THE EFFECTIVENESS OF NON-DIRECTIVE PLAY THERAPY

by

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ABSTRACT

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A variety of therapeutic interventions appear to be effective when used with children who are struggling with issues such as abuse, neglect, divorce, family violence, grief, and severe trauma. Due to the developmental differences between children and adults, children need an alternative approach to conventional talk therapy to meet their needs. Non-directive play therapy is a unique therapeutic process that allows children to act out circumstances that are scary, confusing, or bothersome to them (Woltmann, 1964). The play therapist recognizes the child's wants, needs, and feelings, which are expressed through

play. Each toy selected by the child is a representation of what he/she is trying to communicate (Landreth, 2002).

Recent literature implies that the use of non-directive play therapy is a beneficial therapeutic technique for children. This research paper reviews current literature on play therapy, examines how effectiveness of play therapy is measured, and examines specific studies on the effects of non-directive play therapy. A critical analysis of the literature and recommendations for further research are also included in this study.

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CHAPTER I

INTRODUCTION

Children in today's society are dealing with many complex issues such as poverty, gender issues, disease, and abuse. They are also faced with violence in their schools, at home, or on television, which may teach them to express their feelings in a violent way (Garbarino, 1995). Many are confronted with the pressures of divorce, which according to Amato and Keith (1991) may be associated with difficulty in school, behavior problems, negative self-concepts, and problems with peers. These issues have an adverse effect on society's children, and with our fast paced mentality children may feel there are few resources that will help them cope. According to the U.S. Department of Health and Human Services (1999), one in five children has a diagnosable mental, emotional, or behavioral disorder, and up to one in 10 may suffer from a serious emotional disturbance. Seventy percent of these children, however, do not receive mental health services.

Children need healthy ways to express their feelings and the concerns they have for the difficult issues they are trying to cope with. A plethora of therapies developed for adults have been adapted to meet the needs of children. However, some of these therapies overlook the fact that young children do not have the knowledge or the words to express the conflict that is behind their behaviors (Landreth, 2002). Children also have better "receptive language skills than

expressive language skills" (Kottman, 1995, p. 21). Play therapy has been specifically designed to be developmentally appropriate for children and is based on the idea that children communicate and express inner conflicts and feelings through play (Landreth, 2002).

Different modalities of play therapy include psychoanalytic child therapy, Jungian play therapy, filial play therapy, and client-centered or non-directive play therapy. Psychoanalytic child therapy uses play as a means of establishing contact with the client, as a source of data, as a medium of observations, and as a method for interpretive communication (Kottman, 2001). The therapist has an active role in Jungian play therapy as a facilitator interacting with the child, but not as a leader. Filial play therapy combines play therapy for children and parent education through direct parent involvement in the change process. The therapist provides direction for therapeutic interventions, serving as both a teacher and an empathetic support person for the parents (Kottman, 2001). Client-centered or non-directive play therapy is based on the theory that children have the ability to heal themselves, given the optimal therapeutic conditions (Kottman, 2001). The therapist is non-directive, leaving responsibility and direction to the child. This approach emphasizes empowering the child, self-awareness, decision-making, and acceptance of the child's self. The responses of the play therapist to the child's behaviors, feelings, and cognitions reflect the child's reality. There is no

judgment against the child, no disagreement with the child, and no denial of what the child holds to be true (Kottman, 2001).

A goal of non-directive play therapy is to help the child work through suppressed feelings that may be causing disruptive behaviors at home or in school. There has been little thorough research conducted on the efficacy of play as a therapeutic intervention tool for children. The two major foci of therapeutic work with children are outcome research and the case study approach, which appears to be the preferred method (Carroll, 2000).

The primary function of a narrative case study is to examine the process of healing in a specific client or group of clients. There are different methods to narrative case studies that can be divided into two approaches: therapists who focus on the details of individual sessions and those who describe an overview of the therapeutic process.

Cuddy-Casey (1997) conducted a case study on a depressed eight-year-old boy named Tom who also suffered from inorganic enuresis and encopresis. The therapist conducted fourteen non-directive play therapy sessions with the child. The child's mother reported observable change in Tom's enuretic and encopretic behavior. Six months after termination a follow-up appointment indicated that Tom was accident free (Cuddy-Casey, 1997).

