THE USE OF PLAY THERAPY IN THE PRIVATE CLINICAL SETTING

by

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ABSTRACT

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The purpose of this study was to identify factors relating to the use of play therapy as a counseling tool in private therapy clinics in the Midwest region of the United States.

Play therapy is an interpersonal relationship between a troubled child and a therapist. Toys are the means of interaction and communication between the child and therapist. The selected play materials facilitate the development of a safe relationship in which the child can fully express and explore him/herself. Feelings, thoughts, experiences, and behaviors that occur in the play therapy room are accepted unconditionally by the play therapist. Since play is the natural medium of communication for the child, and expressing these feelings and thoughts is a key to successful therapy, few restrictions are placed on him/her (Landreth, 1991).

For this study, a total of 100 surveys were sent to subjects in eight (8) cities: Madison, WI; Milwaukee, WI; Des Moines, IA; Cedar Rapids, IA; Saint Paul, MN; Minneapolis, MN; Chicago, IL; Rockford, IL. The survey/questionnaire were used to determine the frequency of play therapy use in this clinical setting. It identified

demographic variables of therapists who use play therapy as a counseling tool, and identified issues and problems where play therapy would be implemented by the therapist. The information concerning formal training in play therapy could be used to implement more play therapy workshops and courses in college.

Of the forty-eight (48) therapists who responded to the survey, forty (40) of them use play therapy when counseling children. Results of the survey show a larger number of women (36 or 75%) conducting play therapy than men (12 or 25%).

Certain certifications, such as psychologists and social workers, appeared to represent a large portion of therapists who use play therapy, while school psychologists, psychiatrists, and school counselors did not. Results from the study support key words or phrases cited in literature (e.g. client-centered, empowering) as being defining words of play therapy. Problems/ issues (e.g. aggression, abuse) identified in literature were also identified by the surveyed therapists as being helped by play therapy. The results of the questionnaire affirm the application of play therapy in the private clinical setting.

Table of Contents

I.	Abstract……...	i
II.	Table of Contents……...…..…	ii
III.	Chapter I: Introduction……	1
	Statement of the Problem……	7
	Definition……	8
IV.	Chapter II: Review of Literature…….	9
	Children's Problems…….	9
	Play Therapy……..…….	12
	Children's Problems Related to Play Therapy……..……..	15
V.	Chapter III: Methodology……...	19
	Subjects……..…….	19
	Instrument……..…….	19
	Procedure……...……...	19
	Data and Analysis……..…….	20
VI.	Chapter IV: Results…….	21
VII.	Chapter V: Discussion……	29
	Implications……..……..…….	30
	Limitations……..……..……..	31
	Future Research……..……..……...	31
VIII.	Bibliography……	33
IX.	Appendix A…….……	37
X.	Appendix B…….	38

Chapter I: Introduction

Children in today's society have many problems and issues to deal with; drugs, gangs, academic performance, concerns with the opposite sex, AIDS, and divorced parents, just to name a few. Numerous theories and styles of counseling that are currently used with adults have been modified to aid children in their healing process. These modifications to styles and techniques are needed to simplify the complexity of the underlying philosophies of the individual theories. Although the intricacies of the theories are still there, they are presented in simpler and more easily understandable ways to the young clients.

Rational-emotive therapy (RET) is one approach used to modify negative childhood emotions such as anxiety, depression, and extreme anger (Bernard, 1990). The cognitive changes of RET, as opposed to behavioral, practical, or vocational, are brought about by disputation or "gentle confrontation" by the therapist (Vernon, 1996). Specific thoughts and beliefs of the child are examined; irrational and anti-empirical beliefs are evaluated and challenged. "Absolutistic statements", "awfulizing", and "global ratings" statements are just a few of the cognitive distortions that are displayed by children (Bernard, 1990).

> The goals in the RET treatment of school-age populations are similar to those in adult treatment although the means vary depending on the cognitive-developmental status and intelligence of the student…RET is directed at bringing about a reduction in the intensity of inappropriate, negative emotions of students which are seen to be causing misery as well as making it harder for students to solve current problems and achieve future goals. (Bernard, 1990, p. 295)

Emotional difficulties appear to be more frequent in students over age 12 or 13, or children who are in the concrete operational period of thinking. Children in this stage,

however, lack experience and knowledge of life and therefore hold more erroneous thoughts and faulty beliefs about reality than most adults do (Bernard, 1990).

In counseling these older children using RET, the therapist focuses on the connection between thoughts, feelings, and behaviors; beliefs and behaviors and the difference between rational and irrational thoughts; self-acceptance and developing an awareness of one's own strengths and weaknesses; problem-solving and thinking objectively; and interpersonal relationships such as communication skills and frustration techniques (Vernon, 1996). Visual aids and diagrams in the session, as well as homework outside the sessions are effective with concrete operational thinkers (Bernard, 1990; Vernon, 1996).

RET treatment for a child younger than 7 years old needs to be modified because he/she has not yet reached concrete operational thought. Instead of disputing irrational thoughts, the RET therapist provides rational self-statements in age-appropriate (or simple) language that the child can practice in role-play and eventually in actual problem situations. Over time and with repetition, the child will learn to practice these self-statements silently with self-control and confidence (Bernard, 1990). The child will learn to actualize his/her potential and gain a sense of empowerment (Vernon, 1996). Although this technique may work well with a verbally communicative and compliant child, it has its limits when it comes to the nonverbal and oppositional child. If the child is unwilling to talk, RET has minimal effectiveness.

A counseling style that goes beyond working with the erroneous thoughts and faulty beliefs of RET is cognitive-behavioral therapy. For example, in working with

children with posttraumatic stress disorder (PTSD), the first step is to help children develop the strategies needed to control irrational and intrusive thoughts and images (cognitive). Next, the child is taught skills to control physical symptoms--such as tensing of muscles--that accompany the disturbing thoughts (behavioral). Lastly, children develop a sense of security at home, school, and their "natural" surroundings (Brown, 1996).

