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The Effectiveness of Non-Directive Play Therapy on Decreasing Inappropriate Behavior

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*Eastern Illinois University*  
This research is a product of the graduate program in Clinical Psychology at Eastern Illinois University. Find out more about the program.

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The Effectiveness of Non-Directive Play Therapy on
Decreasing Inappropriate Behavior

(TITLE)

BY

Heather M. Sawyer

THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF

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IN THE GRADUATE SCHOOL, EASTERN ILLINOIS UNIVERSITY
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The Effectiveness of Non-Directive Play Therapy on Decreasing Inappropriate Play Behavior

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Abstract

The present study investigated the effectiveness of non-directive play therapy, operationalized as non-contingent attention (NCA), no-demands, and an enriched environment, on three developmentally normal children with a history of abuse or neglect. A single-case reversal-replication design was employed. Baseline consisted of contingent attention, demands, and a relatively non-enriched environment. Results indicated that for one of the participants, NCA, no-demands, and an enriched environment successfully decreased inappropriate play behaviors. More specifically, destructive and disrupted play behaviors occurred much less frequently in both treatment conditions compared to the two baseline conditions. The other two participants did not show any clear pattern of change in inappropriate play across experimental conditions. The importance of doing empirical research in this area is discussed, as well as future directions.
Dedication

With all my love, admiration, and gratitude, I dedicate this project to my parents, who have always freely and generously given their time, encouragement, and guidance. But, most importantly, all the support and love one person could ever need.
Acknowledgments

I would like to thank my thesis advisor, Dr. Keith Wilson, for all his dedication and guidance throughout the project. I would also like to thank my thesis committee members, Dr. Gary Canivez and Dr. Anu Sharma, for their expertise, enthusiasm, and time. My gratitude also extends to the observers, Amanda, Amy, Jamie, Lori, and Mary, who helped ensure the success of this project.

A big hug, smile, and thanks to all my wonderful friends, who are so special and dear to me and whose friendship I cherish more than words can say. I would especially like to thank three of these beautiful people, who helped me through not only this project, but the past two years, and who are definitely a blessing in my life; Jessica, my “other half” this year, whose constant support, encouragement, and words of wisdom kept me sane. My roommate Paula, for putting up with my erratic behavior and always finding a way to brighten up my day. Valarie, even though a thousand miles away, was always there to listen and help me realize that “I can.”
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The Effectiveness of Non-Directive Play Therapy on Decreasing Inappropriate Behavior

In recent years there has been a renewed interest in non-directive play therapy as an appropriate intervention for maltreated children (Ryan & Wilson, 1996; West, 1996). One reason for this is because of the need for more effective help for the growing number of children and adolescents who are in need of professional intervention. Another reason is because of the heightened awareness by those in the mental health profession of the serious nature of the emotional problems that surround abused and neglected children (Ryan, 1995).

The method of non-directive play therapy was primarily developed by Virginia Axline (McMahon, 1992). She worked in the United States and was influenced by the philosophical approach of Carl Rogers’ active non-directive counseling. This type of counseling used the technique of reflective listening, based on the counseling principles of empathy, warmth, acceptance and genuineness. Axline’s approach is based on the belief that children contain within themselves both the ability to solve their own problems and the growth impulse that makes mature behavior more satisfying than immature behavior (Axline, 1987). She outlined eight principles for non-directive play therapy, stressing the importance of the therapeutic relationship, acceptance, permissiveness, respect, patience, non-directiveness, few limitations, and the reflection by the therapist of the child’s feelings.

The therapist’s task is to recognize the feelings and thoughts which the child is expressing in play and reflect these back to the child. According to Ryan (1999) these verbal reflections appear to help troubled children define and clarify their emotions,
structure and understand the play situation itself, and consciously control and integrate their feelings and thoughts into more advanced self-functioning. Also, no attempt is made to direct play or hurry the child, and the basic premise behind non-directive play therapy is to allow children to determine the contents and actions in the playroom, but within basic limits set by the therapist.

Even though non-directive play therapy has been gaining popularity, due in part to the increasing awareness for sound techniques for communicating with children (McMahon, 1992), it relies heavily on case examples to indicate its effectiveness. For example, Axline dedicated an entire book, *Dibs-In Search of Self* (1947), to illustrate how one boy, through play, achieved resolution and mastery over inner conflicts. Another well known play therapist, Eliana Gil, devoted over half of her book, *The Healing Power of Play* (1991), to six different case examples. Each child presented with a different problem, and, through play, was able to process his or her trauma and work towards the resolution of psychosocial difficulties.

Phillips and Landreth (1998) conducted a study that examined 1166 play therapists’ responses to 26 structured and open-ended items regarding six clinical issues in play therapy, including its effectiveness. The authors found that play therapists considered play therapy mostly or completely successful with 80% of the children who ended treatment. However, these were subjective accounts, with the therapist rating his or her client on success without any direct measures. Therefore the ratings of success may be positively biased because therapists who use the therapeutic technique of play therapy believe it works, and their beliefs may have been reflected in their accounts of the outcome of therapy.
Even though case studies yield rich and interesting data, the deficiency of precise measures and the lack of experimental control for the target behaviors call for the use of a more empirical evaluation. However, few actual studies have been done that empirically support the effectiveness of non-directive play therapy.

Seeman, Barry, and Ellinwood (1964) found that children who were maladjusted in aggression and withdrawal who participated in a median length of 37 non-directive play therapy sessions showed marginally significant improvement, as compared to the control group on the posttest versus follow-up, on a teacher rating scale (Radke-Yarrow, 1946). By follow-up, all children in the aggressive group had lower aggression scores than the average child in the class, while the control group’s aggression scores remained higher than average. On the Tuddenham Reputation Test (Tuddenham, 1952), the experimental group showed favorable changes in sociometric gains. Both the Tuddenham Reputation Test and the teacher rating scale permit classification into categories of high adjustment, aggression, and withdrawal by containing behavior ratings of a personality assessment type. However, it was unclear as to what constituted play therapy in this study. Also, the authors did not describe or adequately support their use of the Tuddenham Reputation Test and the teacher rating scale, besides mentioning that they are readily interpretable and match the theory of therapeutic outcome predictions. This leads one to wonder about their reliability and validity. Nonetheless, the use of a control group was a clear advance from the typical therapy research studies being done at that time.