Unlike the narrative case study design, the process and outcome research approach measures the functioning of a group of children by establishing baseline data first and then grouping the children randomly and providing them with a different intervention (or sometimes, no intervention). At the end of treatment the children are measured again and the outcomes are then compared with the baseline data obtained earlier (Carroll, 2000).

Outcome studies have been used to measure the effect play therapy has on a child's behavior (LeBlanc & Ritchie, 2001). In 1999, Fall conducted a study working with children in a school counseling setting through time-limited play therapy. The study involved 62 students exhibiting specific behaviors, such as using self-defeating coping mechanisms, having a low tolerance for frustration, or exhibiting withdrawn or attention seeking behaviors, which inhibited their learning. The results of the therapy sessions were measured using three different instruments, two of which were conducted by the children's teachers, to measure behavioral outcomes. There was a significant decrease in negative behaviors and a significant increase in self-efficacy behaviors in the children; however there was not a marked increase in positive classroom behaviors (Fall, 1999).

Unfortunately, there are several drawbacks to both forms of research used to measure the efficacy of play therapy. For example, because a case study format usually focuses on an individual child or an individual group of children it is difficult to generalize the results to the rest of the population, because each

child is unique in their own way and may react differently to the therapy. There is also no guarantee that the technique applied will be effective in a different setting. Also, case study research is primarily reported by the therapists conducting the sessions, which makes it difficult to separate the information from the biases of the reporter.

One the other hand, there are also some limitations to the process and outcome approach to play therapy research. For example, children at different developmental stages could possibly react differently to the specific intervention used. It is also impossible to compensate for all the dissimilarities between children such as cultural and social variations (Carroll, 2000).

Statement of the Problem

Previously, some studies have shown the effectiveness of play therapy (Constantino, Malgady, & Rogler, 1986; Elliot & Pumfrey, 1972; Fall, 1994). However, the majority of the research conducted on the efficacy of play therapy has used a case study format, which is rarely accepted as clinical research (Bratton & Ray, 2000). According to Yavari (1997), there has been very little scrupulous research into the process and outcome of play therapy, so that it is difficult to draw any conclusions about the effectiveness of the technique.

Purpose of the Study

The purpose of this paper is to review the literature with regard to the effectiveness of play therapy. After closely examining the general literature in

this important topic, the effectiveness of the non-directive approach of play therapy will specifically be investigated. The following research questions guided this review:

1. How is the effectiveness of play therapy measured?
2. How effective is non-directive play therapy?
3. What are the difficulties with the current research methods and traditional measures used to research the efficacy of play therapy?

Definition of Terms

For the purpose of this paper, several words and phrases have been defined and are listed below:

Play Therapy: According to the Association for Play Therapy (2002), play therapy is a "systematic use of a theoretical model to establish an interpersonal process in which trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development."

*Non-Directive Play Therapy***:** A form of therapy for children where the therapist leaves responsibility and direction to the child. This approach emphasizes empowering the client, self-awareness, decision-making, and acceptance of the client's self. Non-directive play therapy is also referred to as child-centered play therapy.

Limitations of the Literature Review

There are several limitations to this literature review. The researcher attempted to be exhaustive in reviewing all the current literature available on non-directive play therapy; however, some research may have been overlooked. Consequently, this review may portray a biased outlook in regards to the effectiveness of non-directive play therapy. Also, other therapeutic interventions that may be appropriate with children were not explored. Furthermore, this review is just a summarization of current literature on play. Subsequently, this review does not add new empirical information to the field of child therapy.

CHAPTER TWO

LITERATURE REVIEW

Chapter Two will discuss non-directive play therapy as a whole. This chapter will also review current research-based articles focusing on the outcomes of non-directive play therapy and the indicators used to determine the outcomes.

Non-Directive Play Therapy

Play has been described as a "universal and inalienable right of childhood" (Landreth, 2002, p.10). Adults sometimes refer to play as “child’s work” to give some meaning to it, to make a comparison on how play fits into the adult world. Play, however, is the opposite of work. Work has some sort of goal and direction to it such as the completion of a task. In contrast, play is intrinsically motivated and changes to match the child’s view of the world. For example, a child may use a baby bottle as a rocket ship (Landreth, 2002).

