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PLAY THERAPY TECHNIQUES AND THEIR EFFECTIVENESS
WITH ANGRY CHILDREN IN A SCHOOL SETTING

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
Lisa Marie Meyer
Nelly Edith Saucedo

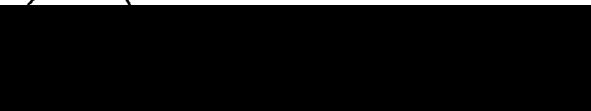
June 2002

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ABSTRACT

The purpose of this study was to determine which play therapy techniques were most effective when applied to working with children who have anger control problems. A total of 70 closed case files were reviewed of children ranging from age 5 to 14. Data were utilized from these file's case notes to determine which interventions were employed. Information from the session summaries was also used to determine if the interventions were successful when applied to these clients. This study concluded that the four most commonly employed interventions were worksheets, use of non-therapeutic games, drawings and a combination of categories. Anger can be used as an indicator that the individual is not in terms with some aspect of their life; various social, school and environmental factors are discussed to contribute to this emotion.

ACKNOWLEDGMENTS

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We would like to acknowledge our friends and family who have supported our efforts throughout this process, and who have made our success possible. Les quiero dedicar las gracias a mi esposo, mis padres y mis hermanos por todo el apollo que me han dado y por hacer mi exito possible.

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CHAPTER ONE

INTRODUCTION

The contents of Chapter One present an overview of the project. The identified problem for children who harbor anger is that it manifests in different negative ways in their lives. Since children have not yet developed cognitively to the level of adults, play therapy can be an effective technique utilized to help them deal with their anger. Unfortunately, while California Education Codes state that children who have absentee problems must be provided services, no specific amount of money is allocated for the services, nor is the type of help specified. Additionally, other issues children may need help with are not addressed. According to the Individuals with Disabilities Education Act (IDEA), children are to be ensured free and appropriate education. Coupled with this right, they are also to receive any support services necessary to have the child benefit from the educational experience. In the school districts where this study takes place, Etiwanda, Rancho Cucamonga, Montclair, and Ontario, California, the districts allocate a general fund to use as needed for each school. Within the school districts that choose to serve the mental and emotional needs of the

students, funds are then delegated towards providing counseling services, however this is something they are not required to do. School aged children who are provided counseling by social workers often participate in play therapy techniques used by the clinician.

The purpose of this study is to determine which play therapy techniques are most effective with angry children, in particular, in the context of a school based counseling program. While the results from this study cannot be said to be true for all play therapy in all contexts, there is significance for social work practice. Findings can be useful for social workers who intervene with angry children and findings of this study open areas for further research for social workers who provide therapy for children.

Problem Statement

Anger is an emotion that has been experienced by everyone. Although it is an emotion that is experienced and expressed in various degrees, no one is immune to it. From primitive times of fight or flight to present times, anger is a shared emotion that can be both healing and harmful. Within the three age categories, adults, adolescents, and children, anger is managed and manifested.

in different manners. Many adults experience physiological symptoms that eventually lead to strokes, heart attacks, and high blood pressure. Adolescents become involved with drugs and promiscuity in order to avoid serious issues by using denial and masking their emotions. Younger children may exhibit anger in maladaptive ways. Children are often the targets of physical, emotional and sexual abuse because of their impulsivity, poor anger management, and high dependency on others (Crosson-Tower, 2002). Many times the perpetrators of these acts are individuals they once trusted; therefore, the feelings of betrayal and lack of trust in others are strong. Maladaptive ways of coping with the anger can then become harmful.

Increasingly, children are becoming involved in drugs, delinquent and criminal acts, and are experiencing high rates of suicidal and homicidal ideations. Escalating forms of anger have long been evident in playgrounds. Bullying and fighting have made a permanent niche in our schools. However, it is important to understand how children commonly manifest anger in order to prevent escalation from reaching destructive outcomes.

Due to recent publicized public and drastic situations, many school districts are now increasing their focus on providing at risk children with counseling

services. Yet, school districts are not alone with their concerns. Parents, family service agencies, and our society in general benefit from increased knowledge of different manifestations of anger, poor coping mechanisms, and effective ways to manage anger. Children will shape our future; therefore, investing time in specific interventions such as anger management and treatment benefit all. The researchers intend to study play therapy techniques and their effectiveness with children who have identified anger management problems.

Policy Context

The California Education Code, Article 7- Section 1760-1762, states that guidance services are to be provided to elementary and high school districts within California. However, these services are specified to students with poor attendance and make no mention of other mental health or behavioral factors that may qualify them for counseling service provision. It is indicated that the services are to be provided by an individual with valid credentials and license. The credential needs to be approved by the California State Board of Education or Commission for Teacher Preparation and Licensing.

California does not allot certain funds specifically for mental health services. Instead, each year the school

districts distribute funds to each school, which they can choose to use for mental health services if they wish. Other school districts choose to pay for certain schools in their districts to provide counseling. In the case of the agency in which this study was conducted, schools contract with West End Family Counseling Services (WEFCS), which is a 501 C3 non-profit agency. Schools pay a fee to obtain a contract package from WEFCS to provide counseling services. The funds to pay for these services are obtained by the schools through categorical or discretionary funds.

Categorical funds are obtained by the district, county, state, or federal governments. They earmark the money specifically for these services. However, this type of fund constitutes a small portion of the funds.

Discretionary funds are monies provided by the school districts. This type of funds can be distributed in two different manners. The district can either choose the schools that must employ these funds for contract packages, or the districts allocate general funds for each school to use at their discretion. The contracting school districts do not outline the modalities in which the services are to be delivered. However, these school districts opt for the contract packages from agencies such as WEFCS because the agency assures quality services. The

school districts also benefit from these services financially because contracting for them is less costly than hiring their own in-house counselor. School districts and school sites determine the amount of service days contracted for. Currently, no school that contracts with WEFCS pays for more than three days a week. The agency outlines for the schools what the services will consist of. At this time, individual counseling can occur for up to twelve weeks, groups can last for twelve weeks, crisis intervention can occur by one counseling session, referrals can be made to staff and parents, and counselors can provide teacher and administration support. Additionally, for an extra charge, the school can pay for counselors to provide parenting classes or community education classes, such as a class on Attention Deficit Hyperactivity Disorder (ADHD).

Practice Context

Individuals in the social worker profession are committed to the concept of social justice by the code of ethics. This means that they must not neglect to serve those in need, regardless of their class, race, or social standing. Due to this, social workers often times work with populations that are vulnerable, oppressed, or living in poverty. Children, because of their dependency and

inability to obtain services on their own, are populations social workers need to focus on. Whether they are serviced at agencies, hospitals or schools, children ideally should receive treatment for their needs. This need is often times anger management.

In the area of this study, school social workers met this need by conducting various interventions. Play therapy is commonly the therapeutic tool utilized. Different interventions within the play therapy model help engage the child to increase the possibility of success.

Purpose of the Study

The purpose of this study was to examine the play therapy modalities utilized by social work and marriage and family therapy interns and therapists at West End Family Counseling Agency. The agency provides stress management classes, parenting courses, and individual and family counseling. The agency maintains contracts with various school districts and operates a school based counseling program. Within their program, social workers and marriage and family therapy interns, along with full time clinicians conduct the therapeutic sessions with the children.