Trostle (1988) found that after ten sessions of non-directive group play therapy, bilingual Puerto Rican children showed significant improvement compared to
the control group on self-control, and on the higher developmental level play behaviors of make-believe and reality. These improvements were measured using the Self-Control Rating Scale (Kendall & Wilcox, 1979) and Play Observation Scale (Yawkey, 1981). Post hoc analyses indicated that boys who participated in the experimental group became more accepting of others than boys or girls in the control group as measured by the Peer Rating Scale, which was adapted from the preschool sociogram procedure described by Asher, Singleton, Tinsley, and Hymel (1979). Girls in the experimental group did not score higher on acceptance measures at the conclusion of the study, however, and the author related this finding to earlier research done on Puerto Rican children regarding gender differences which found differences in aggression, self-control, and sociability levels. The control group participated in unstructured free play sessions as opposed to group play therapy sessions. The play group consisted of four children and a therapist who used five behavioral “tools” during each of the child-centered play sessions: recognition of the child’s feelings and developmental stage, structuring the play environment, reflective responding, setting behavioral limits, and consequences. However, limits and their consequences were verbalized only when a child violated an existing rule, otherwise the children completely determined the nature of play. This study focused on minority children who were faced with a new school environment. The use of child-centered play groups appears to be beneficial to this population by facilitating their social, representational, and adaptive skills in group settings.

Dogra and Veeraraghavan (1994) found that children diagnosed with aggressive conduct disorder (diagnosed according to ICD-10) who received 16
sessions of non-directive play therapy and their parents who received parental counseling, showed significantly fewer extrapunitive responses and significantly higher impunitive and need-persistence responses as compared to the control group. This was measured using the Picture-Frustration test (Pareek & Rosenzweig, 1959) which utilizes six different dimensions of responding. However, the authors did not give definitions for any of the dimensions, making it unclear as to what they were measuring and what improvements were made.

According to the Child Behaviour Rating Scale (Cassel, 1981), the treatment group showed significant positive change on adjustment to self, home, school, social, physical, and personality total adjustment as compared to the control group. The experimental group's symptoms of aggressive conduct disorder reduced in terms of the following: "stopped fighting and bullying, reduction in violence against adults, became more obedient, less frequent and severe temper tantrums, decrease in the parents use of corporal punishment, decrease in parental neglect, and decrease in the child's strong dislike for school." The control group did not receive any intervention and consisted of ten children who were randomly selected. This study focused on the combination of individual non-directive play therapy and parental counseling, however it is unclear what constituted parental counseling, except that it was aimed at helping parents understand their child better. Seeing that the authors felt that parental counseling was such an integral part of the treatment program, it would have helped the reader understand the dynamics of the therapeutic technique if the parameters were clearly defined. Also, it should be noted that the study was conducted in India and cultural factors may have influenced the results.
All three studies showed a reduction of aggressive behaviors and an improvement in self-control. However, the studies focused on group-centered play or individual play therapy coupled with parental counseling. The earlier study (Seeman, et al., 1964) used measures that were not well defined and it leads one to wonder about their validity and reliability. None of these studies specifically examined individual non-directive play therapy as decreasing inappropriate behavior, while employing the use of valid and reliable measures.

Previous studies looked at the effectiveness of play therapy, but were outcome based and did not attempt to delineate its effective components. The vast majority of therapists would agree that the effectiveness of treatment depends a great deal on the relationship between the therapist and the client. The same is true for play therapy. Many of the principles behind Axline’s treatment of children in play therapy are based on the premise of a positive, warm, and empathic relationship. Other play therapists, such as Landreth (1982), McMahon (1992), and Gil (1991) stress the importance of the relationship between the child and the therapist. The results of the survey done by Phillips and Landreth (1998) found that according to the 1166 play therapists questioned, the biggest determinant of success in play therapy is the relationship between the therapist and the child. It is clear that many agree that the therapeutic relationship is extremely important, but the literature on play therapy, and the empirical evidence that looks at what it is about the relationship that makes it effective, is not well documented.

From a behavioral perspective, a component of non-directive play therapy, and one that possibly deals with establishing a therapeutic relationship, is the use of non-
contingent reinforcement (NCR) in the form of attention. NCR involves the delivery of reinforcement on a fixed-time schedule irrespective of whether an instance of challenging behavior occurred during the interval. By using NCR in the form of attention, the child is receiving attention regardless of what behavior he or she emitted. Therefore, an open, warm, and safe environment is provided in which it is communicated to the child that he or she is accepted. According to the play therapy experts mentioned above, this is the background for building a therapeutic relationship with children. Although research on the use of NCR is almost nonexistent in regard to play therapy, studies have been done involving the use of NCR with developmentally disabled individuals.

Vollmer, Iwata, Zarcone, Smith, and Mazaleski (1993) studied the use of NCR in treating the self-injurious behavior (SIB) of three women with severe to profound mental retardation. A functional analysis, which identifies the environmental variables controlling a behavior, indicated that each woman’s SIB was maintained by positive reinforcement in the form of attention. This means that when they would engage in a SIB, another individual would give them reinforcement in the form of attention. Two out of the three women received alternating treatments of differential reinforcement of other behavior (DRO), which involves reinforcement after a specified interval of time, provided the target behavior does not occur during that interval, and NCR in a multiple baseline-across-subjects design. The third woman was exposed to NCR and DRO in an ABAC design. Attention was used as the reinforcer for all sessions. Both DRO and NCR were effective in reducing SIB. Vollmer et al. (1993) indicated that NCR can be just as effective as DRO, which is commonly used to treat SIB, and may
have many advantages over this traditional treatment of attention-motivated SIB. For example, Vollmer et al. pointed out that DRO requires continuous monitoring of a client’s behavior, and it can also result in low rates of reinforcement if the target behavior occurs at a high frequency, which means that clients would not be receiving the social reinforcement that they need.

Derby, Fisher, and Piazza (1996) also studied SIB and the effects of providing both NCR and contingent reinforcement. The subject of the study was a 12 year old girl with profound mental retardation who engaged in severe SIB, (hand- and knee-to-head blows) and self-restraint (holding onto the hand of another individual with both of her hands directly in front of her knees). A functional analysis was conducted which indicated that SIB was maintained by reinforcement in the form of attention. During the NCR condition, attention was given on an almost continuous basis, and self-restraining behaviors were ignored. During the contingent reinforcement condition, verbal reprimands were given for SIB, and self-restraints were ignored. There was also a condition where attention was given to self-restraining behaviors. Results showed an increase in SIB during both the contingent attention phases, and a decrease in SIB during the noncontingent attention phase. Derby et al. (1996) concluded that NCR may be an effective treatment for aberrant responses that are maintained by attention.

Tucker, Sigafoos, and Bushell (1998) in their review of the literature concluded that NCR is an effective treatment for decreasing the maladaptive and challenging behavior of those with developmental disabilities. Many studies have been conducted showing that NCR is effective in decreasing negative behaviors, however all
of the studies to date have dealt with individuals who had developmental disabilities. It remains to be demonstrated whether NCR would be effective in reducing the problematic behaviors of children who are not developmentally disabled.