Child’s play is a way for children to become familiar with their environment. According to Piaget (1962), play brings together concrete experiences and abstract thought, and it is the symbolic function of play that is so important. Play is the one thing children have control of, allowing them to feel more secure (Landreth, 2002).

The therapeutic process of play allows children to act out circumstances that are scary, confusing, or bothersome to them (Woltmann, 1952). Adults naturally communicate through verbalization, whereas a child's natural means of

expression is play. Children are not developmentally ready to use expressive language as a primary means of communicating their feelings (Landreth, 2002) and also have difficulty using abstract verbal reasoning, making it difficult for the therapist to use conventional talk therapy to help children work through their problems (Kottman, 2001).

Although a child's method of emotional expression is different than that of an adult, the feelings the child has are similar, such as fear, happiness, guilt, anxiety or sadness. Therefore, "toys are viewed like words by children, and play is their language. To restrict therapy to verbal expression is to deny the existence of the most graphic form of expression, which is activity" (Landreth, 2002, p. 16). Children use toys to express feelings they may be afraid to talk about. Play reveals several different aspects of a child such as, "what the child has experienced, reactions to what was experienced, feelings about what was experienced, what the child wishes, wants, or needs, and the child's perception of self" (Landreth, 2002, p. 18).

The process of non-directive play therapy is unique in several ways. Axline (1967) created eight basic principles of non-directive play therapy and they are listed as follows:

1. The therapist must develop a warm, friendly relationship with the child, in which good rapport is established as soon as possible.
2. The therapist accepts the child exactly as he is.

3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
4. The therapist is alert to recognize the *feelings* the child is expressing and reflects those feelings back to him in such a manner that he gains insight into his behavior.
5. The therapist maintains a deep respect for the child's ability to solve his own problems if given an opportunity to do so. The responsibility to make choices and to institute change is the child's.
6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.
7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
8. The therapist establishes only those limitations that are necessary to anchor the therapy to the world of reality and to make the child aware of his responsibility in the relationship. (p. 73-74)

When the eight basic principles are applied, the elements of acceptance trust, and empathy are established in the relationship between therapist and child. Several qualities make the effective play therapist unique among other adults in the child's life. The therapist's role is to be fully present, which includes interacting with the child by observing, listening, and making reflective

statements of recognition. This process allows the therapist to recognize the child's wants, needs, and feelings. The play therapist recognizes that child's actions are a message expressed through his/her play. Each toy selected by the child is a representation of what he/she is trying to communicate (Landreth, 2002).

A key component to non-directive play therapy is turning over responsibility to the child, which fosters independence and empowerment. Therapists do not judge or evaluate the child; therefore, interpretation is not generally used. Warmth and acceptance is also another key component to non-directive play therapy. This encourages the child to become comfortable enough to express *any* emotions he or she is experiencing. However, the permissive aspect of non-directive play therapy does not mean the acceptance of all behaviors (Landreth, 2002).

Therapeutic limit setting helps children learn that they have choices, what making choices feels like, and how responsibility feels. Limits generally are not expressed until they are needed and based on clear, definable criteria. According to Landreth (2002),

1. Limits provide physical and emotional security and safety for children.
2. Limits protect the physical well-being of the therapist and facilitate acceptance of the child.

3. Limits facilitate the development of decision-making, self-control, and self-responsibility of children.
4. Limits anchor the session to reality and emphasize the here and now.
5. Limits promote consistency in the playroom environment.
6. Limits preserve the professional, ethical, and socially acceptable relationship.
7. Limits protect the playroom materials and room. (p. 250-257)

According to Landreth (2002), children progress through five stages throughout the process of non-directive play therapy. In the beginning stage children convey and eventually diffuse negative feelings in their play. During the second stage of non-directive play therapy, children manifest reluctant feelings, such as anxiety or hostility. In the third stage children once again express mostly negative feelings; however, the feelings are directed toward parents, siblings, or the therapist or acted out through regressive behaviors. During the fourth stage reluctant feelings, either negative or positive, resurface, but as in the third stage these feelings are focused on parents, siblings, or the therapist. In the final stage of therapy, children express mostly positive feelings, with realistic negative attitudes expressed appropriately without ambivalence (Landreth, 2002).