Through the examination of closed case files, this study determined which techniques were the most utilized and effective within the context of this family agency. This was determined by reviewing closed case studies to quantify the use of their methods. Along with noting how frequently the techniques were employed, this study determined which techniques were the most effective, according to length of therapy and outcome, when applied to the identified client population. These clients were referred to treatment for anger problems by school staff, parents, or self-referrals. These symptoms were evidenced by aggression towards people or animals, destruction of property, defiance of adults, and frequent loss of temper.

Significance of the Project for Social Work

The significance of this project for social work practice is that the findings of this study can help social workers to work more effectively with clients who are of school age and exhibit behavioral problems associated with anger. From the beginning, social workers have experienced the constraints of time and excessive caseload size. By focusing on play therapy techniques that have been most effective, social workers can target clients' core issues more efficiently. It is important for

agency workers to note that this study examined which techniques were most effective overall, however, due to individual needs of clients and social work practice styles, a specific client may respond better to a distinct intervention.

CHAPTER TWO

LITERATURE REVIEW

Introduction

Chapter Two consists of a discussion of the relevant literature. Specifically, anger and interventions utilized with abused children, anger management with adolescents, factors contributing to aggression, and non-directive play therapy will be examined. There are many causes of childhood anger and aggression. Many times, a single occurrence or issue will upset a child. Many researchers have described non-directive play therapy as effective. Yet, the dynamics in which an abused child lives in are complex and dysfunctional. The numerous elements involved in their abusive relationship leaves children with unresolved complicated emotions. One of these emotions is identified as anger.

Contributing Factors to Aggression

Studies and articles such as the ones conducted by Herrenkohl and Russo (2001), and Martin and Linfoot (2000) focus on what familial factors can contribute to childhood anger and aggression. The study conducted by Martin and Linfoot, explored the association between children's aggression and the confidence level the mother has as a

child rearer. Similarly, Colder and Mott (2000) also focused on contributing factors to anger, but from an environmental perspective. They placed importance on the perception of African American children's view of danger. They stated that there exists a positive correlation between perceived neighborhood danger and the child's anger.

Jones, Peacock, and Russo (1992) state that some of the contributing factors to anger among young black adolescents are directly related to the different experience they have due to racial differences. "One factor that plays a significant role in the development of anger within the black population is racial discrimination. The black family structure and the image of what a black male should be pay important roles in the way they experience anger" (p. 462). They state that black youths show higher rates of acts of anger such as delinquency and rage due to the higher rate of one-parent-homes among them which results in lower levels of supervision and adult presence. This study by Jones et al. used a sample of 56 black adolescents from an urban high school. It also stated that another contributing factor could be that boys tend to operate from the justice principle while girls operate from the care principle.

This allows the boys less guilt about using aggression when angry.

Anger Management and Adolescents

When focusing on anger in adolescents, it is important to consider and understand the developmental challenges of those faced with attempting to establish independence and develop a sexual identity (Modrcin-McCarthy, Pullen, Barnes, & Alpert, 1998). Often times these challenges become the source of anger for many adolescents. Findings of Modrcin-McCarthy et al. state that past exposure to violence increases anger symptoms. Similarly, Nathanson (1999) found that there is a strong correlation between children regularly exposed to violence on television and aggressive acts. This study consisted of 394 parents and children in second through sixth grade and concluded that parents' mediation of aggression can improve the child's response and reaction to acting out aggression.

However, in regards to the interventions suggested, Modrcin-McCarthy et al. (1998) suggests that the precipitants of anger be considered in the treatment intervention plan. A similar study by Blechman, Dumas and Pritz (1994) targeted how coping was affected by the

youth's exposure to violence. "Chronic exposure to violence encourages youth to cope with challenges via a mixture of asocial, depressive and antisocial, aggressive tactics rather than prosocially in ways that benefit the self without harming others" (p. 205). The intervention used in this case study was a school-based prosocial coping-skills group that took place once a week for 45 minutes. Groups consisted of six to eight members. In the groups, the adolescents were able to express emotions and thoughts, receive feedback, and learn prosocial coping skills. One of the reasons they state this intervention works well, is because it provides for the adolescents an increased social support and provides mentors and role models they may have not previously had. However, Modrcin-McCarthy et al. disagree that verbalizing and venting anger is an adequate intervention. They state this process may actually increase the anger experience and response due to the strength of the emotion. For some this emotion is terrifying "...to express it may mean a loss of control" (1998, p. 75).

Anger and the Abused Child

There are many causes of childhood anger and aggression. Many times, a single occurrence or issue will

upset the child, but may not cause anger problems within the child. The dynamics in which an abused child lives are complex and dysfunctional. The many elements involved in an abusive relationship leave many different complicated emotions for the child. One of these emotions is anger. "Abused children harbor a suppressed anger over their lack of control of their lives" (Crosson-Tower, 2002, p. 51). According to Crosson-Tower, the children who do not suppress their anger express it in various ways such as poor control, aggression, and sporadic impulse control. Gil (1991) states that the actions angry children take may become more drastic when not treated. She states that if left untreated, the children may become violent, they may elicit abuse, and sometimes they may self-mutilate and torture or kill animals.

A study by Drisco (1992), focused on adolescent boys who had been physically abused and who use intimidation on peers. In this study, intimidating behavior was recognized as a tool used to free the adolescents from feelings of helplessness as well as giving them a sense of control. In the group process in which nine male adolescents participated, researchers concluded that the most effective manner to break through their defense mechanism of intimidation was for the group leader to observe,

recognize and verbalize the threatening feeling stirred by the intimidating behavior. By doing so, the group members began to believe the group held potential to give them a sense of safety and for positive change.

Shipman, Zeman, Penza and Champion's (2000) study included 21 maltreated girls and 21 non-maltreated girls. They showed girls different pictures of children feeling emotions and were then asked to reflect their understanding of the causes and consequences of emotional experience. The results concluded that abused girls have a decreased ability to regulate their emotions and less impulse control, making them more likely to express anger with aggression.

Play Therapy

When utilizing play therapy, ideally the therapist would have a theoretical background to substantiate the use of chosen techniques. Astramovich (1997) presented the role and goal of a therapist in client-centered, psychoanalytic, and release/structure play therapy theories. Client-centered theory promotes that a therapist needs to convey unconditional acceptance to create a real relationship. Directive therapy, tries to urge a child to deal with issues for which the child is not ready. The

goal is for the child to self-explore to increase self-esteem. Structured play therapy entails letting the child know limits and boundaries of sessions to foster a sense of safety.

In psychoanalytic play therapy the therapist's role is to bring about transference to let the child gain increases self-awareness (Astramovich, 1997). The goal is for the child to have increased self-esteem by expressing unconscious thoughts and feelings to be able to begin accepting them. Limit setting is the only structure involved so that neither the child nor therapist is harmed.

Release/structured play therapy was an offshoot of psychoanalysis that involves more direction (Astramovich, 1997). Recreating the child's trauma to release the pain of the experience is the main goal, however there is also the added necessity of non-directed playtime to build rapport and transition a child out of a session. Structure, then, is needed to recreate the child's past traumatic event.