Children with a debilitating level of social anxiety, or social phobia, also may benefit from cognitive-behavioral therapy. For these children, cognitive restructuring is used to analyze and focus on anxiety-provoking self-statements in an attempt to reduce "overgeneralizations", “personalizations", "all-or-none thinking”, and other cognitive distortions (King et al., 1997; Brown, 1996). Behavioral techniques, such as relaxation training (deep breathing), social skills training (modeling), and real life exposure (en vivo) are used to help reduce social phobia as well (King et al., 1997). Self-monitoring (such as diaries) and homework assignments appear to work more effectively with older children as compared to younger ones (Brown, 1996; King et al., 1997). This is mostly due to the differences in thought processing and cognitive abilities of older and younger children.

Behavior modification techniques are, “based on concepts of learning principles, normal child development, and family interactions; it focuses on the client’s overt, observable behavior as controlled by both external reinforcement and internal cognitions; it is carried out with highly individualized treatment planning by an active therapist who promotes the active involvement of the clients” (Graziano & Dorta, 1995, p. 176). As an example, a "token economy," may be used to deal with the delinquent acts of children.

The token economy is set up to give children immediate rewards (ex. a poker chip) paired with verbal praise for good behaviors, with the purpose of receiving a primary reward when enough chips are accumulated. The social reinforcement and verbal praise are given so that the child associates them with the good behavior and eventually is motivated by them instead of just the chips. For example, when Joe does something good, he receives 1 chip and an “Excellent job!” At the end of the day, Joe has 15 chips and 15 verbal reinforcements. On an already pre-determined list of rewards, Joe sees that he can "buy" 30 minutes of video game time (or whatever may be less costly on the list). Chips can be saved to obtain a larger and more rewarding reinforcer for good behavior. Over time, Joe is less externally motivated by the chips and more internally motivated by the good feelings he gets with the social reinforcers he is receiving. The negative action is replaced with a more positive one.

Murphy (1994) proposes a different way to go about eliminating problem behaviors. He proposes a solution-focused model of utilizing exceptions to create changes in behavior. "It is often more productive to increase existing successes, no matter how small, than it is to eliminate problems" (p. 59). Here, the counselor talks to the child and discovers a time when the problem did not exist, or "discovers the exception." Once this is done, the child is encouraged to "do more of it." Goals are set at the onset of counseling as to what the child hopes to accomplish. If these goals are not achieved, “blame” is placed on all parties involved, not just the child (Murphy, 1994). In doing this, the child feels less attacked, more willing to change, and actually takes on more responsibility to produce change.

Jungian therapy with children is based upon three (3) stages: chaos, struggle, and resolution. The therapist makes suggestions and gives direction to the child's actions. By being aware of emerging unconscious themes in the child's actions and verbalizations, the therapist is able to uncover deeper affective expressions, provide deeper understanding of issues, and help the child move forward in development. The goal is to find and maintain a state of equilibrium between the child's inner world (feelings, impulses) and outer world (home, school) (Allan & Brown, 1993). For a child to do this, however, articulation of feelings, abstract thinking, and a strong sense of knowing one's self may be needed.

Adlerian therapy with children believes there are four (4) goals of misbehavior: attention, revenge, power, and inadequacy. The techniques used involve re-stating actions (tracking), reflecting feelings, encouraging positive actions, and empowering children. A family atmosphere or constellation is drawn by the children to reflect family members and their roles in the family. In Adlerian therapy, metaphors are presented and interpreted by the therapist to the children to communicate important messages, present "hypothetical" problems, and give encouragement and support (Koffman & Johnson, 1993).

Play therapy has a different philosophy and uses a very different approach in helping a child with problems. The philosophy underlying play therapy believes that a child, especially a very young child, often has difficulty expressing and communicating his/her feelings, emotions, and cognitions (Fall, Balvanz, Johnson, & Nelson, 1999). Developmentally, the child lacks life experience, cognitive ability, and a sufficient vocabulary to verbally share with the therapist. However, the child is more than likely

"capable of recapitulating [the] struggles and projecting those issues, needs, and desires onto…toys" (Norton & Norton, 1991, p. 23). Since verbal communication is not a child's forte, play is used as the medium for the child to reveal and convey ideas and thoughts to the adult therapist without speaking a word (Landreth, 1991). This is all done in an environment that is non-judgmental, unconditionally accepting of the child's behaviors and actions, and empathic toward the child (Axline, 1947).

Since play is a child's natural medium for expression (Axline, 1947), toys are the proverbial words. Because open and honest expression of concerns and feelings are key to successfully resolving the conflicts the child is encountering or has encountered in the past, he/she is allowed to play with the toys (e.g. puppets, dolls, trucks, etc.) in the room in any way he/she sees fit. There are few limitations to the child's play. Conflicts and problems are seen in the child's play through repetitive acts (Fall, Balvanz, Johnson, & Nelson, 1999), use of metaphors (Bowman, 1995), and symbolic play (Norton & Norton, 1997). The therapist needs to be skilled in observation and interpretation of the child's behaviors. For example, in Norton & Norton (1997), a session with a young boy named Juan is presented. Verbalization and actions are given along with the therapist's comments and interpretations of what was truly going on.

Session	Comments
1. Juan: (Stands waiting for the therapist, swinging his arm, pounding the bop bag in the face. As he doubles up his fist and hits the bop bag right in the face, he says:) *I'm just practicing!*	1. As they first walk into the room together, the groundwork is laid for their relationship. Since he does not know what to expect, Juan is metaphorically demonstrating his perception of relationships. Hitting is his *rehearsal-for-life* play.
2. J: (Kicks the bop bag in the face and then then punches it in the face. Whack!) *My*	2. This is Juan's metaphor for his spirit and his sense of well-being

dad always does like this to my back. He breaks my back.	that has been broken. The theme of shattered self-esteem is becoming apparent.
3. Therapist: *And that hurts you when he treats you like that.*	3. It is important to remain empathic With children as they reveal their struggles, even though at times it is very difficult.