The absence of demands may be another component of non-directive play therapy that plays a role in its effectiveness. Landreth (1991) stated how important it is for the therapist to establish a feeling of permissiveness, and to facilitate decision making by the child. Axline (1987) also stressed how consequential it is to establish a feeling of permissiveness in the relationship and that there should never be any attempt to direct play because the child is to lead the way while the therapist follows. Placing demands on a child does not allow him or her to direct play or to feel in control. It also takes away his or her responsibility to make choices and institute change. However, like NCR, the empirical research on the role of a demand free environment in non-directive play therapy is lacking.

One study examining the source of reinforcement for the SIB of three individuals with developmental disabilities used functional analyses for all subjects who were exposed to four conditions: demand, attention, alone, and play (Pace, Iwata, Cowry, Andree, & McIntyre, 1993). The demand condition consisted of academic tasks. Praise was delivered contingent on correct responses, and time-outs from the task were implemented contingent on the occurrence of SIB. In the attention condition, the experimenter instructed the subject to play and, contingent on the occurrence of SIB, delivered verbal reprimands, expressed concern, and briefly interrupted the SIB. The alone condition consisted of the subject being alone in an room that was empty, with the exception of one chair. The last condition, play, was
used as a control for the other three conditions. All three subjects engaged in high levels of SIB during the demand condition, and very low levels during the other three conditions. Therefore, it appeared that demands may elicit problematic behavior in some individuals who have developmental disabilities.

Mace, Browder, and Lin (1987) looked at the stereotypic mouthing behavior of a six year old boy. Phase one of their study looked at high versus low response activities. High response activities consisted of table games with two peers in which none of the students were skilled and the teacher rated the tasks as being difficult for the subject. Low response activities involved the preparation of a novel skill, such as making a sandwich. During the high response activities, which demanded more of the child, the stereotyped mouthing behaviors occurred at a high rate, but they occurred at a low rate during low response activities. Phase two of the study examined familiar versus novel activities. Results showed that stereotypy occurred at higher rates during novel activities, which demands the child to acquire new skills, than during familiar activities. Mace et al. (1987) concluded that for some individuals, the function of stereotypic behaviors, which are maladaptive, may be to avoid or escape demand situations, which were defined in the study as high response and novel activities.

A third component of non-directive play therapy that does not deal directly with the therapeutic relationship, but receives a lot of attention in the play therapy literature, is the playroom. More specifically, the environmental richness of the play therapy setting. From a non-directive play therapy perspective, a variety of toys is needed so that each child has the opportunity to choose the mode of communication in which he or she is able to express his or her feelings (Landreth, 1991). In play therapy
children communicate through play. Each child has a different medium through which he or she communicates, and it is crucial that his or her preferred mode of communication is available. By providing an enriched environment that has an array of toys from several different categories, the chances that a child will be able to find a suitable means of communication increases dramatically. An enriched environment has been investigated for individuals with SIB, but again, data regarding play therapy on this topic is nonexistent.

Lindauer, DeLeon, and Fisher (1999) studied the effects of an enriched environment, based on a paired-choice preference, on both rates of SIB and percentage of session intervals during which signs of negative affect were displayed by a 23 year old woman with mental retardation and a mood disorder. The enriched environment consisted of twelve items that were included because of a preference assessment on SIB and on signs of positive and negative affect. Results indicated that SIB and signs of negative affect were highly correlated and that the enriched environment reduced both effectively.

Horner (1980) looked at the effects of an environmental enrichment program on five profoundly retarded females. Adaptive and maladaptive behaviors were measured across five conditions: baseline, enriched environment, enriched environment plus differential reinforcement, enriched environment plus noncontingent reinforcement, and follow-up. The enriched environment consisted of adding a large number of toys and objects to the observation room. The experiment consisted of the time-sample measurement of four categories of adaptive and maladaptive behavior under the five conditions arranged in ten phases. Results indicated that in the enriched
environment condition, there was a substantial reduction in maladaptive self-directed behavior. However, when an enriched environment was coupled with differential reinforcement, the reduction in maladaptive behavior was 30% greater than an enriched environment alone. Horner concluded that when objects are in the environment, maladaptive behaviors decrease. He also stated that it is important to design environments in which the child can initiate behaviors to produce reinforcers. It is reinforcing for a child to play with a toy that he or she finds fascinating. By providing an environment that is enriched with such objects, he or she will have those environmental reinforcers.

Ringdahl, Vollmer, and Marcus (1997) investigated the role of stimulus preference with regard to environmental enrichment. Three children with developmental disabilities, and whose SIB seemed to be maintained independent of the social environment were participants. Results varied for all three subjects, with the two who were identified as having stimuli that they preferred over aberrant behavior showed success in the environmental enrichment condition. More specifically, their aberrant behavior decreased. The authors pointed out the importance of conducting a free-operant assessment to establish stimuli that are preferred for an individual. This means that stimulus engagement and SIB need to be measured to serve as indices of relative preference in a therapy room where access to items are continuously available. The purpose is to find alternative items that are more stimulating when manipulated than the stimulation produced by aberrant behavior. They concluded that stimuli that are preferred may be effective in reducing aberrant behavior through either environmental enrichment or differential reinforcement. In the present study, the
environment will be enriched with many objects during the play therapy treatment, increasing the likelihood that a preferred stimulus will be present.

Clearly, more research needs to be done to delineate the effective components of play therapy as well as investigating its effectiveness. Ryan (1999) called for more controlled experimental studies and single-case research designs to test specific hypotheses about non-directive play therapy. She stressed the importance of this research because it will help individuals in the mental health profession become more effective therapists for children.

Many play therapists believe that play therapy is effective. They have all claimed to see it work in their therapy sessions with children. However, there is little empirical data to back this claim. Along with being effective, the question arises as to what elements of non-directive play therapy make it an effective therapeutic intervention. Again, experts in this area support the notion that the relationship between the child and the therapist is key to effective treatment, yet the research on what exactly it is about the relationship that makes it so crucial is sparse. Looking at research from other areas it has been found that NCR, no-demands, and an enriched environment are three possible components of non-directive play therapy that have an impact on maladaptive behaviors.

It was the intention of this study to examine if non-directive play therapy, which was operationalized in this study as NCR, no demands, and an enriched environment, impacts the inappropriate behavior of three abused and/or neglected children that were not mentally handicapped. The design of the present study was a single-case reversal-replication design (ABAB). Baseline consisted of demands,
contingent attention, and a relatively non-enriched environment. Single-case designs allow the researcher to make immediate changes to the experimental design to adjust to the variability and also test out hypotheses about the causes of these changes. Plus, identifying sources of variability in one subject gives important information about possible sources of variability in other similar subjects that are in the same treatment.