Measuring the Effectiveness of Play Therapy

Merriam-Webster (2002) defines efficacy as the power to produce an effect. Play therapy is presumed to produce effects, such as changes in the

behavior of the child, otherwise known as behavioral outcomes. Behavioral change may be associated with positive changes in the child's inner self, such as improved self-concept. A child's maladaptive coping mechanisms, such as tantrums, self-injury, social withdrawal, or obsessive-compulsiveness, may no longer be needed and would in effect wane (Reams & Freidrich, 1994).

Researchers use several approaches to measure the effectiveness of play therapy. Two principle approaches have been the outcome approach and the case study approach. The case study approach is not comparative in nature, and researchers usually focus on assessing the progress of an individual child exposed to a particular intervention. On the other hand, outcome research usually involves a comparison between two groups of individuals using a quantifiable pretest and posttest format (Carroll, 2000).

The case study method is most frequently used by researchers of play therapy and involves an individual child as the focus of the research. Researchers may use a combination of quantitative and practical measures, which may include baseline data and/or qualitative assessment. Case studies are qualitative in nature and include detailed documentation of the child's progression throughout therapy. Case studies are usually reported by the therapist conducting the sessions and can be divided into two categories; studies that focus on the elements of individual sessions and those that examine the therapeutic process (Carroll, 2000).

The outcome approach is a more accepted research approach than the case study approach; however, it is not as widely used by professionals in the field of play therapy. Researchers using the outcome method assess the functioning of a group of children before any intervention takes place; this is referred to as baseline data. After the baseline data is collected, the subjects are randomly divided into groups and exposed to different interventions or possibly none at all. After the intervention is complete, the subjects' functioning is measured again and the results are compared with the information obtained earlier. The researcher then draws conclusions as to the efficacy of the therapy (Carroll, 2000).

General Findings

One method for examining the overall effectiveness of play therapy is to conduct a meta-analysis of the outcomes. LeBlanc and Ritchie (2001) reviewed 23 journal articles, 16 dissertations, and three unpublished documents in conducting a meta-analysis of play therapy outcomes. The following characteristics were analyzed to determine which factors have the most significant effect on the outcomes of play therapy:

1. the modality of play therapy used (e.g., behavioral, non-directive)
2. the inclusion of parents in the play therapy process
3. the duration of therapy
4. the gender composition of the participants
5. the presenting problems

6. the use of other therapies in conjunction with play therapy
7. the date of publication
8. the source of the article (i.e., journal, dissertation)
9. whether the study was published or not
10. the average age of participants
11. whether the study used a control group or a comparison group (used as a measure of study quality)
12. the type of research design used
13. the use of group or individual therapy. (p.152)

As a result of their meta-analysis, LeBlanc and Ritchie (2001) concluded that parental involvement was one of the most significant predictors of play therapy outcomes. There are several ways parents can be involved in the play therapy process. One way parents can be involved in the play therapy process is to work directly with their child and the therapist in play sessions using techniques such as tracking, restating content, reflecting feelings, and setting limits. Therapists can also work simultaneously with children and parents by dividing sessions between play therapy with the child and consultation with the parent. Another way parents can be involved in the play therapy process is to actively participate in the development and implementation of their child's treatment plan (Kottman, 2001).

On the other hand, according to Landreth (2002), play therapy can also be effective without parents being directly involved in the therapeutic process or receiving therapy or training. Parental involvement in non-directive play therapy involves interviews with the parents to obtain background information to better understand the child's life outside the play therapy room. This information provides the therapist with the opportunity to be more sensitive and empathic with the child, which will assist in facilitating the therapeutic relationship. Parental or guardian permission must be obtained before any therapeutic intervention proceeds. Therapists may involve parents in the therapeutic process by spending a brief amount of time each session consulting with parents about parenting skills and family interactions (Landreth, 2002).

In addition, LeBlanc and Ritchie (2001) found that the other most significant predictor of play therapy outcomes was the duration of therapy, i.e. the number of therapy sessions the child participated in. As a result of the study, LeBlanc and Ritchie (2001) concluded that therapy is most likely to be effective when the child receives approximately 30 to 35 sessions. There appeared to be a decrease in efficacy in the benefits of therapy for the children after 35 sessions (LeBlanc & Ritchie, 2001).