(p. 121-122)

Forcing a child to cognitively process a situation or issue that he/she is not mentally or emotionally ready for can be more traumatic than the original circumstance. "Suppression is a necessary defense [mechanism] that allows the individual to store intolerable material in the unconscious so that it no longer interferes with current functioning" (Gil, 1991, p. 69). The repetitive acts, metaphors, and symbolic play of non-directive play therapy allows the child to drop the defense mechanism and deal with the problem situation at his/her own pace.

A review of the literature shows that some adult talk therapies have been modified to work with older children. Studies have also shown that play therapy is the "natural medium" for all children (especially younger children), and can be modified and used with a large age range and diverse populations. Therefore, the research hypothesis for this study is that play therapy should be the most widely accepted and used form of therapy in dealing with children's problems.

Statement of Problem

The purpose of this study is to identify factors relating to the use of play therapy as a counseling tool in private therapy clinics in the Midwest region of the United States. This study will focus on the following objectives:

1. To determine the frequency of play therapy use in a private clinical setting.
2. To identify demographic variables of therapists who use play therapy as a counseling tool.
3. To identify issues and problems where play therapy would be implemented.
4. To determine possible explanations why therapists are not using play therapy in practice.

Definition

The term "play therapy" has been defined in many different ways throughout the literature. For this study, Landreth's (1991) definition will be used.

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

Chapter II: Review of Literature

Literature recognizes many of the issues and problems children deal with as they are growing up. These issues can cause serious psychological and developmental problems for children. Play therapy has been recognized as an effective way of helping children confront and deal with many issues in life. Play therapy has many advantages over other forms of therapy; non-directiveness, the medium of toys which allows children to express thoughts and emotions non-verbally; and unconditional acceptance permitting children to open up and reveal their fears, concerns, and problems. Although there are numerous play therapy styles, they all work with children in a similar fashion.

Children's Problems

Children of today face many potential problems while growing up; physical, sexual, and mental abuse; death of a parent; developmental issues; and dysfunctional family setting, just to name a few. Responses to these situations are just as numerous as the problems; high anxiety, depression, withdrawal, psychosomatic symptoms, low self-esteem, adjustment disorders, and the list goes on.

In 1994, protective services investigated maltreatment reports involving 2.9 million children. In one year, 6.9 million children are physically assaulted by their parents with many more cases never coming to the attention of authorities. Research clearly shows damaging emotional, psychological, behavioral, and social effects of untreated abuse (Rudo, Powell, et al., 1998). Seven characteristic behaviors of abused children are exhibited during play. These behaviors are developmental immaturity, opposition and aggression, withdrawal and passivity, self-deprecation and self-destruction, hypervigalance, sexuality, and dissociation (White & Allers, 1994). While

observed in play, one could assume many of these behaviors extend beyond the play environment and into other realms of abused children's lives.

Maltreated children as young as preschoolers have been identified as performing lower than peers both intellectually and socially (Reams & Friedrich, 1994). High aggression, less social competence (Rudo, Powell, et al., 1994), social withdrawal, and failure anxiety are just some of the symptoms caused by abuse and maltreatment (Hovland & Smaby, 1996). Kaplin and Pelcovitz (1998) also stated that abuse increased the risk and added to the diagnosis of mental disorders such as major depression, conduct disorders, and drug abuse in children.

Sexual abuse may be more traumatic for a child than physical abuse. The sense of inadequacy and inferiority, along with the massive violation of trust, quite often by a family member or someone the child knows, leaves the child insecure, depressed, confused, and feeling broken (Griffith, 1997). In fact, sexual or any abuse can be so devastating for a child, that he/she develops post-traumatic stress disorder (PTSD; Terr, 1981; Brown, 1996; Griffith, 1997). Sexual and physical abuse have some very similar symptoms, such as hypervigilance and developmental immaturity (Brown, 1996, White & Allers, 1994). The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association [APA], 1994) recognizes additional symptoms for children with PTSD, such as partial amnesia, reenactment of the violent act through repetitive play, psychotic numbing of emotions, and exaggerated startle response. Terr (1981) states that post-traumatic play is more anxious, less elaborate, joyless, and constrictive, while the child's drawings are simple, repetitive, and give no relief of anxiety.

A child being involved in or seeing something occur that was traumatic may bring about acute traumatic stress. For example, a child may be one of 3.3 million children in the United States each year who have seen or heard at least one incident of physical conflict between his/her parents. Although the child may not be the one directly getting abused, the exposure to the situation can cause negative psychological effects (as cited in Henning & Leitenberg, 1996). Another example of acute traumatic stress is the death of a parent. Symptoms such as depression, irritability, withdrawal, and inability to concentrate are normal reactions to the death. However, the stress may lead to suicidal thoughts which are not normal, and immediate help for the child is needed (as cited in USA Today Magazine, 1996).

Environmental stress factors such as socioeconomic status (SES), deprivation of food, family size, and single parent households also cause psychological stress for children. Because 40% to 50% of marriages are expected to fail (Easterbrook, 1999), children will need to learn how to deal with separation, depression, anxiety, and numerous other feelings that arise from new circumstances in their lives.

An estimated 6.6 million children under 18 years old are children of alcoholics (COAs; Allen, 1990). These children face uncertainties every day of their lives. "Will mom come home drunk again?" "Why does dad drink so much?" and "Is it my fault they drink?" are just a few of the questions that go through the minds of COAs. Shame, denial, aggression, depression, and mistrust are only a few of the thoughts and feelings these children have (Allen, 1990; Carmichael & Lane, 1997). Maladaptive behaviors these children may exhibit are obsessive-compulsive disorder (OCD), eating disorders,

extreme mood swings, poor adaptability, and low emotional and cognitive functioning (Austin & Prendergast, 1991).