Method

Participants

Three abused or neglected children, two boys and one girl, between the ages of four and six participated in this study. They were referred from local community health centers because of aggressive and/or oppositional behaviors. All participants participated in a functional analysis study prior to this study and their names have been changed in order to protect confidentiality. Prior to the functional analysis, the participant’s behavior was assessed using the Behavior Assessment System for Children (BASC, Reynolds & Kamphaus, 1992), and a therapeutic interview by an independent researcher (Bauer, 2001).

Danny, a four year old boy, lived with his biological mother and younger sister. His parent’s separated in June of 1999 and filed for divorce one week before the onset of this study. Danny’s mother reported that he had trouble adjusting to this change, which increased his primary behavior difficulties of hostility, aggression, hyperactivity, and anger. Carle Hospital diagnosed Danny with childhood depression, Oppositional Defiant Disorder, and Attention Deficit Hyperactivity Disorder (ADHD). As a result of his behaviors, he had been asked to leave several day care facilities. Prior to the onset of this study, Danny began taking Ritalin twice a day. During the baseline phase,
his dosage increased to three times a day (15 mg total). No official reports of abuse/neglect were indicated, however Danny lived with his two older half-brothers who reportedly threw him around and were “physical” with him. It was reported that he has also observed his father be aggressive with his mother.

Abby, a six year old girl, was adopted at the age of four and lives with her adoptive parents and their seven year old son. Her biological parents gave up all rights to their five children when Abby was three. She and her four older siblings were then placed in foster care. However, before this placement, a Department of Child and Family Services (DCFS) investigation revealed neglect, physical, and sexual abuse. Abby was diagnosed with ADHD and receives 15 mg of Ritalin three times a day. Her adoptive mother reported that Abby is impulsive, noncompliant, hyperactive, and aggressive.

Andy, a five year old boy, resided with his two older siblings in foster care. His foster parents have taken care of all three children for one and a half years and are planning on adopting them all. DCFS became involved when the biological father went to jail and it was determined that the biological mother was not fit to care for the children. All the children reportedly witnessed violence and may have experienced abuse, either verbal or physical, themselves. Andy’s foster mother reported that he is aggressive, impulsive, and destructive. He has also exhibited self-injurious behaviors and wet the bed on a nightly basis. He receives 15 mg of Ritalin three times a day. However, on the days he participated in the study he did not receive his third dose, which was normally at 4pm.
Therapist

This trained clinical researcher was the therapist for all the participants in the study. She was a second year Clinical Psychology graduate student at Eastern Illinois University. During her graduate studies at Eastern, she completed numerous classes on therapeutic assessment and intervention. This therapist also worked in a day treatment facility designed to serve preschool age children with emotional and behavioral difficulties, and was also a child advocate for the CCMHC. Her internship was at the Center for Children's Services as a counselor where she worked with emotionally and behaviorally disturbed children and their families.

Assessment

The assessment phase consisted of a description of the play therapy project, a therapeutic intake interview, the BASC, and a functional analysis. All assessment procedures were conducted by a second researcher (see Bauer, 2001).

Assessment procedures began with the therapist explaining non-directive play therapy, the purpose for this type of research, and a description of a typical play therapy session that his or her child would receive. The therapist then conducted the therapeutic interview, which consisted of eight questions that the parent(s)/caregiver answered regarding the child’s behavior, the antecedents to the behavior, the consequences of the behavior, any medications the child is on, and all pertinent family information (see Appendix A).

This informal functional assessment revealed that the main antecedent to Abby’s inappropriate behavior is “hyperactivity.” The mother reported that time-outs typically work as a disciplinary method, and she felt that Abby was trying to control
her environment when she became oppositional. Danny’s mother was unable to identify anything that could be a possible antecedent to his inappropriate behavior, however she reported that it increases when she tries to discipline him with time-outs or spankings. Like Danny, Andy’s foster mother was unable to determine any possible antecedents to his oppositional behavior. She reported that his behavior and mood is quite variable, and that she has not found an effective form of discipline.

The BASC (Reynolds & Kamphaus, 1992) is a questionnaire used to assess and identify children with emotional and behavioral difficulties. There are three versions of the BASC: a Teacher Rating Scale, a Parent Rating Scale, and a Self Report of Personality Scale. For the purposes of the present study, only the Parent Rating Scale (PRS) was used. There are three different forms of the PRS depending on the age of the child (4-5 years, 6-11 years, and 12-18 years). The parent(s)/caregiver answered questions on a four point Likert scale, with “never” on one end and “almost always” on the other. Internal consistency coefficients, as reported by Reynolds and Kamphaus, range from .70 to .80, interrater reliability is .59, and test retest coefficients are moderate.

There are composite (global) scales and subscales that the BASC measures. The Externalizing Problems Composite includes hyperactivity and aggression has an internal consistency reliability of .89 for those 4-5 years old as well as those 6-7 years. The test-retest reliability for this scale is .85 (2 ½-5 year olds) and .91 (6-11 year olds). The Internalizing Problems Composite includes anxiety, depression, and somatization and the internal consistency reliability for those 4-5 years is .86, and is .87 for 6-7 year olds. The test-retest reliability for this scale is .88 (2 ½-5 year olds)
and .94 (6-11 year olds). The Adaptive Skills Composite includes adaptability and social skills and has an internal consistency reliability of .87 for those 4-5 years and .93 for those 6-7 years old. It has a test-retest reliability of .89 (2½-5 year olds) and .90 (6-11 year olds). The last three scales, Atypicality Scale, Withdrawal Scale, and Attention Problem Scale, can all be grouped together to form the Behavioral Symptoms Index (BSI). The BSI has an internal consistency reliability of .92 for those 4-5 years and 6-7 years. The BSI also has a test-retest reliability of .90 (2½-5 year olds) and .91 (6-11 year olds).

All three participants had elevated Externalizing Problems Composite (T>60). In fact, all three scored above 70, which is clinically significant, and had at least a 16 point difference between their Externalizing Problems Composite and their Internalizing Problems Composite. This indicates that they all may have a tendency to display elevated levels of behaviors such as hyperactivity, aggression, and conduct problems and suggests a high level of maladaptive behavior (Reynolds & Kamphaus, 1998). One of the participants, Abby, had a significant score on the Internalizing Problems Composite (T=60). This was due to her clinically significant score (T=74) on the depression scale. The other participants did not significantly elevate the Internalizing Problems Composite.

After the parent(s)/caregiver was asked to sign a parental consent form (see Appendix B), he/she was given a parental daily report (see Appendix C). This is a behavioral checklist of 23 behaviors adapted from Chamberlain and Reid (1987) that the parent(s)/caregiver completed during the functional analysis and continued to complete throughout the present study. The parent(s)/caregiver checked whether or
not a certain behavior occurred during the course of the day and then totaled the amount of inappropriate behaviors for that day. Examples of behaviors are arguing, defiance, hitting others, lying, and whining.