LeBlanc and Ritchie (2001) concluded that several variables do not predict outcomes as a result of play therapy. Presenting problems, group therapy verses individual therapy, age of the participants and genders of the clients have no

significant effect on therapy outcomes. Overall, the results of the meta-analysis concluded "on average, children who receive play therapy performed 25 percentile units higher on the given outcome measures when compared to children who did not receive treatment" (LeBlanc & Ritchie, 2001, p. 154).

Other studies support LeBlanc and Ritchie's (2001) findings that play therapy is an effective therapeutic tool when used with children. Bratton and Ray (2000) conducted a comprehensive literature review summarizing the results of 82 play therapy research studies. As a result of their study, they concluded that play therapy is effective therapeutic intervention, particularly with children who have difficulty in the area of self-concept, behavioral change, cognitive ability, social skills, and anxiety. Kottman (2001) also reviewed several studies and concluded that play therapy is an effective intervention for children struggling with issues such as, abuse, neglect, divorce, family violence, grief, and severe trauma.

Effect of Non-Directive Play Therapy (Specific Studies)

According to a recent survey conducted by Kranz, Kottman, and Lund (1998), the majority of practitioners who use play therapy as a treatment method most commonly use the non-directive play therapy approach. The following section will review specific studies regarding the effectiveness of non-directive play therapy.

Cuddy-Casey (1997) conducted a case study on a depressed eight-year-old boy named Tom who also suffered from inorganic enuresis and encopresis. The

therapist conducted fourteen non-directive play therapy sessions with the child. The child's mother reported observable change in Tom's enuretic and encopretic behavior. Six months after termination a follow-up appointment indicated that Tom was accident free (Cuddy-Casey, 1997).

Fall (1994) examined the effects of non-directive play therapy sessions on the self-efficacy of a six-year-old Caucasian girl named Miranda using a case study format. During the initial parent interview, Miranda's parents described her as "bossy, sullen, unhappy, and never satisfied" (Fall, 1994, p. 23) and stated that the problems had increased since the birth of her brother. As a result of Miranda's negativity, she had no positive peer relationships and was at-risk of school failure. Miranda had characteristics that represented low self-efficacy, such as her rigid behaviors, lack of persistence on all tasks that did not end with instant success, and accusations that her failure was contributed to other individuals or the environment (Fall, 1994).

After the completion of five one-hour play therapy sessions Miranda's parents, teacher, and therapist agreed that her behavior had dramatically changed from the first visit to the last. She interacted with other children, gained a friend, smiled, and appeared happy at home and at school (Fall, 1994).

Fall (1999) also conducted a study examining the impact non-directive play therapy has on self-efficacy related to learning and coping behaviors and behaviors in the classroom; however, she used the process and outcome approach

to conduct her research. Fall's study was theoretically and empirically based on four factors that influence self-efficacy: mastery performance, verbal persuasion, vicarious experiences which provide for social comparison, and physiological responses (Bandura, 1986, 1989).

Subjects were randomly selected from a list of children provided by the teachers for participation. The children selected exhibited coping strategies that did not facilitate learning, for example social withdrawal, low frustration tolerance, acting out, and attention seeking (Fall, 1999). Non-directive play therapy sessions were conducted with the children; each child participated in one 30-minute session a week for six weeks. The children's behavior was assessed using three different measures: classroom observation, the Self-Efficacy Scale for Children (S-ES), and the Conner's Teacher Rating Scale (CTRS) (Conners, 1986). Researchers employed a pretest/posttest format with these measures.

The study found a significant increase in self-efficacy of the children who participated in the experimental group (Fall, 1999). Both the experimental and the control group showed an increase in unspecified positive behaviors; however, there was not a significant increase in positive classroom behaviors. Children from the control group and the experimental group showed no significant difference in pre and post-test scores of off-task behaviors observed in the classroom.

The outcome of Fall's (1999) study suggests that non-directive play therapy has a favorable impact on the self-efficacy of children. On the other hand, the results showed no significant effect on an increase in positive classroom behaviors.

In addition to Fall (1999), Jones & Landreth (2002) conducted a study focusing on the outcomes of non-directive play therapy; however, his population sample was chronically ill children. Participants of Jones & Landreth's study included 30 children, ages seven to eleven, attending a three-week summer camp that provided therapeutic interventions for children living with insulin-dependant diabetes mellitus. During the three-week camp, children selected for the experimental group attended 12 play therapy sessions, conducted by trained play therapists. The children who participated in the control group were also attendees of the camp.