One relatively common symptom found in abused, neglected, or distraught children is enuresis (urinating one's self) and encopresis (soiling). Estimates between 5% and 17 % of the population between ages 3 and 15 years old have primary and secondary enuresis (as cited in Cuddy-Casey, 1997). Underlying psychological conflict or distress may be occurring in children who exhibit these behaviors. It should be noted, however, that there may be organic factors involved, in which psychotherapeutic techniques will not be effective and may be psychologically damaging to children (Cuddy-Casey, 1997). Whether the problem is psychological or organic, one form of therapy--play therapy--can be effective in helping a child work through these and other problems.

Play Therapy

There are many types of play therapy models: cognitive-behavioral play therapy (CBPT; Knell, 1998), experiential (Norton & Norton, 1997), Jungian (Allan & Brown, 1993), and Adlerian (Kottman & Johnson, 1993). These and others fall somewhere between non-directive or unstructured (Axline, 1947) and directive/structured play therapy (Gil, 1991). Although they use variations from different theoretical backgrounds, they all have similarities. To begin, the basis for all play therapy is that "play is [the] natural medium for self-expression" (Axline, 1947, p. 16). Because children often do not have the knowledge of or the words to express feelings and conflicts (Fall, Balvanz, Johnson, & Nelson, 1999), play allows children to symbolically externalize these struggles from within through the use of toys (Axline, 1947). Repetitive play (Fall,

Balvanz, Johnson, & Nelson, 1999), use of metaphors (Bowman, 1995), and symbolic play (Norton & Norton, 1997) provide children with a means of releasing psychological conflict and stress. All forms of play therapy maximize the potential for resolution of conflict by allowing children to play in these ways.

Like many other forms of therapy, play therapy begins with establishing good rapport with the child client. Establishing trust, being empathetic, actively listening and providing support and encouragement to the child will help the healing process move more quickly and effectively (Brown, 1996; Axline, 1947; Norton & Norton, 1997). These basic principles of counseling are seen in all forms of play therapy.

Non-directive or client centered play therapy parallels the theory of Carl Rogers' client-centered approach. Virginia Axline modified the theory to work with children in a non-intrusive and age appropriate atmosphere (Gil, 1991). The theoretical basis for non-directive play therapy is that "the individual has with himself [or herself], not only the ability to solve his [her] own problems satisfactorily, but also this growth impulse that makes mature behavior more satisfying than immature behavior" (Axline, 1947, p. 15). The non-directive therapist gives the child total attention, seldom asks or answers questions, gives little or no direction to the play, and does not make interpretations (Gil, 1991). This lack of intrusiveness on the part of the therapist allows the child to move forward at his/her own pace without being led or pushed. The therapist's role in the relationship is that of an observer and reflector of actions, thoughts, and words. Completely accepting the verbalizations, behaviors, and cognitions of the child creates an atmosphere of growth, empowerment, and respect for the child.

Axline (1947) outlined 8 basic principles in all non-directive play therapy. The principles are:

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 responsibilities in the relationship.

(p. 73-74)

Directive play therapy is based on the assumption that the child needs to grow and develop, but needs a push to reach this new maturity. Although Norton & Norton (1997) would disagree with the role of the therapist as stated above, Gil (1991) states that the directive play therapist structures and creates play situations, challenges defense mechanisms, directs the child's play, asks questions, and interprets the child's verbalizations and behaviors. Whatever the case may be, directive play should be non-threatening, empathic, and empowering for the child (Norton & Norton, 1997).

Play Therapy Related to Children's Problems

When dealing with both sexually and physically abused children, two major themes of play arise: unimaginative and literal play, and repetitious and compulsive play (White & Allers, 1994). In dealing with the latter, the term "repetition compulsion" is used to describe children's compulsions to "reenact the traumatic event in an effort to master it" (Gil, 1991, p. 72). The repetitive act may be conscious or unconscious on the part of the child (Gil, 1991; White & Allers, 1994). In either case, using play to communicate provides a mechanism for releasing pent-up feelings and exposing concerns (Gil, 1991). Using unimaginative or literal play may consist of sweeping the floors, washing play dishes, "cleaning house", then quietly waiting to leave the room (White & Allers, 1994). The behaviors and mood of the child may appear depressed, devoid of enjoyment, and passive. If this type of play occurs, intervention on the part of the therapist may need to be implemented. Gil (1991) lists some techniques for the therapist to use, including asking the child to physically move arms, legs, or breath deeply; manipulate dolls, or role play with the child.

In acknowledging and observing these themes of an abused child in play, and allowing a child to move toward a healthier self, the maladaptive coping skills will eventually not be necessary for the child to survive and the dysfunctional themes will disappear (Reams & Friedrich, 1994).

When dealing with children of alcoholics (COA's), Carmichael and Lane (1997) use play to overcome COA's sense of guilt and shame, resolve trust and control issues, encourage discussions about alcoholism in the family, learn alternative and safe ways to deal with denial and rigidity in the alcoholic family, and find positive ways to express

emotions. By using toys as the medium of expression, pressure to verbalize thoughts and feelings to the therapist is minimized.

Play therapy can also be used to reduce symptoms of underlying psychological conflicts, such as bed-wetting. Maria Cuddy-Casey (1997) gives a case study about an eight (8) year old boy who is in play therapy to deal with his enuresis and encopresis. In play therapy, the boy was given the opportunity to express his frustrations, embarrassments, and fears in a comfortable, safe, and age appropriate way, thus alleviating his symptoms. Although alternative methods of therapy-such as behavior modification-may work for these issues, play therapy allows the child to increase self-awareness and self-esteem and ultimately make his own decision to change his behaviors, without manipulation from outside sources.