The functional analysis investigated whether environmental demands and/or attention governed the behavior of the three participants identified as having aggressive/oppositional behavior. Bauer (2001) utilized a multi-element design, in the same play therapy setting that was used in the present study, and looked at three different conditions: demands plus contingent attention, contingent attention, and non-contingent attention. All three conditions took place in a relatively non-enriched environment.

The results from Danny and Andy’s functional analysis were inconclusive. There was no clear delineation between any condition, and it appeared that their behaviors were sporadic with a moderate level of inappropriate behavior throughout all conditions. Abby, on the other hand, tended to exhibit more total inappropriate behavior in the two conditions that consisted of contingent attention compared to the non-contingent attention condition. Therefore, it was suggested that contingent attention may be what is governing her aggressive/oppositional behavior.

Setting

The experiment was conducted in a room, located in Eastern Illinois University’s Play Therapy Research Laboratory, that was approximately 3 meters by 5 meters with a one-way mirror, video camera, and a microphone that allowed observers to hear the interaction between therapist and child. A 10 second interval tape was used to assist the observers in recording procedures.
The playroom had a wide variety of toys available for the child to play with during each session (see Appendix D). Eliana Gil (1991) stressed how important the choice of toys is because it is the most central aspect of play therapy. The toys chosen for this study were based on a set of toys put forth by Lebo that evoked statements from children (James, 1997), as well as from a generic list of recommended toys for play therapy (Landreth, 1982). Some of the toys that were used include: a Mickey Mouse bop bag, a doll house with miniature family members, war figures, art materials, and a rice tray.

The toys were evenly dispersed throughout the playroom. There was one table located in the south west corner. A rice tray as well as art materials, were located on the table. The inflatable sword and shield were placed in the north west corner and the Mickey Mouse bop bag was across the room. The therapist was seated in the south east corner, with the doll house to the therapist’s immediate right.

Response Measurement

Behavioral definitions. Inappropriate play was defined as any play behavior that is not acceptable for a child to engage in while supervised or unsupervised (Stahmer & Schreibman, 1992). Examples of inappropriate play were destructive play and disrupted play. The content of play, particularly aggressive and sexual play, were also recorded.

Destructive play was any behavior that ruined the structure, organic existence, or condition of an object. It was scored when a child stomps, breaks, kicks, bangs, throws or mutilates an object (Fisher, Ninness, Piazza, & Owen-DeSchryver, 1996,
and Hanley, Piazza, & Fisher, 1997). Examples of destructive play include pulling a
doll’s head off, tearing pages out of a book, and writing on the wall with crayons.

Disrupted play was defined as any behavior that causes the break down or
interruption of play. This was scored when the child (a) hoarded play materials, (b)
grabbed materials from the therapist, (c) left activities, or (d) had a tantrum (Plummer,
Baer, & Le Blanc, 1977). Examples of disrupted play included collecting toys in one
small area, limiting visual or physical access to them by anyone else, attempting to
leave the playroom, throwing self on floor, kicking, or crying, sitting or standing for
more than three seconds without engaging in play behavior, turning from play or
walking over to stand near the therapist to ask a question, and stopping play to shout a
directive.

Symbolic aggression was defined as any play behavior symbolizing an offensive
action or procedure. Symbolic aggression was scored when (a) the use of toys,
writing implements, or body parts were used as weapons, thematically causing death,
injury, or destruction, accompanied by any gestures and words or imitations of noises
produced by the instrument, (b) any verbalization to self or others that imitated the
sound of exploding bombs or gunfire, or verbalizations about the use, design, or action
of weapons, (c) any mention of destructive/aggressive items or themes in the course of
play, or (d) initiation and offers to begin or continue violent or aggressive theme play
or other dramatic play activities that center around the themes of death, injury, killing,
nuclear war, or similar topics (Sherburne, Utley, McConnell, & Gannon, 1988).
Physical aggression was not included in this measure. Some examples include pointing
a finger and shouting, "Bang, you’re dead," using action figures to simulate a battle, and acting out the role of a Power Ranger or other super hero in battle.

Symbolic sexual play was defined as any play behavior that symbolized an activity that related to or involved sexual themes. It was scored when (a) toys were used to simulate sexual activity, or (b) sexual activity was described. Some examples include having Barbie and Ken take their clothes off, and using sexual slang during play.

Attention was defined as verbal attention directed toward the child by the therapist. It was scored any time the therapist spoke to the child. However, it was not scored if the verbal attention directed towards the child is in the form of one of the demands used in the demand condition. Examples of attention are “you are happy to be coloring,” or “you have decided to have the soldier kill the other soldier.”

Demands were defined as any time the therapist requested the child to do something. It was scored any time the therapist asked one of the four demands. Examples of demands were telling the child to move to a different part of the playroom, telling the child to put some toys away, telling the child to stop what he or she is doing, and telling the child to do something else.

Appropriate play was also tracked by looking at the number of intervals that were not coded as disrupted or destructive. However, this was done by looking at the intervals at a later date, not while the session took place.

Recording. A play observation and recording system sheet (PORS) was used by the observers to check whether the behaviors, destructive, disrupted, and the content, aggressive, and sexual, took place during the 10-sec interval (see Appendix
E). If more than one behavior or content occurred during an interval, each was scored. The content of the play was not used to determine Total Inappropriate Play (TIP), but it was looked at in correlation with changes in inappropriate play. TIP was determined by the percentage of intervals that destructive and/or disrupted play took place.

Every time the child was brought to the playroom the observer(s) were behind the one-way mirror. The child never saw the observer(s) go in or out of the room. The same observation check sheet was used for both the baseline and treatment phases. A separate sheet was used for each experimental session, therefore each time the child came to the playroom, each therapy session, the observer(s) used three sheets. All of the observers used in the study were blind to the experiment and were instructed not to talk to each other while observing.

**Interrater reliability.** A second observer was used approximately 33% of the time to ensure interrater reliability. This means that two observers were behind the one-way mirror and each had their own PORS. Interobserver agreement was calculated by adding up the number of 10-sec intervals that each observer scored identically, and then dividing the number of agreements by the number of agreements plus disagreements and multiplying by 100 (Martin & Pear, 1999).

Interrater reliability was calculated for both inappropriate play behaviors and both play contents, as well as TIP. Across all participants reliability averaged 95.22%, with a range of 73.33% to 100%, for TIP; 96.10%, with a range of 75% to 100%, for destructive play; 99.01%, with a range of 93.33% to 100%, for disrupted play; 99.41, with a range of 91.67% to 100%, for sexual play content; and 97.05%, with a range of
71.67% to 100%, for aggressive play content. However, when interrater agreement is used, there is always the possibility that the observers may agree that a behavior occurred simply due to chance. It is also possible that the observers agree that no behavior occurred when behaviors are infrequent, which can inflate interrater agreement.