Both directive and non-directive play therapy techniques have been utilized in child-centered groups. Chen (1984) compared two of three types of therapy groups for maladjusted children conducted at a school in China.

The first group was based on unstructured psychodynamic theory using games, discussion, and art. The second group was more short-term and utilized "indoor play activity, outdoor play, indoor ball game, outdoor ball game, arts, crafts, chess, storytelling, dramatic play, and music" (p. 486). The final group was short-term and included two directed activities of storytelling and puppet shows. Children who presented with behavior problems of restlessness and truancy were most helped by the first group. Both the first and third group work helped with fighting and disobedience. Neither group was helped with lying. The author notes, however, that with a total sample size of 136 between all three groups, more experimentation is needed before conclusions can be made.

Ryan, Wilson, and Fisher (1995) believe that non-directive play therapy breaks down the child's resistance by allowing the child to feel a sense of control so trust in the therapist can develop. They add that the therapy must be in conjunction with all other helping professional involved in the child's life.

Caregivers provide valuable information in therapy to provide support and a secure environment at home. A social caseworker is also needed to work with the caregivers,

other family members, and any law issues that arise concerning the child.

Carmichael and Lane (1997) discovered that two primary symptoms children of alcoholics exhibit are aggression and impulsivity. They suggest using non-directive play therapy by establishing a safe child-therapist relationship and reflecting a child's feelings back to the child. Goals of therapy are to overcome shame that often leads to anger, overcome lack of trust and control issues, examine issues in the family that have enforced dysfunction, talk about alcoholism, and to identify and express feelings. While a child needs to be allowed to choose their own toys or art to feel a sense of control they have not had in their alcoholics' homes, the items would ideally be ones that would help a child to express his or her feelings. The therapeutic items should also be consistently kept in the same place at the beginning of every session to further empower the child's feeling of control. Boundaries and rules for the sessions were clearly stated to the child so the child feels free enough to explore and eventually gain a feeling of self-control (Carmichael & Lane, 1997).

McDonald, Billingham, Conrad, Morgan, and Payton (1997) described two ways of using play in family therapy.

One is called "special play" wherein parents and children play together without disturbances. Parents allow the children to play however they wish in order to increase positive communication.

The second technique utilized by McDonald indicates the children are asked to draw "scribbles" followed by the parents asking positive questions about the art. Both play methods are used to increase the child's self-esteem.

Non-directive play therapy has been effective with sexually abused children who often show anger as one of the symptoms of their pain. Wilson and Ryan (1994) have argued that victims need a strong therapeutic relationship, which requires sexually abused children to not only be part of family therapy, but also individual therapy. Children are unable to communicate effectively in family therapy sessions due to the mature nature of the interactions. Therefore, Wilson & Ryan encourage the combination of individual, couple, and family therapy. As with children of alcoholics, sexually abused children need boundaries, to be listened to, and reflected back to as to increase their self-awareness while gaining a sense of control that was lost in the abuse. Directive play therapy risks making a child feel a loss of control similar to that during the abuse (Wilson & Ryan, 1994).

Human Behavior in the Social Environment Theories

The theory most evident when dealing with anger and aggression is behavioral (Deffenbacher, 1999); yet, there are other theories, such as social-cognitive, that have proven effective with angry children (Dykeman, 1995). Albert Ellis's humanistic theories regarding the emotions of anger may also be utilized as a foundation to understanding children's emotions of anger.

Understanding one's feelings and attempting to reconcile them with reason is yet another method to utilize (Rothschild, 1999). This Humanistic perspective deals with the misconception that emotions are separate from ideas. This can be especially useful when the clients surface emotions that interfere with effectiveness of treatment. When utilizing non-directive play therapy for dealing with anger, psychodynamic theories are often used as guides. Freud's concept of the unconscious is thought to have an effect on children's anger. According to Freud, when children are allowed to express their unconscious feelings through play they then begin moving away from dysfunctional behaviors.

Summary

There are many situations and factors that contribute to anger in children. Family factors, such as parenting techniques and relationship dynamics, have been shown to be contributing factors to aggression. Family is not the only factor that contributes to anger; the perspective the child has of his or her environment also effects how the child feels and expressed anger. A child may have many experiences, which may result in angry feelings. Abuse is one of them. A child who experiences abuse has experienced a loss of trust and control. The trauma of this experience may mean the child exhibits his or her angry feelings through poor impulse control, fighting, and aggression. A way to facilitate and to help the child come to terms with anger is to engage in a form of anger management appropriate for the child's developmental level.

Anger management in adolescents consists of many interventions. Interventions examined in the literature included teaching coping skills, increasing the child's support system, allowing the person to verbalize and ventilate the emotions, and engaging in brief therapy. When dealing with younger children, non-directive play therapy was proven to be an effective model that uses techniques such as games, discussion, and art. This model

is used with both individual and group therapy. As shown in the research, play therapy not only allows the child to express and resolve their anger issues, but is also increases the child's self-esteem.

CHAPTER THREE

METHODS

Introduction

This chapter documents the steps used in developing the project. Specifically, it discusses the study's design and how the sampling population was selected. The sample was selected from closed case files and was approved by the University Institutional Review Board. This chapter also discusses what data was collected, and the procedures involved in the implementation and completion of this study.

Study Design

The purpose of this study was to determine which play therapy techniques were found to be most effective in working with angry children. To best address this, this research focused on a quantitative study method using evaluative goals. A decrease in aggressive and impulsive behaviors determined the success and effectiveness of treatment.

Service information and client files had been collected over the years and were stored at West End Family Counseling. Case records were utilized for data collection using quantitative measures. Clients were not

approached personally to obtain data due to the conflict of interest that could arise if individuals had been clients of the researchers. It was not feasible to speak to the individuals who had terminated from treatment due to the fact that there was no formal follow-up conducted by the agency after treatment termination. Because the agency had been serving individuals for an extensive time, there was adequate information from the case files to form a suitable source of data. This study focused on the 2000-2001 school year. The sample files were limited to children age five to fourteen.

The limitations of this study included obtaining information from subjective case notes, variables of the individual clients, such as culture, age, familial factors, and gender. Since the sample was only derived from one specific agency it is impossible to generalize findings to all agencies serving children.

Sampling

This study obtained its sample from closed case files. The case files included children from five to fourteen years of age who participated in a school based counseling program for identified anger issues. Case files were limited to clients who underwent complete services

and were terminated by the clinician. Systematic random sampling was conducted to obtain sufficient cases. Of a total 242 possible case files, 172 were disregarded due to other treatment focus, leaving 70 case files that met the criteria for this study.

Data Collection and Instruments

The data collected included: whether or not a child had displayed anger issues, information regarding specific play therapy techniques utilized to treat these issues, characteristics of the children and the outcome of treatment.

This study utilized a data extraction instrument designed by the researchers. This single-page case analysis form was utilized to gather information about the manner in which the child displayed anger, the play therapy techniques employed by the clinician, the effectiveness of those techniques, and the number of sessions conducted. Individual characteristics of the child, such as gender, age, ethnicity, and the number of siblings were also noted. The closing summary, referral, and intake information form in each individual case file was examined to identify the anger issues present. Specific behavior descriptions were provided in the

closing summaries of each case, therefore, that information assisted in operationalizing anger. Through the use of those descriptions the researchers were able to determine whether a child was experiencing anger management problems. The recognized indicators included the following notations by the treating clinician: anger, aggression, hitting, fighting, arguing, yelling, cursing, destruction of property, easily annoyed, provoking others, loss of temper, and loss of control. Any identification of these behaviors classified the case file valid for the purpose of this study.