A study by Fall, Balvanz, Johnson, & Nelson (1999) showed that in six (6) play therapy sessions at school, 30 minutes long, teacher ratings of children's self-efficacy, which was deemed an "important variable in learning for some children" (p. 202), showed significant increases. Teachers also saw improvements in the children's learning from seven weeks prior to the play therapy intervention. In essence, there is sound evidence of a positive relationship between successful play therapy and increased self-efficacy, as well as preliminary evidence relating successful play therapy to improved learning for those children who have difficulty in school (Fall, Balvanz, Johnson, & Nelson, 1999).

Play therapy has also been identified as an effective therapeutic approach for: alleviation of hair pulling, increasing verbal expression in selectively mute children, decreasing aggressive/acting out behavior, improving emotional adjustment in children

with divorced parents, reducing stress and anxiety of children in a hospital setting, increasing academic performance in learning disabled children, correcting speech (ex. stuttering) and reading problems, improving social and emotional adjustment, relieving psychosomatic problems, and reducing separation anxiety (as cited in Landreth, 1993).

"Toys in play therapy are not selected at random but serve as a symbolic representation of a need or deficit" (Norton & Norton, 1997, p. 47). An exhaustive list of toys appears in the literature. They can be broken down into the groups of toys that have purpose and toys that work on a specific issue.

Examples of toys with purpose include: relationship-oriented toys (balls, telephones, and puppets) which facilitate interaction with the therapist; fantasy toys (dinosaurs and flying saucers) which allow the child to "escape" reality; and decision making toys (Lego's and puzzles) which allow the child to solve problems and feel empowered by the accomplishment. A more complete list of toys can be found in Reaching Children Through Play Therapy (Norton & Norton, 1997).

Toys that deal with a child's specific problem may include plastic beer and wine bottles for COAs (Carmichael & Lane, 1997) or baby bottles and dolls for the child with enuresis or encopresis who feels the need to regress to an earlier developmental stage (Cuddy-Casey, 1997; Knell, 1998; Norton & Norton, 1997). Play therapy allows the child to act any way he/she wishes and not be judged or ridiculed for doing so. It should be noted that although certain toys elicit specific play responses and interactions in the session, the child should not be directed to specifically play with that toy or toys; they should be placed along with other toys and used at the child's discretion.

All of the problems and concerns above have been dealt with effectively using play therapy techniques. Other client disorders that are appropriate for play therapy include: conduct disorders-childhood onset, oppositional defiant disorder, anxiety disorders, somataform disorders, adjustment disorders with depressed mood, developmental issues, eating and sleeping disorders, dysfunctional family setting, selective mutism, lack of empowerment, identity problems, dissociative identity disorder, OCD, and working with narcissistic children (Norton & Norton, 1997). Play therapy can also be used with handicapped children, children with study problems, speech, and reading problems (Axline, 1947).

Play therapy, however, is not the panacea of all children's problems. Norton and Norton (1997) identify numerous disorders where experiential play therapy will have limited effectiveness. Although adaptations (e.g. more structure, fewer toys, shorter play sessions) to play therapy may be needed to make the experience more successful, other forms of therapy may show greater effectiveness in helping clients. Examples of disorders where play may not be the best modality include: mental retardation, pervasive developmental disorders (autism and Asperger's), childhood disintegrative disorder, schizophrenia, attention-deficit/hyperactivity disorder, and reactive attachment disorder.

Chapter III: Methodology

Subjects

Approximately twenty-five (25) private clinics (from here on called subjects) from each state (Wisconsin, Minnesota, Iowa, and Illinois) were chosen to take part in this study. The two largest cities in each state produced a list of one hundred (100) subjects (Des Moines, IA; Cedar Rapids, IA; Saint Paul, MN; Minneapolis, MN; Milwaukee, WI; Madison, WI; Chicago, IL; Rockford, IL).

Instrument

A self-made survey was mailed to subjects to complete (Appendix A). The survey was able to be completed within approximately 5-10 minutes. The survey asked the demographics of the subject (counselors' sex, counselors' approximate age, age range of clients, city of employment, and certification). Next, subjects were asked if they use play therapy. If they answered yes, they continued with the next question; if no, they were asked to complete the subsections of the question and end their participation in the survey. All questions could be responded to by checking the line(s) that corresponded with their answers to the question. An "other" response was offered along with room for subjects to write in any response that was not offered to them for that question.

Procedure

The Internet yellowpages was used to identify a list of private clinics in the cities specified above. Key words, such as "counseling," "counselor," "child counselor," and

"marriage and family counselor" were used to produce a list of tentative subjects. Subjects were chosen randomly from the Internet listings of counseling centers. Once a list of possible subjects was established, they were contacted by phone to see if they worked with children in one style of counseling or another. If they did not provide this service, they were dropped from the subject list and a new subject was chosen and contacted. Once it was confirmed they worked with children, subjects received a survey and a cover letter (Appendix B) via mail. The cover letter briefly explained the survey, directions for completing the survey, and their rights concerning the completion of the survey (i.e. consent). A self-addressed, stamped envelope was included for subjects to return the survey when complete.

Data and Analysis

Frequency counts and percentages were determined on all questions. Each possible answer to questions also received analysis to obtain the frequency and percentage. A cross-tabulation between question eight (8) ("Do you use play therapy") and questions 1-7 was also conducted to obtain frequencies and percentages to determine demographic difference between those therapists who do use play therapy and those who do not.

Chapter IV: Results

For the purpose of this thesis, this researcher developed a survey to determine the frequency of play therapy by therapists in private clinical settings, to identify demographic variables of therapists who use play therapy, to identify child issues and problems where play therapy would be implemented, and to determine why some therapists do not using play therapy as a counseling tool.