In order to investigate agreement beyond chance, Kappa, a statistic that measures interrater reliability was calculated. Kappa ranges from +1.00 to -1.00, with positive indicating that the proportion of observed agreement is more than the proportion of chance agreement and negative indicating that the proportion of observed agreement is less than the proportion of chance agreement (Oud & Sattler, 1984).

Observed agreement (Po) and Chance agreement (Pc) percentages as well as Kappa coefficients can be found in Table 1. Kappa was significant for ten out of the twelve days that interrater reliability was calculated, p<.05. Andy's day three Kappa calculation was 0. This was due to the fact that the observers agreed that he emitted one of the targeted behaviors for several intervals. Therefore, Po was 100%, but Pc was also 100%, making Kappa non-significant.

Observer Training

Observers were undergraduate students at EIU who were majoring in psychology. The first day of training began by reviewing ethical considerations, such as confidentiality, and practical considerations, such as dress and professionalism. The trainees were then given a packet containing behavioral definitions, and numerous examples of when to score a certain behavior. This packet was carefully reviewed,
and any questions were addressed. The trainees were then given an introduction to the PORS. Trial 1 was then initiated.

Trial 1 consisted of watching a 30-min practice tape, 10-min at a time, of two individuals depicting a therapist and a child in the playroom. The trainees and the trainers scored the behavior. The tape was then dissected interval by interval, and each trainee told what he or she scored and the trainers explained what the score should have been. Any questions were addressed and problems were identified and cleared before moving on to Trial 2.

During Trial 2 the trainees watched another tape and scored the PORS along with the trainers. At the end of each 10-min segment interobserver agreement was calculated between the identified trainer and the trainees. A trainee passed when agreement for each category reached 90% or better for two consecutive segments.

Procedural Fidelity

To monitor and maintain procedural fidelity across conditions, therapist attention and demands were recorded on the PORS. This allowed researchers to determine if the therapist remained true to the contingencies of the study. The percentage of inappropriate play receiving attention (CA-P) and the percentage of attention to non-destructive or non-disrupted play (NCA) provided by the therapist for every experimental session was calculated. Total CA-P for each experimental session was calculated by adding up the number of intervals in which attention was given during or immediately following an interval with an occurrence of inappropriate play and then dividing that number by the total number of intervals of inappropriate play. Total NCA was calculated by adding up the number of intervals in which attention was
given and there was not an occurrence of inappropriate play in that same interval or the one immediately preceding and then dividing that number by the total number of intervals of attention. The percentage of attention contingent on inappropriate play (CA) was also calculated for each experimental session. This was done by adding up the number of intervals in which attention was given during or immediately following an interval with an occurrence of inappropriate play and then dividing that number by the total number of intervals of attention.

The mean percentage of CA~P, NCA, and CA across baseline and treatment conditions can be found in Table 2. Danny and Andy's CA~P did not differ much from baseline to treatment because of the fact that they exhibited inappropriate play behaviors sporadically in each condition. Therefore, even though the therapist was giving attention non-contingently during treatment, when they displayed high levels of inappropriate play, it would fall in intervals in which non-contingent attention was being delivered, which meant that it was then counted as contingent attention. However, NCA increased in the treatment conditions compared to the baseline conditions. Moreover, there is a distinction between NCA and CA in the two phases, which indicated that the experimental conditions were followed by the therapist.

Abby, on the other hand, decreased in the amount of inappropriate play behavior emitted during treatment, therefore the amount of CA~P during treatment reflects this. The differences between her percentages during baseline compared to those during treatment indicates that the therapist followed the experimental conditions of the study.
Procedure

All subjects participated in a functional analysis prior to this study (Bauer, 2001). This functional analysis helped determine which condition, or combination of conditions, was thought to be governing their aggressive behavior and therefore served as baseline (A). Based on the assessment procedures, it was determined that Abby’s baseline would consist of contingent attention plus demands. The other two participant’s functional analysis did not have as clear of results as to what was governing their inappropriate behavior, therefore the use of contingent attention plus demands was used for baseline due to the literature. For all three participants, a non-enriched play environment was also a component of the baseline phase.

The relatively non-enriched environment consisted of removing eight toys from the playroom. The parent(s)/caregiver were asked to rank the toys in the order they believed would be their child’s most to least favorite. However, if the parent mentioned the bop bag, the sword and shield, the army men, or the gun, at least two of them always remained in the playroom, and the next ranked toy then took its place on the list. The top eight toys were then excluded from the playroom. The relatively non-enriched environment was thought to approximate the number and variety of toys freely available in problem situations at the children’s homes.

Toys excluded from the play laboratory for Abby were the cell phone, the plastic food, the Legos, the masks, the puppet families, the books, the doll house, and the doll house family. Toys excluded for Danny included the small camp set, the Hot Wheels cars, the Play Doh, the plastic food, the Legos, the books, the doll house, and the doll house family. Toys excluded for Andy include the Hot Wheels cars, the Play
Doh, the Telletubbie dolls, the plastic food, the masks, the doll house, the doll house family, and the easel, paper and crayons.

Each of the three participant's baseline phases (A) included demands, which meant that the playroom was non-enriched, and four different demands were placed on them in a fixed order. The four demands and their order were: telling the child to move to a different part of the playroom, telling the child to put some toys away, telling the child to stop what he or she was doing, and telling the child to do something else. For complete order and listing of demands see Appendix F. Demands were given on a fixed time 60-sec schedule (FT 60). This meant that a demand was given every minute regardless of what the child was doing.

Each of the three participant's baseline phases (A) also included contingent attention, which meant that the attention directed toward the child from the therapist was contingent upon inappropriate play behavior emitted by the child. Attention was delivered using a fixed interval 15-sec schedule (FI 15). In a FI schedule, the first response after a set amount of time is reinforced. In this case, after 15-sec has passed, the first inappropriate play behavior the child emitted was reinforced, and then a new interval began. Inappropriate play behaviors were reinforced using phrases similar to those in the play therapy phase (B) like, "You have decided to throw the ball at the wall" or "It looks like you are wondering what to play with."

Each time the child was brought to the play therapy laboratory, it was called a therapy session. Each therapy session consisted of three experimental sessions that were 10-min each. The first time the child was brought in, and baseline data was taken, he or she was in the playroom for 10-min, received a short break, returned to
the playroom for another 10-min, received a second short break, and then returned
again to the playroom for a third time for the final 10-min session. Three therapy
sessions made up the first baseline phase for both Abby and Andy. However, due to a
switch in his medication, Danny’s first baseline phase consisted of four therapy
sessions. Each time a child came in, three experimental 10-min sessions, with short
breaks in between, were done. Therefore, for the first baseline phase, a total of 9 10-
min experimental sessions were done for Abby and Andy, and a total of 12 10-min
experimental sessions were done for Danny.