Other characteristics examined included the gender, age and ethnicity of the child and the number of siblings living in the home. Siblings living in the home were categorized as biological, half, step, adoptive or foster siblings. Gender of the child was either male or female at the nominal level of measurement. Age and number of siblings were continuous variables since they were real numbers. Ethnicity was a nominal measurement. Categories included Caucasian, Hispanic, African-American, Asian, Multicultural, and Unspecified. Multicultural, for the purpose of this study, included any combination of Hispanic, African-American, Asian, Middle Eastern and Caucasian.

For each case note where anger was identified the types of play therapy interventions employed by the clinicians were noted. For the purpose of this study, the techniques were categorized into twelve categories. These included: Therapeutic Games, Non-therapeutic Games, Arts and Crafts, Guided Imagery, Sand-tray, Role-Play, Clay/Play-dough, Worksheets, Drawings, Toy Play, Books and Story telling, Physical Play, and a category identified as Combination of categories. The category Combination was given when a therapist utilized two or more categorical techniques with the same frequency. The following constituted the category of therapeutic games: Feelings Tic-Tac-Toe, Talking-Feeling-Doing Game, The Ungame, Stop-Think-and Relax, The Conflict Resolution Game, The Angry Monster Machine, Lets See About Me, and Dinosaur's Journey to High Self Esteem. Therapeutic games were considered by the researchers of this study to be those games specifically designed for use by clinicians for therapy with children. The Non-Therapeutic games included: Hot Potato, Babysitters, Uno, Jenga, Chess, Checkers, Connect Four, Chinese Checkers, Perfection, Sorry, Life, Operation, Monopoly, Guess Who, Yahtzee, Memory, Candyland, Chutes and Ladders, Cards, Trouble, and free play. Arts and Crafts, Guided imagery, Sand-tray, Role

Play and Clay/Play-dough were considered as individual categories. The category defined as Worksheets included: worksheets, activity books, genogram, behavioral contracts, feelings charts, memory books and writing letters or stories. The Drawing category included: Family kinetic drawings, Person-House-Tree, Self-portraits, and directive and non-directive drawings. Toy Play included: dolls, dollhouses, puppets, figurines, and forts. The Book/Story-telling category included reading books, story-telling, "what's your wish" question, and singing songs. Finally, Physical Play constituted cops and robbers, ball games, marbles, bataka, blocks, paper-towel throwing and outdoor play.

In order to measure the effectiveness of the techniques, information was obtained from the closing summaries of each individual case. Because clinicians employ a variety of techniques and interventions during treatment, a tally sheet was utilized by the researchers to determine the dominant interventions. These interventions were then paired with the outcomes of treatment.

When examining which play therapy techniques were most effective with children who had identifiable anger problems, the dependent variable was whether or not the

child was able to successfully use skills taught in the course of therapy to demonstrate positive coping and management of anger. The outcomes were divided into four categories: no change, increased insight and verbalization, improved behavior in only one setting, and overall improved behavior. These were nominal measurements, and were measured by quantitative means.

The independent variables of this study included the different play therapy techniques utilized by the treating clinicians. Different strategies illustrated varying results, allowing for examination of their effectiveness and exploration of the differences among the strategies. These variables were given a nominal descriptions, noted as intervention one, intervention two, and so forth. Gender and age were additional independent variables measured for influence with treatment techniques and outcomes. Age was measured by obtaining the information from the case file on how old the client was at the time of treatment. The level of measurement for age was ratio. The number of siblings was also ratio in measurement.

This study addressed the questions of reliability and validity. Due to the fact that information was obtained and gathered from files and documentation, it was unlikely that similar studies would gather different data and

information from the same files. The following impacts the validity of the data collected. The cases and files were managed by various social workers with differing backgrounds and theoretical orientations, therefore, there is a difference in the content documented and excluded from each file. Regardless, if the agency required documentation of certain sets of behaviors or treatments, the information actually documented would be skewed by subjective views.

Procedures

The study was conducted in a private room with only the two researchers. The door was closed to protect the confidentiality of the case files and decrease the possibility of interruptions. Random sampling was conducted by choosing every fifth case from the 2000-2001 case files and those selected were evenly divided between the researchers. Each case selected was provided with an identification number that would allow the researchers to access that specific case in the future if needed. Case notes, referral sheets, intake forms and closing summaries in each file were examined by the researchers. The data collected on each file included which intervention techniques were employed by the clinician, the age and

gender of the child, number of siblings living in the home, number of sessions seen, and the ethnicity of the child. The variables of age, number of siblings living in the home, and the number of sessions employed were later collapsed into three categories each. Age was categorized into ages 5-8, 9-11, and 12-14 years of age. The number of siblings living in the home were categorized as 0, 1-3, and 4-5. The number of sessions employed were divided as follows: 4-8, 9-14, and 19-20 sessions. All of the interventions noted in the files were identified and calculated. Interventions were then grouped into categories including Therapeutic Games, Non-therapeutic Games, Arts and Crafts, Guided Imagery, Sand-Tray, Role-Play, Clay/Play-Dough, Worksheets, Drawings, Toy Play, Books and Story telling, Physical Play, and a category identified as Combination. The dominant technique utilized during treatment was the one paired with the outcome for each case. The results were then reported.

Protection of Human Subjects

In order to protect clients anonymity and maintenance of confidentiality, no names, phone numbers or addresses were recorded on the data collection instrument. No individuals from the case files were contacted. This study

did not include information that would lead to the identification of the individuals in the case files. The identifying characteristics that were utilized were too general to allow for identification. Characteristics included the child's gender, age, number of siblings living in the home, and ethnicity. All information was obtained from pre-existing data located in the closed case files and was reviewed in a private, locked room by the researchers.

Data Analysis

Univariate analysis examined the distribution and frequency of specific variables including: gender, age, ethnicity, the number of siblings living in the home, and intervention categories. Bivariate analysis was then conducted on the variables of intervention against gender, age, ethnicity and number of siblings. This process was then repeated with treatment outcomes and number of sessions. Multivariate analysis was conducted between the dependent variable of outcome and the paired independent variables of gender and age and ethnicity, age and method, gender and method, ethnicity and method, method and number of sessions, gender and number of sessions, and age and

method and number of sessions to determine if there were any significant correlations between them.

Summary

This study was a quantitative, evaluative study utilizing case files as the units of analysis. The confidentiality of the individuals whose files were utilized for data collection was maintained throughout this study. Closed case files were examined to determine play therapy techniques utilized by the treating clinician in the child's sessions for identified anger cases. From the categorizing of these techniques, this study examined those most commonly employed at the site with an effective outcome. This study determined which techniques were proven most effective. At the conclusion of this study, the different play therapy techniques used at West End Family Counseling Agency were ranked in their effectiveness with angry children.