Of the one hundred (100) surveys sent out, a total of forty-eight (48) or forty-eight percent were returned. Of those forty-eight (48), twelve (12) or twenty-five percent, were male and thirty-six (36) or seventy-five percent were female. A breakdown of therapists' ages are reported in Table 1.

Table 1.

Age of Therapists	Frequency	Percent
21-32 yrs old	9	18.8
33-40 yrs old	5	10.4
41-48 yrs old	13	27.1
49-56 yrs old	17	35.4
57-64 yrs old	4	8.3
65 and older	0	0.0

Therapists reported the age range of their child clients. Twenty-four (24) therapists indicated that they work with all age groups (Under 5; 5-10; 11-15; 16 and older), and twelve (12) reported working with ages 5-10, 11-15, and 16 and older. The ages of the child clients and the frequency and percentage of therapists who work with them are reported in Table 2.

Table 2.

Age of Child Clients	Frequency	Percent
4 yrs old and younger	27	56.3
5-10 yrs old	43	89.6
11-15 yrs old	45	93.8
16 yrs and older	39	81.3

Therapists indicated that they have been working with children for anywhere from one (1) year to more than twenty-six (26) years. Table 3 lists a breakdown of how many years the therapists have been working with this population.

Table 3.

# of years working with children	Frequency	Percent
1-3 yrs	4	8.3
4-8 yrs	12	25.0
9-13 yrs	10	20.8
14-17 yrs	4	8.3
18-21 yrs	8	16.7
22-25 yrs	5	10.4
26 yrs or more	5	10.4

There are a wide variety of certifications of therapists. Table 4 shows their reported certifications. Therapists use numerous other certifications, including MSW (Masters in Social work), LMSW (Licensed Masters in Social Work), LCPC (Licensed Clinical Professional Counselor), Art Therapist, and RPT (Registered Play Therapist). If

alternative "SW" certifications were to be taken out of the "Other" category and concentrated into the SW category, there would be significantly more therapists in the SW category.

Table 4.

Certification	Frequency	Percent
Psychologist	17	35.4
Social Worker	15	31.3
Other	14	29.2
M..H. Counselor	7	14.6
MFT	5	10.4
Family Therapist	5	10.4
AODA	1	2.1
School Psych.	1	2.1
Psychiatrist	1	2.1
School Counselor	0	0.0

Of the forty-eight (48) total responses to the survey, half of the males (6) and half of the females (18) marked that they were formally trained in the use of play therapy. With this in mind, a total of forty (40) or eighty-three percent of the therapists stated that they use it in counseling children. Of the remaining eight (8) reasons listed for not using it included: "I do not feel proficient in its use" (5); "Other"-no play therapy room, personal preference, work with family- (4); "It is too time consuming" (1); "It is too expensive" (1); "Other techniques are more effective" (1); and "Insurance will not cover it" (1).

Therapists who do not use play therapy listed the techniques that they do use when working with children, and are reported in Table 5. Techniques mentioned in the "Other" response includes: family therapy, cognitive therapy, cognitive-behavioral therapy, and art therapy.

Table 5.

Technique Used	Frequency	Percent
Behavior Modification	7	87.5
Problem Solving	7	87.5
Other	6	75.0
Guided Imagery	5	62.5
Empty Chair	2	25.0
Psychopharmacology	2	25.0
Hypnosis	0	0.0

Table 6 lists the theory/theories of play therapy in which therapists described the way they counsel children.

Table 6.

Theory	Frequency	Percent
Experiential	21	52.5
Cognitive-Behavioral	18	45.0
Solution-Focused	17	42.5
Behavioral	16	40.0
Rogerian	15	37.5
Cognitive	11	27.5
Gestalt	9	22.5

Table 6. (cont.)

Theory	Frequency	Percent
Structural	8	20.0
Adlerian	8	20.0
Other	6	15.0
MFT	6	15.0
Axlinian	5	12.5
Group	5	12.5
Jungian	4	10.0
REBT	3	7.5
Freudian	3	7.5
Filial	2	5.0

The terms therapists used in defining play therapy are listed in Table 7. Zero (0) therapist identified “confrontational” or “judgmental” in their definition, and only two (2) therapists identified “intrusive” as a defining term to play therapy.

Table 7.

Term	Frequency	Percent
Client-centered	33	82.5
Non-judgmental	32	80.0
Empowering	32	80.0
Symbolic	29	72.5
Metaphoric	24	60.0
Non-directive	24	60.0
Cathartic	22	55.0
Spontaneous Play	22	55.0
Interpretive	20	50.0
Non-intrusive	20	50.0

Term	Frequency	Percent
Prob. Focused	17	42.5
Present Oriented	16	40.0
Goal Oriented	16	40.0
Structured	11	27.5
Past Oriented	9	22.5
Directive	8	20.0
Questioning	8	20.0
Future Oriented	7	17.5
Talk Oriented	5	12.5
Other	3	7.5

Identifying issues/problems where therapist use play therapy is listed in Table 8. “Schizophrenia,” “organic disorders,” and “other” were each identified by four (4) therapists, while “autism” and “narcissism” were identified by five (5), and “eating disorders” by seven (7).

Table 8.

Issue/Problem	Frequency	Percent	Issue/Problem	Frequency	Percent
Family Issues	35	87.5	ADHD	18	45.0
Aggression	35	87.5	Selective Mutism	16	40.0
Depression	34	85.0	Conduct D/O	15	37.5
Sexual Abuse	34	85.0	Sleep	13	32.5
PTSD	33	82.5	Enuresis/Encopresis	13	32.5
Anxiety	33	82.5	Dissociative Identity	13	32.5
Physical Abuse	33	82.5	ODD	12	30.0
Adjustment D/O	32	80.0	OCD	12	30.0
Withdrawal	25	62.5	Conduct D/O	11	27.5
Identity Problems	24	60.0	Somatization	10	25.0
Phobias	21	52.5	Academic Issues	8	20.0
Mood Swings	21	52.5	Suicide	8	20.0

A cross-tabulation of question eight (8) ("Do you use play therapy") with question three (3) ("What is the age range of your child clients") was conducted. Twenty-seven (27) of thirty-nine (39) therapists who use play therapy work with very young children, ages 0-4. Of the eight (8) therapists who do not use play therapy, zero (0) of them work with this age group of 0-4.