After the first baseline phase, the treatment phase (B), non-directive play
therapy, was implemented. Just like the first baseline phase, the treatment phase
consisted of three therapy sessions for Abby and Andy and four for Danny. Each
therapy session contained three experimental sessions.

During the treatment phase (B), the playroom was enriched. This meant that
all the toys on the toy list were available for the child. Along with an enriched
environment, non-contingent attention and a demand free environment were instituted.
The non-contingent reinforcement was on a fixed time 20-sec schedule (FT 20). This
meant that every 20 seconds the child was attended to, no matter what play
behavior(s) he or she emitted. Play behaviors, both inappropriate and appropriate,
were attended to with facilitative responses. Landreth (1991) went into detail
describing important components of facilitative responses. He stated that they should
be short, never questioning, conveyed in a warm and friendly manner without the
therapist becoming overly excited, and feelings need to be touched on whenever
possible. They also need to address the presence of the child by using “you” and never
include the therapist by using "we," and they should always direct responsibility back to the child. Some examples of facilitative responses are, "That can be whatever you want it to be," "Tell me what to do to help you," "You really like hitting the bop bag" or "You have decided to paint with yellow."

When the first treatment phase was completed, there was a reversal to baseline. It should be noted that conditions were changed after there was stability or an appropriate trend in the data. The second baseline phase was exactly like the first. Again, a total of 9 10-min experimental sessions were done for Abby, however, Andy did not show stability in the data, therefore baseline was extended to 12 10-min experimental sessions. Danny also received 12 10-min experimental sessions. The second baseline phase was followed by a replication of the treatment phase.

Results

Abby. Results for Abby are shown in Figure 1, 2, 3, and 4. Figure 1 shows the percentage of intervals of Total Inappropriate Play (TIP) for each experimental session across baseline and treatment conditions. There were more instances of TIP in the baseline conditions than there were in the treatment conditions. In fact, TIP during the treatment conditions remained relatively low, while TIP in baseline conditions reached over 35% during six separate experimental sessions. During the first baseline phase TIP ranged from 0% to 58.33%, with a mean of 21.67%. When the treatment phase was implemented there was an immediate drop in TIP to 0% for the first three experimental sessions of this phase and TIP remained low throughout. The mean TIP for this phase was 2.22%, with a range of 0% to 10%. However, once there was a switch back to baseline, mean TIP increased to 27.04% with a range of 3.33% to
78.33%. When the treatment phase was reimplemented, there was again an immediate drop in TIP. The mean TIP for this phase was 1.48%, with a range of 0% to 5%.

Figure 2 shows Abby’s percentage of intervals of destructive and disrupted play for each experimental session across conditions. Both destructive and disrupted play behaviors appear to occur at higher percentages during the baseline conditions than the treatment conditions. However, of the two, destructive play occurred more frequently than disrupted play. Examples of Abby’s destructive behavior were jumping on the bop bag, painting on the tea set, and kicking and throwing the toys. During the initial baseline phase, there were several experimental sessions in which relatively high levels of destructive play occurred. The mean destructive play was 18.52%, with a range of 0% to 58.22%. With the implementation of treatment, destructive play remained close to 0% with a mean of .93% and a range of 0% to 5%. During the second baseline phase, there were again high levels of destructive play, which had a mean of 20.70% and a range of 0% to 63.33%. However, when the last treatment phase was implemented, destructive play decreased and did not rise above 5%. Destructive play had a mean of .56% and a range of 0% to 5%. Abby’s disrupted play remained relatively low with the highest frequency being 20% in the second baseline phase. Examples of her disrupted play include asking to leave the playroom and sitting on the floor without playing with a toy. The mean disrupted play during the initial baseline was 3.70%, with a range of 0% to 8.33%. With the implementation of treatment, both disrupted play remained close to 0% and had a mean of 1.30%, with a range of 0% to 6.67%. During the second baseline phase there were some occurrences of disrupted play, which had a mean of 6.85% and a range of
0% to 20%. Disrupted play decreased during the last treatment phase and had a mean of .93% and a range of 0% to 5%.

Figure 3 shows Abby's percentage of intervals of sexual and aggressive play content. The frequency of sexual and aggressive play content became less variable during treatment conditions, with the means decreasing as well. Examples of Abby’s sexual content include putting the dolls in bed together and undressing the Barbies. During the first baseline phase, sexual play content was variable, with some experimental sessions having relatively high percentages. The mean sexual content was 10.37%, with a range of 0% to 46.67%. Sexual play content dropped during the first treatment phase, with only one instance of high sexual content. The mean sexual content was 2.78%, with a range of 0% to 23.33%. During the second baseline phase, the mean percentage of sexual content rose to 15.74%, however this primarily reflected two experimental sessions with high percentages. The range during this phase was 0% to 100%. During the second treatment phase sexual play content remained at low rates, but spiked once. The mean sexual content in this phase was 6.30%, with a range of 0% to 41.67%. During the first baseline phase aggressive play content was variable, with some experimental sessions having relatively high percentages, and had a mean of 16.67%, with a range of 0% to 70%. Aggressive play content dropped during the first treatment phase, with a mean of 2.59% and a range of 0% to 13.33%. Aggressive play content during the second baseline phase was variable with a mean of 5.19% and a range of 0% to 33.33%. The mean aggressive content decreased in the last treatment phase with a mean of 2.22% and a range of 0% to
Examples of Abby’s aggressive play content include playing with the bop bag and the gun.

Abby’s mother completed a Parent Daily Report (PDR) each week that she was in the study. On a daily basis, she checked whether one or more of the 23 behaviors occurred and then tally up the number of behaviors for that day. The results of Abby’s PDR are found in Figure 4. The number of behaviors recorded appeared to remain relatively high and stable throughout the study. During the first baseline phase the mean number of behaviors was 10.3, with a range of 6-15. During the first treatment phase the mean number of behaviors was 11, with a range of 5 to 17. During the second baseline phase the mean number of behaviors was 10.63, with a range of 8 to 14. During the second treatment phase the mean number of behaviors was 10.23, with a range of 8 to 15.

Danny. Results for Danny are shown in Figure 5, 6, 7, and 8. Figure 5 shows the percentage of intervals of TIP for each experimental session across baseline and treatment conditions. TIP was highly variable in all phases. The mean percentage in each phase was within 11 percentage points of the other’s and did not systematically vary across conditions. During the first baseline phase, TIP ranged from 18.33% to 88.33% with a mean of 55.98%. The first treatment phase evinced a range of 20% to 80% and a mean percentage of 42.36%. The second baseline phase had a range of 3.33% to 81%, and a mean of 52.36%. The last treatment phase had a range of 13.33% to 90%, and a mean of 42.22%.