Parents of the campers were requested to fill out the Filial Problems Checklist (FPC) and the Diabetes Adaptation Scale-Parent Form (DAS-Parent Form) at the beginning and end of their child's therapy sessions. Also, each child was asked to complete the Revised Children's Manifest Anxiety Scale (RCMAS) and the Diabetes Adaptation Scale-Child Form (DAS-Child Form) prior to and after play therapy sessions. Parents and children were asked again to complete the same forms three months after the camp ended (Jones & Landreth, 2002).

The results of the study found no significant decrease in anxiety symptoms among the experimental group when compared to the control group. However, individual clients showed improvement during sessions. For example, a child who was part of the experimental group appeared at the camp hospital on a daily basis complaining of stomachaches. During the fifth play therapy session the following conversation occurred (Jones & Landreth, 2002):

Child: "Does your stomach ever have anxious, um, I mean, anxiousness?"

Therapist: Hmm. Sounds like someone said something to you about anxiousness.

Child: Yeah. What does that mean?

Therapist: In here, it can mean whatever you would like it to. *(Child looked confused.)* What does it mean to you?

Child: That you are excited to do something?

Therapist: Ah. I think it can mean that. It can also mean that you feel worried or nervous sometimes.

Child: Oh! I feel that.

Therapist: Hmm.

Child: Let's play house. (p. 127)

The days proceeding the fifth session, the play therapist and the nurses had noticed that the child no longer came to the camp hospital complaining of stomachaches.

Both experimental and control groups showed improvement on the Filial Problems Checklist posttest, but only the experimental group showed significant improvement on the three month follow-up survey. Finally, there was a significant increase ($p < .05$) in diabetes adaptation within the experimental group, which was indicated on the Diabetes Adaptation Scale-Parent Form; however, there was no significant improvement on the Diabetes Adaptation Scale-Child Form at posttest and during follow-up. This indicated that parents whose children participated in the experimental group perceived improvement in diabetes adaptation; however, their children did not (Jones & Landreth, 2002).

In summary, Jones & Landreth's (2002) study reported mixed results on the effectiveness of non-directive play therapy. There was no significant decrease in the participants' anxiety levels, nor was there a change in the subject's perceptions of diabetes.

Post (1999) conducted a study on the effect of non-directive play therapy on self-esteem, locus of control, and anxiety involving 186 at-risk 4th, 5th, and 6th graders. Sessions were conducted by 12 graduate students who received on-going supervision and had completed a graduate level *Introduction to Play Therapy* course. To measure outcomes, the researcher used the Coopersmith Self-Esteem

Inventory (Coopersmith, 1981), the Intellectual Achievement Responsibility Scale-Revised (Crandall, Katkovsky, & Crandall, 1965), and the State-Trait Anxiety Inventory (Spielberger, Gorsuch, & Lushene, 1968; 1970).

The results of the study indicated that non-directive play therapy did not improve the students' overall self-esteem; however, children who participated in the control group had a significant decrease in self-esteem throughout the school year. Students in both the experimental group and control group had a more external locus of control preceding client-centered play therapy interventions. Children with an external locus of control rely on extrinsic factors to motivate them, such as tangible rewards and social reinforcement. Children with an internal locus of control rely on intrinsic resiliency and motivation. Results showed that the experimental group had a decrease in external locus of control; however, the control groups' stayed the same. There were no significant changes in the anxious behaviors of children participating in the control group and the experimental group (Post, 1999).

In summary, Post's (1999) study reported mixed results on the effectiveness of non-directive play therapy. Non-directive play therapy did not appear to significantly improve self-esteem or locus of control. Also, the therapeutic intervention did not appear to have an effect on anxiety. However, play therapy was associated with preventing a decline in self-esteem and improved locus of control.

Kelly (1995) used a case study format to study two children who were inpatients at a residential psychiatric facility for seriously emotionally disturbed children. Both children were exhibiting self-defeating behaviors such as running away and withdrawing from family members. Kelly's (1995) first subject was a seven-year-old girl named Jeanie who had been subjected to physical, emotional, and sexual abuse by her biological and foster families. Jeanie exhibited angry and rebellious behaviors similar to the symptoms of conduct disorder.