Thirty-eight (38) of thirty-nine (39) therapists who use play therapy work with children ages 5-10. Five (5) of the eight (8) therapists, or sixty-two percent, also work with this population. A total of 91.5% of all the therapists reported working with this age group of 5-10 year olds.

Thirty-seven (37) of thirty-nine (39) therapists who use play therapy work with children ages 11-15. All eight (8) of those who do not use play therapy as a counseling tool, do work with this age group. A total of 95.7% of all therapists reported working with the population of 11-15 year olds.

Thirty-two (32) of thirty-nine (39) therapists who use play therapy work with children ages 16 and older. Seven (7) of the eight (8) who do not use play therapy also work with this population. A total of 83.0% of all therapists report working with this more grown-up population of children, ages 16 and older. A summary of these results can be seen in Table 9.

Table 9.

Age Range of Child Clients	Percent of Therapist who Work with Age Range
11-15	95.7
5-10	91.5
16 and older	83.0
4 and younger	57.4

A cross-tabulation of question eight (8) ("Do you use play therapy") with question six (6) ("What certifications do you currently have") was conducted, and results are shown in Table 10.

Table 10.

Certification	Question 8 "Yes"/total # of Responses
Psychologist	14/16
Other	14/15
SW	12/15
M.H. Counselor	7/7
Family Therapist	3/5
MFT	3/5
AODA	1/1
School Psych.	0/1
School Counselor	0/0

Chapter V: Discussion

Children of today are facing problems that were almost nonexistent 25 years ago; AIDS, high divorce rate of parents, drugs, and gangs. Children, like adults, often need help in working through these issues. Although modifications have been made to traditional talk therapies (e.g. RET, cognitive) to work with children, they are not the most effective forms of therapy.

Play therapy's philosophy is that children lack a vocabulary sufficient enough to communicate feelings, thoughts, and emotions. Children do, however, have a natural propensity to play, and they use toys as their words of expression. Metaphors, symbolism, and repetitive acts allow children to play through their troubles without needing to put them into words.

The research hypothesis for this paper is that play therapy should be the most widely used and accepted form of therapy in dealing with children's problems.
The survey (Appendix A), was developed to determine four (4) main objectives: 1) to identify how often play therapy is used by therapists in private clinical settings, 2) to identify demographic variables of therapists who use play therapy, 3) to identify child issues and problems where play therapy would be implemented, and 4) to determine why some therapists do not using play therapy as a counseling tool for children.

The results of the survey appear to affirm the hypothesis of play therapy being the most widely accepted and used form of therapy in dealing with children's problems by therapists in a clinical setting. Forty (40) of the forty-eight (48) therapists indicated that they use play therapy when working with children.

Therapists were asked to select key words to describe play therapy. Results from the study support key words or phrases cited in literature (Landreth, 1991; Norton & Norton, 1997) as being essential for a successful therapeutic experience, such as client-centered, non-judgmental, empowering, and symbolic, just to name a few (see Table 7). With many therapists identify these as defining words, they are also identifying the techniques (e.g. non-directive, spontaneous) they use in play therapy. When this is done, children will get the most out of the play therapy experience.

When identifying issues/problems in which play therapy is used with children, the survey appears to support the literature (Norton & Norton, 1997; Axline, 1947). Family issues, abuse issues, depression, anxiety, and many others (see Table 8) were indicated by a large majority of therapists as situations that they were most likely to treat using play therapy.

Implications

An overwhelming majority of therapists who responded to the survey were women (75%). Although it is encouraging to see this large portion of women working and helping children, it is advisable at times for children to see a male therapist if so desired. Although many factors are present when creating the most successful "match" between children and therapists, some issues children have may be handled more effectively by one gender verses another. In having a smaller portion of play therapists being males, children may be denied the opportunity to have the most effective therapist to work with.

Four (4) of the eight (8) therapists who indicated they did not use play therapy did indicate that if more training were available, they would be interested in it. These responses are encouraging in that it supports the need for more training programs and course work available for counselors, social workers, psychologists, and any other person in the helping profession who works with children. Specialized schools in play therapy and graduate and undergraduate schools could recognize this demand for more play therapy training, and ultimately fill the counseling/therapy profession with qualified and trained play therapists.

Limitations

The term "formal training" in question seven (7) has room for interpretation. Four (4) of the therapists who responded that they have had formal training in play therapy indicated that their training consisted of having taken seminars regarding its use. For the purpose of this survey, they were counted in the "Yes" category. Others who marked "Yes" may have been referring to formal graduate coursework in play therapy. Because of the ambiguity of the terminology, this researcher acknowledges the chance that others in both the "Yes" and "No" categories may also have taken seminars or coursework regarding the use of play therapy.

Future Research

A limited number of play therapy schools exist in the world. There are also few graduate and undergraduate programs that have even one course on the techniques of play therapy. Results of this can be seen by the limited number of Certified Play

Therapists and therapists who are able to implement play therapy techniques. Even seminars regarding the use of play therapy are minimal. Schooling, seminars, and the availability of training programs in play therapy need to be investigated.

The survey presented in this study was focused on play therapy in the private clinical setting. Not all people, however, can financially afford to take a child to a private clinic for help. Schools often have the time and the means for providing this service to children and their families. Further research needs to be done to identify School Counselors and School Psychologists who use play therapy in that milieu.

