioned at any time. Data will be collected from January 1, 2000 to approximately April 30, 2000. Please note that the agency can withdraw from the study at any time.

At the conclusion of the study, a copy of the findings may be requested by the agency. If you have any questions about the study, or if you would like a report of the findings, you may contact Dr. Glicken at (909) 880-5557. If you have any questions about research participants' rights or injuries, please contact the Institutional Review Board at (909) 880-5027.
REFERENCES