During the first session, Jeanie refused to enter the play therapy room and denied that there were any problems. As the sessions progressed, the therapeutic work was centered on Jeanie's anger and the therapist's understanding and acceptance her feelings. Jeanie began to respect and direct her anger rather than feeling overwhelmed by it; however, she still continued to deny that she had any problems. No report was made as to how many play therapy sessions were conducted with Jeanie (Kelly, 1995).

Kelly (1995) conducted a second case study on an eight-year-old boy named Jeff. Since birth, his family had exposed him to ritualistic, violent sexual abuse. Jeff refused to discuss the abuse and responded to questioning by closing his eyes and bowing his head. He was a non-reader because he feared books due to the concept that certain numbers and letters could harm him. Jeff's presenting problems were characteristics of posttraumatic stress disorder: sleep disturbances such as nightmares and nocturnal enuresis, fear of being alone, numbness, and

withdrawal from relationships. Throughout therapy, Jeff's play themes involved incapacitated, but dangerous parent figures, loss of safety and security, mourning and grief, and feeling of power that came with the courage to face pain and fear. After a year of therapy, he began to talk openly about his background and became an avid reader (Kelly, 1995).

According to Kelly (1995), her subjects appeared to benefit from non-directive play therapy. Jeanie showed favorable improvement exhibiting a reduction in aggressive behaviors; however, she continued to deny that she had any problems. Before therapy, Jeff refused to discuss any of his problems and had a fear of books. After a year of therapy, he began to talk openly about his background and became an avid reader

In summary, recent research indicates that play therapy is an effective treatment modality for children. In particular, parental involvement and duration of play therapy appear to have the most favorable impact on the outcomes of play therapy. Although non-directive play therapy is the treatment of choice among play therapists, current research has shown mixed results on the effectiveness of the intervention.

CHAPTER THREE

SUMMARY AND DISCUSSION

According to the U.S. Department of Health and Human Services (1999), one in five children has a diagnosable mental, emotional, or behavioral disorder, and up to one in 10 may suffer from a serious emotional disturbance. Seventy percent of these children, however, do not receive mental health services. Children need healthy ways to express their feelings and the concerns they have for the difficult issues they face.

Non-directive play therapy is a therapeutic process that allows children to act out circumstances that are scary, confusing, or bothersome to them (Woltmann, 1964). Non-directive play therapists use specific techniques, such as interacting with the child by observing, listening, and making reflective statements of recognition. Some goals of non-directive play therapy are to foster independence and empower the child by returning responsibility back onto him/her. The therapist conveys a warm and accepting demeanor towards the child promoting a comfortable environment, which allows the child to express any emotions they may be experiencing.

There have been several studies conducted to determine the effectiveness of play therapy. LeBlanc and Ritchie (2001) reviewed 23 journal articles, 16 dissertations, and three unpublished documents conducting a meta-analysis of play therapy outcomes. Overall, the results of the meta-analysis concluded "on

average, children who receive play therapy performed 25 percentile units higher on the given outcome measures when compared to children who did not receive treatment" (LeBlanc & Ritchie, 2001, p. 154). Only parent involvement and duration of play therapy emerged as significant influences on play therapy outcomes.

Cuddy-Casey (1997) conducted a case study on a depressed eight-year-old boy named Tom who suffered from inorganic enuresis and encopresis, six months after termination a follow-up appointment indicated that Tom was accident free.

Fall (1999) also conducted a study examining the impact of non-directive play therapy on self-efficacy related to learning and coping behaviors and behaviors in the classroom. The study found a significant increase in self-efficacy of the children who participated in the experimental group.

In addition to Fall (1999), Jones & Landreth (2002) conducted a study focusing on the outcomes of non-directive play therapy; however, his population sample was chronically ill children. The results of the study found no significant decrease in anxiety symptoms among the experimental group when compared to the control group. However, the authors maintained that individual clients showed improvement during sessions.

In summary, due to the developmental differences between children and adults, children need an alternative approach to talk therapy to meet their needs. Recent literature describes moderate amounts of research supporting the

effectiveness of non-directive play therapy as a therapeutic tool for working with children with mental health disorders.

Analysis of the Literature

Although a fair amount of literature supports the efficacy of non-directive play therapy, very little of it is empirically based. A large portion of the research that exists uses a narrative case study format, which is rarely accepted as clinical research. Case studies contain very small samples, making it difficult to generalize the findings to the universal population. Also, it is impossible to assume that subsequent children exposed to non-directive play therapy will respond in the same way or that the technique will be effective in a different setting.