Every individual has his/her own personality; everyone is unique. There are, however, certain personality characteristics that people have in common. It takes a special type of person to become a therapist, and life circumstances, attitude, and personality traits play a major role in becoming this type of person. Future research may want to identify the characteristics of competent and productive play therapists. Once identified, they can be applied to screenings for therapists who want to enter the field of play therapy.

People that work with troubled children--teachers, counselors, parents--know it is a difficult task at times. The age difference often does not allow one to understand where the other is coming from. Play therapy, with its non-directiveness, focus on empathy, and the non-judgmental atmosphere, allows these two very different groups to "work" and "play" on a common ground. Efforts to promote play therapy need to continue in order to provide better support to those children whom will best be served by this unique intervention.

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Appendix A
Questionnaire for Child/Adolescent Therapists

1. Your sex: ____ Male ____ Female

2. Your age: ___ 21-32 ___ 33-40 ___ 41-48 ___49-56 ___57-64 ___65 and older

3. What is the age range of your child clients? ___ Under 5 ___ 5-10 ___ 11-15 ___ 16 and older

4. How many years have you been working with this population?
   ___ 1-3 ___ 4-8 ___ 9-13 ___ 14-17 ___ 18-21 ___ 22-25 ___ 26 or more

5. What city and state are you currently working in?
   ___ Des Moines, IA ___ Cedar Rapids, IA ___ Saint Paul, MN ___ Minneapolis, MN
   ___ Milwaukee, WI ___ Madison, WI ___ Chicago, IL ___ Rockford, IL

6. What certification(s) do you currently have?
   ___ SW ___ Mental Health Counselor ___ School Psychologist
   ___ MFT ___ Family therapist ___ School Counselor
   ___ AODA ___ Psychologist ___ Psychiatrist
   ___ Other (please list: _____)

7. Were you formally trained in play therapy? ___ Yes ___ No

8. Do you use play therapy?
   ___ Yes (If Yes, continue at Question 9.)
   ___ No (If No, please answer questions 8a-8c, stop, and return this sheet)

   8a. Check the reason(s) why you do not use play therapy:
   ___ it is not a viable tool ___ I do not feel proficient in its use
   ___ it is too expensive ___ it is too time consuming
   ___ I have never heard of PT ___ my clinic will not allow the use of PT
   ___ insurance will not cover it ___ other techniques are more effective
   ___ other (reason: _____)

   8b. Check the techniques you use:
   ___ hypnosis ___ empty chair ___ psychopharmacology
   ___ problem solving ___ guided imagery ___ behavior modification
   ___ other (please list: _____)

   8c. If play therapy training were available for you now, would you be interested in it?
   ___ Yes ___ No

9. How many years experience do you have working with children in play therapy?

   ___ 0-1 ___ 2-4 ___ 5-7 ___ 8-10 ___ 11-13 ___14-16 ___ 17-19 ___ 20 or more

10. Check the theory/theories that your form of play therapy is based upon:
    ___ Behavioral ___ Rogerian ___ Experiential ___ Cognitive-Behavioral
    ___ Jungian ___ Cognitive ___ MFT ___ Solution Focused
    ___ Freudian ___ Gestalt ___ Axlinian ___ Adlerian
    ___ REBT ___ Group ___ Filial ___ Structural
    ___ Other (please list: _____)

11. Check the key words you would use in defining play therapy:
    ___ non-directive ___ client-centered ___ empowering ___ cathartic
    ___ spontaneous play ___ nonjudgmental ___ questioning ___ symbolic
    ___ metaphoric ___ talk oriented ___ judgmental ___ structured
    ___ future oriented ___ past oriented ___ present oriented ___ directive
    ___ non-intrusive ___ interpretative ___ problem focused ___ intrusive
    ___ goal oriented ___ confrontational ___ other (please list:_____)

12. Check what issues/problems you would use play therapy for:
    ___ depression ___ eating disorders ___ mood swings ___ adjustment disorder
    ___ anxiety ___ sexual abuse ___ physical abuse ___ PTSD
    ___ aggression ___ academic issues ___ family issues ___ selective mutism
    ___ autism ___ sleep ___ identity problems ___ ADHD
    ___ schizophrenia ___ organic disorders ___ phobias ___ enuresis/encopresis
    ___ withdrawal ___ conduct disorder ___ narcissism ___ dissociative identity

___ OCD ___ somatization ___ ODD ___ conduct disorders
___ suicide ___ other (please list:_____)

Appendix B

My name is Jeremy Burtch and I am currently a graduate student in Counseling-Mental Health at the University of Wisconsin-Stout. I am in my final semester here and looking forward to entering the counseling field. The focus of my thesis, and thus, the accompanying questionnaire, is play therapy in the private clinical setting.

The purpose of this survey is to discover how prevalent play therapy is in the professional field of counseling. Demographic characteristics of therapists and issues where play therapy would be implemented are also examined.

The enclosed questionnaire should be filled out by a counselor/therapist who works with children (approximately ages 2-16).

Consent

I understand that by returning this questionnaire, I am giving my informed consent as a participating volunteer in this study. I understand the basic nature of the study and agree that any potential risks are exceedingly small. I also understand the potential benefits that might be realized from the successful completion of this study. I am aware that the envelope is coded for the sole purpose of a possible follow-up questionnaire. Once received, the researcher will destroy the envelope and confidentiality will be guaranteed. I realize that I have the right to refuse to participate and that my right to withdraw from participation at any time during this study will be respected with no coercion or prejudice.

NOTE: Questions or concerns about participation in the research or subsequent complaints should be addressed first to the researcher, Jeremy Burtch, phone (715) 232-9305, or research advisor, Jo Olsen-Murray, and second to Dr. Ted Knous, Chair, UW-Stout Institutional Review Board for the Protection of Human Subjects in Research, 11 HH, UW-Stout, Menomonie, WI 54751, phone (715) 232-1126.