CHAPTER FOUR

RESULTS

Introduction

The data collected was entered into Statistical Package for Social Sciences 9.0 and calculated using univariate, bivariate and multivariate analysis. The research was able to determine the frequency and percentages of client's genders, ages, ethnicities, methods used in treatment, and outcomes of services of those individuals involved in the study. Chi-square was calculated and statistical significance was not found due to sample size and small cell size. The findings were therefore ungeneralizable beyond the cases reviewed.

Presentation of the Findings

The variables of gender, age, ethnicity, siblings, interventions, number of sessions, and outcomes of treatment were run for the measurement of frequencies (see Appendix B). The sample consisted of 70 cases (n = 70) from the agencies closed case files. From these, the majority 67.1% (n = 47) of the cases were male clients and 32.9% (n = 23) were females. The ages ranged from age 5 to age 14. In this sample, 42.9% (n = 30) were between the ages of 5-8, 34.3% (n = 24) were between ages 9-11, and

22.9% (n = 16) were between ages 12-14. From these, the average age was 7 with the highest number of cases falling within the 5-8 year old category.

Ethnicity was examined and (see Appendix B) 41.4% (n = 29) of the children were Caucasian, 30.0% (n = 21) Hispanics, 10.0% (n = 7) African Americans, and 18.6% (n = 13) individuals of multicultural or unspecified ethnicity. Family composition was examined and the majority, 68.6% (n = 48) of the clients were living in a home with 1-3 sibling. This was followed by 21.4% (n = 15) clients who had no siblings living in the home, and 8.6% (n = 6) of the clients who had 4-5 siblings living in the home.

From the twelve previously mentioned therapeutic interventions employed by treating clinicians, five methods were more frequently utilized than others (see appendix B). The intervention most frequently introduced was worksheets 25.7% (n = 18). This intervention was closely followed by the use of non-therapeutic games, 22.9% (n = 16) of the time. Drawings and the use of a combination of interventions were equally employed in 14.3% (n = 10) of the cases. Finally, therapeutic games were used 5.7% (n = 4) of the time with the sample cases of the study.

The number of sessions for the client cases reviewed ranged between four and twenty. For the purpose of this study the number of sessions were divided into three categories. It was found that 30.0% (n = 21) of the clients were seen between 4-8 times while 2.9% (n = 2) of the clients were seen 19-20 times. The majority, 67.1% (n = 47), of the number of sessions utilized fell between 9-14. When examining the outcomes of treatment, only 15.7% (n = 11) of the clients did not show any improvement (see Appendix B). From the remainder, 22.9% (n = 16) exhibited improvement in verbalization and insight, 11.4% (n = 8) improved in one setting, and 50.0% (n = 35) showed overall improvement in behavior. The findings indicated that 84.3% (n = 59) of the clients served by West End Family Counseling Services (WEFCS) showed some improvement in verbalization, insight, or behavior in one or more settings.

Variables were combined to run bivariate analysis. The independent variables of age, number of sessions, ethnicity, gender, intervention utilized and number of siblings living in the home were run against the dependant variable of treatment outcome to determine if there were any statistically significance relationships found (see Appendix C). Improved behavior in one or more setting was

the most prevalent outcome for all age groups represented in the sample. There were 44 (62.9%) 5-8 year olds, 36 (51.4%) 9-11 year olds, and 25 (35.8%) individuals ages 12-14 who improved in one or more setting. When viewing the impact of the number of sessions on outcomes, it was evident that the most frequent duration of 9-14 session had the most positive results for 59.98% (n = 42) individuals who experienced improved changes in either verbalization, insight or improved behavior in one or more setting. No change in outcome was noted for 6 (8.6%) individuals attending 4-8 sessions, and for 5 (7.1%) individuals who attended 9-14 sessions.

Assessing the influence of an individual's ethnicity on the treatment outcome, it was noted that 34.3% (n = 24) of Caucasians experienced an improvement in insight, verbalization, or change in behavior in one or more setting 34.3%. Nineteen or 27.1% of the Hispanic clients experienced a change in insight, verbalization, or change in behavior in one or more setting. Nine or 12.8% of the individuals with Multi-cultural and unspecified ethnicities experienced improvement in insight, verbalization, or behavior. Five or 7.2% of the African American clients did not experience improvement in verbalization or insight, but demonstrated a change in

improved behavior in one or more settings. Regardless of ethnicity, 11.4% (n = 8) of the males exhibited no change in behavior while 4.3% (n = 3) of the females demonstrated no change in behavior. However, the majority of the males, 55.6% (n = 39) demonstrated a positive improvement in insight, verbalization, or change in behavior in one or more settings. Twenty or 28.6% of the females improved insight, verbalization, or behavior in one or more settings.

The independent variable of intervention was viewed against the dependent variable of outcome from treatment. The use of worksheets was the most prevalent when there was no change in outcome and when there was improvement in behavior in one setting. There were four (5.7%) worksheets used with no change in outcome, while they were three (4.3%) used to obtain the outcome of improved behavior in one or more setting. Non-therapeutic games were used the most frequently, four times (5.7%), to obtain improvement in insight and verbalization. Finally, worksheets and non-therapeutic games were each used at a rate of 12.9% (n = 9) to dominate the outcome category of overall improved behavior.

Bivariate analysis was conducted for the independent variables of age, ethnicity, and gender and the dependent

variables of number of sessions and intervention.

Frequencies concluded that 67.1% (n = 47) of the sample were seen in treatment between 9-14 sessions. Nineteen (27.1%) of the clients between the ages of 5-8 years of age had participated in an average of 9-14 sessions. This group was the largest followed by 25.7% (n = 18) of the clients between the ages of 9-11 years old, and 14.3% (n = 10) 12-14 years of age.

By assessing whether the ethnicity of the clients influenced the number of sessions attended it was found that both Caucasians and Hispanics were seen on average 4-20 sessions when African Americans, Multi-cultural clients, and clients of unspecified ethnicity were only seen on average 4-14 sessions. Caucasians were more frequently seen 9-14 sessions at 25.7% (n = 18). There were 66.7% (n = 14) Hispanics who utilized 9-14 sessions, while only 57.1% (n = 4) African Americans participated in 4-8 sessions. There were 12 (92.3%) individuals of multi-cultural and unspecified ethnicity who participated in 9-14 sessions.

Males and females most frequently utilized 9-14 sessions. From this, 63.8% (n = 30) males and 74.1% (n = 17) females were seen within 9-14 sessions. The number of sessions utilized was crosstabulated with the

variable of intervention employed to determine which methods were most commonly utilized in categories of sessions. Within the category of 4-8 sessions, worksheets were employed 11.4% (n = 8) of the time, non-therapeutic 8.6% (n = 6) of the time, and a combination of interventions 4.3% (n = 3) of the time. Within the category of 9-14 sessions an equal use of worksheets and non-therapeutic games were employed at 14.3% (n = 10), drawings at a rate of 11.4% (n = 8), a combination of interventions at a rate of 10.0% (n = 7), and therapeutic games were employed 5.7% (n = 4) of the time within this category of sessions.