Another limitation to research conducted using a case study format is that, due to the fact that studies are frequently conducted by a practitioner/researcher, the information reported is subjective. For example, Fall (1994) made assumptions about the significance of Miranda's play. Fall (1994) believed the positive change in Miranda's negative behavior resulted from her ability to express a need for complete control within the play therapy room. However, because the motivation of a child's play is mostly unconscious, assumptions cannot be certain. Also, factors that occur outside the play therapy room such as maturation or change in environment were not considered.

Due to the subjectivity of current case study research there is a great need to receive feedback from outside sources; for example, parents. LeBlanc and Ritchie's (2001) research indicated that parental involvement is a significant predicator of play therapy outcomes. Also, it is easier for parents to recognize changes in their child's behavior within the environment outside the play therapy room. The Jones and Landreth (2002) article was the only study included in this review that surveyed parental perceptions of play therapy outcomes.

The outcome approach is also used in research to support the efficacy of play therapy; however, less frequently. Although the outcome approach is a more accepted component of research, there are also limitations to this method. Most outcome research on non-directive play therapy uses a control group design, which generally compares play therapy to no intervention. For example, the outcome research studies examined in this review, Jones & Landreth (2002), Fall (1999), and Post (1999), used a control group design. Due to this limitation it is impossible to determine if non-directive play therapy is more effective than other therapeutic interventions used with children.

It is also impossible to include and control all variables involved in a study. For example, Jones & Landreth's (2002) experimental group was 86.6% Caucasian, 6.7% African Americans, and 6.7% of Indian descent. On the other hand, their control group was 86.6% Caucasian and 13.3% Hispanic, not including individuals of African Americans or Indian decent. Due to the uneven

distribution of minority populations, it may not be valid compare both groups. Along with individual differences of each child, it is also difficult to account for the natural changes in a child's functioning, the effect parents have on the child, or environmental factors. For example, the play therapy sessions Kelly (1995) conducted with Jeff occurred over the course of a year. Changes in Jeff's behavior could have been the result of maturation or a change in his environment.

Another variable that is difficult to control is the variation in the skill of the therapist and the quality of the therapeutic relationship. Very few studies reported the educational background or work experience of the therapists. Exceptions included Fall (1999), who explained that the therapists used in her study were school counselors trained in play therapy and Jones & Landreth (2002), who also described the training of the therapists who participated in the implementation of their study.

LeBlanc & Ritchie (2001) indicated that duration of play therapy is a significant predictor of play therapy outcomes; for example, children appeared to benefit most when they participated in 30-35 sessions. Unfortunately, only one study, Post (1999), conducted long-term sessions with a child. The subjects in Jones and Landreth's (2002) study only participated in 12 play therapy sessions over a three-week period. Cuddy-Casey (1997) only conducted 14 sessions with her subject and Fall (1994) only conducted five sessions with her client. Also,

some children progress more rapidly than others; as a consequence, one child may benefit from long term therapy while another may not.

Implications for Future Research

Future research is needed into the effectiveness of play therapy. Specifically, more research should include studies that involve parents' perceptions of the outcomes of play therapy. This research would examine whether behavioral changes seen within the play therapy room are generalizable to the child's outside environment. Another direction for future research results from the fact that most play therapy research contains small sample sizes. Larger sample sizes should be used in future studies. Also, LeBlanc and Ritchie's (2001) study indicated that 30-35 sessions significantly predicted outcomes of play therapy. Due to the fact that most of the studies included in this review conducted less than 30-35 sessions, more research is needed on longer term therapy. In addition, current research on play therapy mostly uses a no-treatment control group design, making it difficult to determine whether play therapy is more effective than other therapeutic interventions. Therefore, future research should include comparative studies between play therapy and other therapeutic interventions.

In conclusion, the effectiveness of play therapy generally has been studied using the outcome and case study approach. The efficacy of non-directive play therapy has been found to have significant effects on self-efficacy and locus-of-

control. However, current studies showed mixed results on the effectiveness of non-directive play therapy. Because of the limitations of research conducted on non-directive play therapy, additional research is needed on this subject.

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