The independent variables of age, ethnicity and gender were then crosstabulated with treatment intervention. Worksheets were the most commonly employed intervention totaling 25.7% (n = 18). Within the different age groups it was employed at a rate of 7.1% (n = 5) with 5-8 year olds, 10.0% (n = 7) with 9-11 year olds, and 8.6% (n = 6) with 12-14 year olds. The second most widely used intervention was the use of non-therapeutic games totaling 22.9% (n = 16) utilization. Within the different age groups it was employed at a rate of 11.4% (n = 8) with 5-8 year olds, 7.1% (n = 5) with 9-11 year olds and 4.3% (n = 3) with 12-14 year olds. The use of drawings and

combinations of methods were both used at a rate of 14.3% (n = 10). However, the use of combination of methods was only employed 10.0% (n = 7) of the time with 5-8 year olds and 4.3% (n = 3) with 12-14 year olds. Drawings were introduced to all three age groups with its use being equal at ages 5-8 and 9-11 at a rate of 5.7% (n = 4) and at ages 12-14 at a rate of only 2.9% (n = 2).

To assess whether ethnicity influenced the use of various interventions, bivariate analysis was performed. It was found that Caucasians experienced worksheets as an intervention 37.9% (n = 11) of the time followed by non-therapeutic games at 37.5% (n = 6) of the time. However, they did not experience the methods of sand tray or physical play. Hispanics were equally exposed to drawings and non-therapeutic games at a rate of 23.8% (n = 5), this was followed by the use of combined methods at 19% (n = 4) and worksheets at 14.3% (n = 3). African Americans were most exposed to non-therapeutic games at 42.9% (n = 3) and worksheets at 28.6% (n = 2). The method most employed with individuals of multicultural or unspecified ethnicity was the use of a combination of methods at a rate of 57.1% (n = 4).

When the use of various interventions was cross-tabulated with gender it was noted that males were

most exposed to worksheets at a rate of 25.51% (n = 12), non-therapeutic games at 23.4 (n = 11), drawings at 19.1% (n = 9), and a combination of methods at 20.8% (n = 5). Females were exposed the most to worksheets at a rate of 26.1% (n = 6) followed by equal use of non-therapeutic games and a combination of methods at 21.7% (n = 5). Overall, therapeutic games were used by both genders in an equal amount of 2.9% (n = 2) of the time although they were only employed with Hispanics, African Americans and multi-cultural individuals.

Multivariate analysis was performed with the variable of treatment outcome. The following variable groupings were then crosstabulated to assess trends between them and treatment outcome: ethnicity and age, gender and age, ethnicity and gender, intervention and gender, gender and number of sessions, intervention and number of sessions, intervention and ethnicity, intervention and age, ethnicity and number of siblings, gender and number of siblings, age and number of siblings, and ethnicity and number of sessions. Upon analysis, chi-square values did not note statistical significance and, the majority of the cells had an expected count less than five. None of the multivariate analysis tables displayed statistical significance at the level of .05 or less. It would be

beneficial for future studies of this kind to obtain a larger sample size, as these combinations of variables are of interest to social science studies and helping professionals.

Summary

The results presented in this study provided the frequency of variables such as gender, age, ethnicity, intervention utilized, number of sessions employed, and outcome of treatment in percentages. The results demonstrated that there were more male clients served than females, most of the clients were of Caucasian decent, and the most common age of the client fell between the ages of five and eight. When determining what interventions were the most employed within this sample, it was noted that the use of worksheets was the most widely utilized with this client population. In running bivariate and multivariate analysis there was no significance in the statistical values of chi-square. This was likely due to small sample size. Therefore, the findings in this research can not be generalized to cases beyond those examined, nor to the general population.

CHAPTER FIVE

DISCUSSION

Introduction

After collecting information and analyzing data, the study found that there was no statistical significance or correlation between the variables. This may be due partly to various external factors that contribute to the outcome by affecting the variables.

Discussion

While there was no statistical significance, there were notable observations. Overall, the study sample consisted of more male clients than female clients. This was due to more males having been referred to the counseling program than females. Because it was a school based counseling program it was likely that students who exhibited overt behavioral problems would more readily be referred than students who internalized anger with no overt actions. Studies have shown that boys tend to act out behaviorally when angry while girls internalize and display anger less frequently.

Another observation concerning gender involved the gender of the client compared to the outcome of treatment. It was likely that males were more prevalent in each

outcome category due to their larger numbers in this sample. Whereas females represented only 33% of the sample cases. The study demonstrated an increased array of interventions with the males than with the females. One discrepancy was noted with the intervention of Drawings. Overall, a larger sample size could have shown more statistical significance between the variables. A larger sample size would thus be something to take into consideration for future studies.

The study determined that worksheets, non-therapeutic games, and drawings were the most commonly used methods of interventions with those who displayed anger. It is not surprising that non-therapeutic games were not as frequently used due to the limited supply that West End Family Counseling (WEFC) provides. Similarly, WEFC has a high abundance of worksheets and non-therapeutic games accessible to treating intern clinicians. Likewise, worksheets appeared to have the most favorable outcome of 'overall change in behavior' and the least favorable outcome of 'no change' due to their frequent utilization.

Ethnicity did not appear to be a factor when determining which method of intervention to employ. Congruently, the representation of ethnicity in the sample was indicative of the community in which WEFC serves,

which has a higher percentage of Caucasians than other ethnicities. Consequently, it was not surprising to see that Caucasian clients demonstrated the largest representation in both the categories of 'improved overall behavior' and 'no change.'

Factors that could have affected the outcome in regards to age were also observed. It was found that 'increased insight' was seen most in clients ages nine to eleven. This could be explained by considering Erickson's Developmental Stage Theory which indicated that children at this level are becoming increasingly perceptive of their own emotions.

Due to the high number of subjects ages five to eight, they represented the most cases in each number of sessions category. The most frequently number of sessions participated in was between nine and fourteen. This number correlated with WEFCS's policy of seeing each client a minimum of eight sessions and a maximum of twelve sessions. Therefore, most of the changes in outcome occurred between sessions nine and fourteen.

Additionally, it appeared that the interventions utilized were consistent with age appropriateness of the client, therefore, there was no evidence of more sophisticated methods employed with younger age groups.

Further studies should not only attempt to obtain larger sample sizes, but it would be beneficial to consider other factors. Other external factors for consideration include: previous counseling experience, does the child live in an intact home, source of the referral, mental health history, whether the child is in special education, and the clinician's style and theoretical orientation.

Limitations

The following limitations apply to the project:

1. Only one agency was studied, therefore findings cannot be generalized to all agencies that provide school based counseling services.
2. The information obtained from the closed case files were subjective to what the treating social worker or marriage and family counseling intern's perspective was.
3. The research did not have a baseline measurement of the degree of anger experienced by the child prior to receiving counseling services.
4. The study was unable to account for outside environmental factors that influence treatment outcomes such as family support, dynamics and previous counseling experience.

5. The study identified the case's primary intervention employed by taking the most utilized method in that case, therefore, findings did not account for the influence the other methods that may have effected outcome of the treatment.

Recommendations for Social Work Practice, Policy, and Research

It would be beneficial for future studies of this kind to obtain a larger sample size, as these combinations of variables are of interest to social science studies and helping professionals. Although it would have been beneficial to social workers to have found an efficient intervention that would work with the time constraints of the profession, it is important to recognize that there are many external factors that influence treatment outcome. Therefore, each treating clinician should consider these when individually working with clients similar to those in the study's sample.

Conclusions

The conclusions extracted from the project are as follows.

1. In order to obtain more significant and accurate results in a similar study, larger sample sizes should be considered. This includes the use of more than one agency in addition to and increased sample size.
2. Although specific methods may be generally effective with specific behaviors, the clinician's individual style and subjectivity will affect how the method is introduced and received by the client.
3. The child's cognitive development, willingness to participate, and each client's individual needs determine what method of intervention will be most effective, even when the presenting problems are similar between client cases.
4. Outcomes of treatment are affected by other external factors other than those considered in this study. For example, some may be previous counseling experience, does the child live in an intact home, family, school, and community

support level, family dynamics, source of the referral, mental health history, and whether the child is in special education.

APPENDIX A
DATA EXTRACTION SHEET

DATA EXTRACTION SHEET

File Number:

Child's Gender:

Child's Age:

Child's Ethnicity:

Number of Siblings:

Manner in Which Child Exhibited Anger:

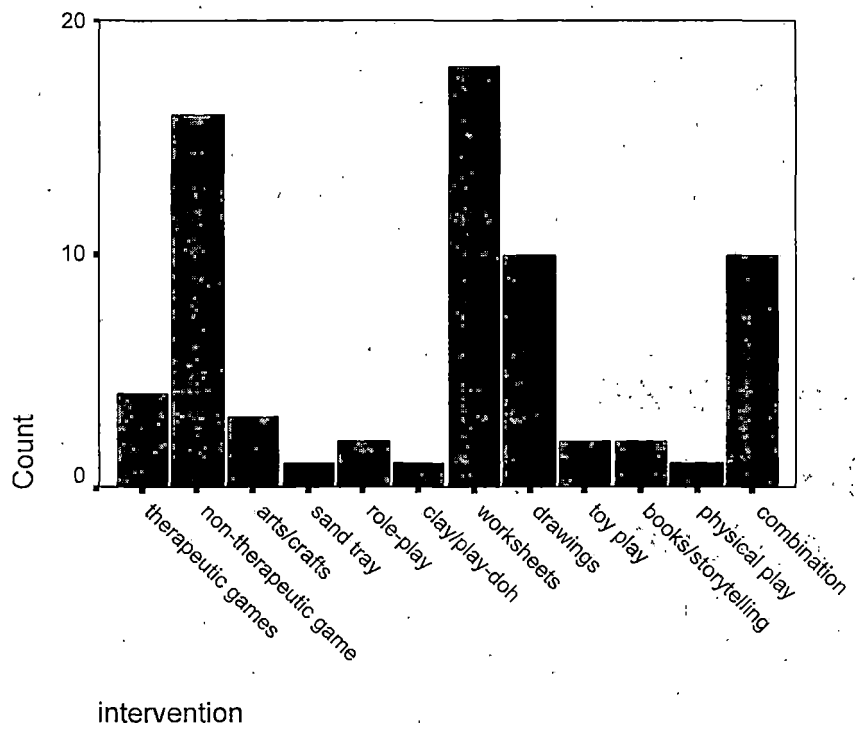
Type of Intervention Used:

Outcome of Treatment:

Number of Session in Treatment:

APPENDIX B

GRAPHS



Frequencies

Statistics

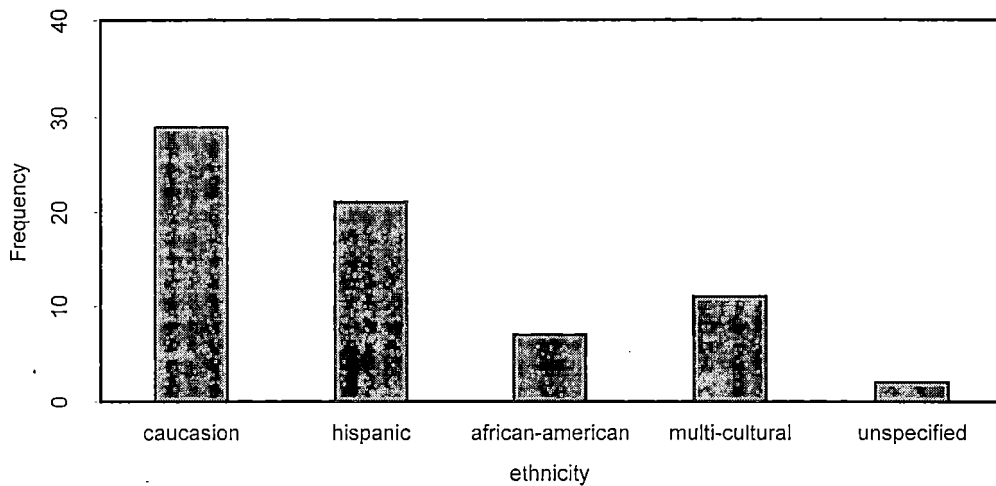
ethnicity

N	Valid	70
	Missing	0

ethnicity

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	caucasian	29	41.4	41.1	41.4
	hispanic	21	30.0	30.0	71.4
	african-american	7	10.0	10.0	81.4
	multi-cultural	11	15.7	15.7	97.1
	unspecified	2	2.9	2.9	100.0
Total		70	100.0	100.0	

ethnicity



Frequencies

Statistics

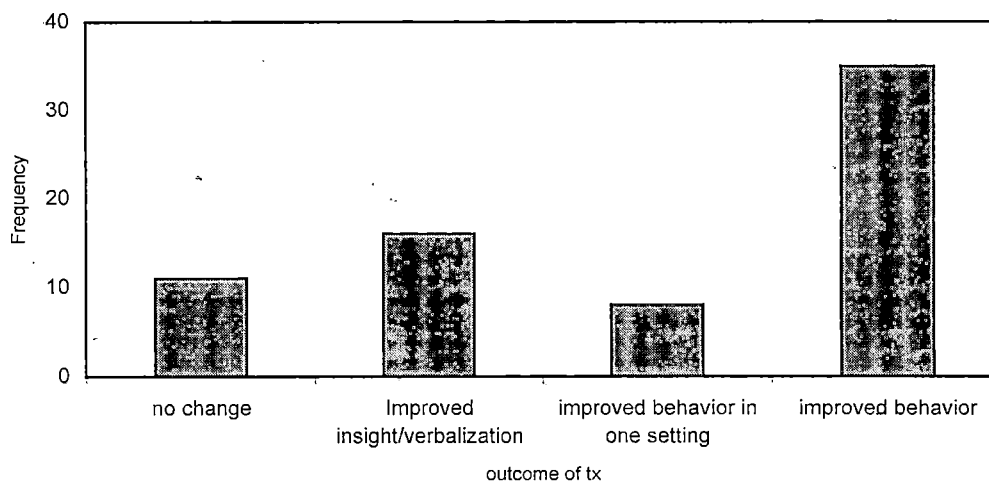
Outcome of tx

N	Valid	70
	Missing	0

outcome of tx

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	no change	11	15.7	15.7	15.7
	Improved insight/verbalization	16	22.9	22.9	38.6
	improved behavior in one setting	8	11.4	11.4	50.0
	improved behavior	35	50.0	50.0	100.0
Total		70	100.0	100.0	

outcome of tx



APPENDIX C

CROSSTAB

Crosstabs

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
outcome of tx * age in three categories	70	100.0%	0	.0%	70	100.0%
outcome of tx * session in three categories	70	100.0%	0	.0%	70	100.0%
outcome of tx * ethnicity	70	100.0%	0	.0%	70	100.0%
outcome of tx * gender	70	100.0%	0	.0%	70	100.0%
outcome of tx * intervention	70	100.0%	0	.0%	70	100.0%
outcome of tx * siblings in three categories	69	98.6%	1	1.4%	70	100.0%

outcome of tx * age in three categories

Crosstab

			age in three categories			Total
			5-8	9-11	12-14	
outcome of tx	no change	Count	8	3		11
		% of Total	11.4%	4.3%		15.7%
	improved insight/verbalization	Count	5	7	4	16
		% of Total	7.1%	10.0%	5.7%	22.9%
	improved behavior in one setting	Count	3	2	3	8
		% of Total	4.3%	2.9%	4.3%	11.4%
	improved behavior	Count	14	12	9	35
		% of Total	20.0%	17.1%	12.9%	50.0%
Total		Count	30	24	16	70
		% of Total	42.9%	34.3%	22.9%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.112 ^a	6	.311
Likelihood Ratio	9.154	6	.165
Linear-by-Linear Association	2.188	1	.139
N of Valid Cases	70		

a. 7 cells (58.3%) have expected count less than 5. The minimum expected count is 1.83.

outcome of tx * session in three categories

Crosstab

			session in three categories			Total
			4-8	9-14	19-20	
outcome of tx	no change	Count	6	5		11
		% of Total	8.6%	7.1%		15.7%
	improved insight/verbalization	Count	4	12		16
		% of Total	5.7%	17.1%		22.9%
	improved behavior in one setting	Count	2	5	1	8
		% of Total	2.9%	7.1%	1.4%	11.4%
	improved behavior	Count	9	25	1	35
		% of Total	12.9%	35.7%	1.4%	50.0%
Total	Count	21	47	2	70	
	% of Total	30.0%	67.1%	2.9%	100.0%	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.038 ^a	6	.317
Likelihood Ratio	6.295	6	.391
Linear-by-Linear Association	2.105	1	.147
N of Valid Cases	70		

a. 7 cells (58.3%) have expected count less than 5. The minimum expected count is .23.

outcome of tx * ethnicity

Crosstab

			ethnicity					Total
			caucasian	hispanic	african-american	multi-cultural	unspecified	
outcome of tx	no change	Count	5	2	2	2		11
		% of Total	7.1%	2.9%	2.9%	2.9%		15.7%
	improved insight/verbalization	Count	7	6		3		16
		% of Total	10.0%	8.6%		4.3%		22.9%
	improved behavior in one setting	Count	1	5	1	1		8
		% of Total	1.4%	7.1%	1.4%	1.4%		11.4%
	improved behavior	Count	16	8	4	5	2	35
		% of Total	22.9%	11.4%	5.7%	7.1%	2.9%	50.0%
Total	Count	29	21	7	11	2	70	
	% of Total	41.4%	30.0%	10.0%	15.7%	2.9%	100.0%	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.751 ^a	12	.550
Likelihood Ratio	13.019	12	.368
Linear-by-Linear Association	.065	1	.798
N of Valid Cases	70		

a. 16 cells (80.0%) have expected count less than 5.
The minimum expected count is .23.

outcome of tx * gender

Crosstab

			gender		Total
			male	female	
outcome of tx	no change	Count	8	3	11
		% of Total	11.4%	4.3%	15.7%
	improved insight/verbalization	Count	12	4	16
		% of Total	17.1%	5.7%	22.9%
	improved behavior in one setting	Count	5	3	8
		% of Total	7.1%	4.3%	11.4%
	improved behavior	Count	22	13	35
		% of Total	31.4%	18.6%	50.0%
Total		Count	47	23	70
		% of Total	67.1%	32.9%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.973 ^a	3	.808
Likelihood Ratio	.992	3	.803
Linear-by-Linear Association	.748	1	.387
N of Valid Cases	70		

a. 2 cells (25.0%) have expected count less than 5. The minimum expected count is 2.63.

outcome of tx * intervention

Crosstab

		intervention											Total		
		therapeutic games	non-therapeutic games	arts/crafts	sand tray	role-play	clay/play-doh	worksheets	drawings	toy play	books/storytelling	physical play		combination	
outcome of tx	no change	Count	2					4	1					2	11
	% of Total		2.9%					5.7%	1.4%					2.9%	15.7%
	improved insight/verbalization	Count	2	4	2		1			2	1			3	16
	% of Total		2.9%	5.7%	2.9%		1.4%			2.9%	1.4%			4.3%	22.9%
	improved behavior in one setting	Count		1		1				3	1			2	8
	% of Total			1.4%		1.4%				4.3%	1.4%			2.9%	11.4%
	improved behavior	Count	2	9	1		1	1	9	7	2			3	35
	% of Total		2.9%	12.9%	1.4%		1.4%	1.4%	12.9%	10.0%	2.9%			4.3%	50.0%
Total	Count	4	16	3	1	2	1	18	10	2	2	1	10	70	
	% of Total		5.7%	22.9%	4.3%	1.4%	2.9%	1.4%	25.7%	14.3%	2.9%	1.4%	14.3%	100.0%	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	32.719 ^a	33	.481
Likelihood Ratio	30.767	33	.579
Linear-by-Linear Association	.777	1	.378
N of Valid Cases	70		

a. 44 cells (91.7%) have expected count less than 5.
The minimum expected count is .11.

APPENDIX D
AUTHORIZATION LETTER



West End
Family Counseling Services

...serving our communities since 1955

November 28, 2001

To whom it may concern:

This letter is to verify that Nelly Saucedo and Lisa Meyer have received authorization to conduct research per their University requirements at this agency.

In an effort to gain information regarding what play therapy techniques are most efficient/effective with children exhibiting anger problems in a school setting both students have received permission to review closed case files. The files and confidential information therein is to remain at the agency.

Upon conclusion of this research, the agency would like to review Nelly and Lisa's findings, as it may be useful in serving our clients.

If you request any additional information, do not hesitate to call me at (909) 983-2020 ext. 242.

Sincerely,

Lisa Albert, LCSW, PPSC
Program Coordinator

Ontario Headquarters
855 North Euclid Avenue
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ASSIGNED RESPONSIBILITIES PAGE

This was a two-person project where authors collaborated throughout. However, for each phase of the project, certain authors took primary responsibility. These responsibilities were assigned in the manner listed below.

1. Data Collection:

Assigned Leader: Nelly Edith Saucedo

Assisted By: Lisa Marie Meyer

2. Data Entry and Analysis:

Assigned Leader: Lisa Marie Meyer

Assisted By: Nelly Edith Saucedo

3. Writing Report and Presentation of Findings:

a. Introduction and Literature

Team Effort: Lisa Marie Meyer and
Nelly Edith Saucedo

b. Methods

Team Effort: Lisa Marie Meyer and
Nelly Edith Saucedo

c. Results

Team Effort: Lisa Marie Meyer and
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d. Discussion

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