Figure 6 shows Danny’s percentage of intervals of destructive and disrupted play for each experimental session across baseline and treatment conditions. Of the
two inappropriate play behaviors, destructive play had the highest percentage of occurrence across all phases. Destructive play was highly variable in every phase, and mean percentages were within 10 percentage points of each other throughout all phases. Examples of his destructive play include such behaviors as throwing the rice and other toys, painting the Barbies and wall, and smashing the cars together. During the first baseline phase, destructive play had a mean of 40.97%, with a range of 6.67% to 81.67%. The first treatment phase evinced a mean of 38.61%, with a range of 15% to 73.33%, for destructive play. The second baseline phase had a mean of 47.36% and a range of 0% to 83.33%. During the last treatment phase, destructive play had a mean of 39.81%, with a range of 5% to 90%. Disrupted play did not show much variability and remained at low levels across all phases.

Figure 7 shows Danny’s percentage of intervals of sexual and aggressive play content. The percentage of sexual play content was low and relatively stable for the first baseline and both treatment phases, however during the second baseline phase it increased dramatically. Undressing and playing with naked Barbies constituted most of his sexual content. During the first baseline phase sexual content had a mean of 0%. During the first treatment phase, sexual content evinced a mean of 7.78%, with a range of 0% to 91.67. During the second baseline phase the mean sexual content was 25%, with a range of 0% to 71.67%. Sexual content evinced a mean of 2.64%, with a range of 0% to 28.33%, during the second treatment phase. The range of aggressive play content was highly variable throughout all phases and centered around war, and acting out a battle with the army men. During the first baseline phase, aggressive content had a mean of 56.53%, with a range of 0% to 96.67%. The first treatment
phase evinced a mean of 20.69%, with a range of 0% to 71.67%. The mean during the second baseline was 12.08%, with a range of 0% to 55%. During the second treatment phase, aggressive content had a mean of 21.81%, with a range of 0% to 83.33%.

Danny's mother and day care teacher together completed a PDR each week he was in the study. The results of this report are in Figure 8. No evident treatment effect can be seen although there is a definite decreasing trend throughout the length of the study on the PDR. During the first baseline phase the mean number of recorded problematic behaviors was 7.79 with a range of 5 to 11. The first treatment phase had a mean of 6.15 with a range of 4 to 8. The second baseline phase had a mean of 5 with a range of 2 to 7 while the final phase in the study had a mean of 3.2 and a range of 2 to 7. The days where no data are plotted represent those Danny was with his father.

Andy. Results for Andy are shown in Figures 9, 10, 11, and 12. Figure 9 shows the percentage of intervals of TIP for each experimental session across baseline and treatment conditions. TIP was high in the first baseline phase, decreased during the first treatment phase, but did not return to previous baseline levels during the second treatment phase. High levels of TIP were present during the last treatment phase. During the first baseline phase TIP ranged form 0% to 63.33%, with a mean of 21.11%. When the treatment phase was implemented TIP dropped to 0% for three consecutive experimental sessions, and the mean for the entire phase was 5.74%, with a range of 0% to 23.33%. There was an immediate increase in TIP when the second baseline was reimplemented, however halfway through the phase levels dropped
drastically and remained low. The mean for the entire phase was 11.39%, with a range of 0% to 51.67%. TIP increased in the last treatment phase and had a mean of 19.02%, with a range of 1.67% to 53.33%.

Figure 10 shows Andy's percentage of intervals of destructive and disrupted play for each experimental session across conditions. Of the two inappropriate play behaviors destructive play had the highest percentage of occurrence across all phases. Examples of his destructive play include jumping on the bop bag, throwing rice, and painting the tea set. During the first baseline phase destructive play had a mean of 20.37%, with a range of 0% to 63.33%. The first treatment phase had a lower mean, 5.19%, with a range of 0% to 21.67%. The mean rose slightly in the second baseline phase, 10.56%, however the range was quite variable, 0% to 48.33% and the last six experimental sessions never rose above 3.50%. The last treatment phase had a mean of 17.22%, with a range of 0% to 51.67%. Disrupted play did not vary across conditions and never occurred more than 5% of the time during any experimental session.

Figure 11 shows Andy's percentage of intervals of sexual and aggressive play content. The content, both sexual and aggressive, remained relatively low and stable across the first baseline and treatment phase. However, during the second baseline phase both sexual and aggressive content become highly variable and increased drastically in frequency. Sexual and aggressive content both returned to relatively low and stable rates during the second treatment phase. During the first baseline phase, sexual content had a mean of 0%. The first treatment phase had a mean of 2.96%, with a range of 0% to 15%. Sexual content evinced a mean of 24.03%, with a range
of 0% to 100%, during second baseline phase, and a mean of 2.22%, with a range of 0% to 6.67%, during the second treatment phase. Andy’s sexual content mainly centered around undressing the Barbies. During the first baseline phase, aggressive content had a mean of 5.93%, with a range of 0% to 26.67%. The first treatment phase evinced a mean of 1.66%, with a range of 0% to 8.30%. Aggressive content had a mean of 12.78%, with a range of 0% to 56.67%, during the second baseline phase, and a mean of 7.5%, with a range of 0% to 30%, during the second treatment phase. Examples of Andy’s aggressive content include playing with the bop bag and tying up the stuffed animals.

Andy’s foster mother completed a PDR each week that he was in the study. The results of this report can be found in Figure 12. No evident treatment effect can be seen, meaning that his behaviors at home did not systematically vary when conditions were changed. However, there is a decreasing trend throughout his participation in the study in the number of problematic behaviors the foster mother reported at home. During the first baseline the mean number of behaviors was 8.79, with a range of 7 to 14. The first treatment phase had a mean of 8.53, with a range of 3 to 15. The second baseline had a mean of 6, with a range of 1 to 10, and the last treatment phase had a mean of 7.25, with a range of 3 to 10.

Discussion

Play therapy as an acceptable and worthwhile intervention for abused and neglected children has been gaining popularity over recent years (Ryan & Wilson, 1996; West, 1996). Even with the increasing popularity of this type of intervention, it continues to rely heavily on case examples to indicate its effectiveness. Case studies
can yield interesting data, but the lack of experimental controls and precise measurement calls for a more empirical evaluation. This study examined if non-directive play therapy, operationalized as non-contingent attention (NCA), no demands, and an enriched environment, would have an impact on the inappropriate play behavior of three abused and/or neglected children.

For one of the participants, Abby, NCA, no-demands, and an enriched environment, successfully decreased inappropriate play behaviors. More specifically, her destructive behavior occurred much less frequently in both treatment conditions compared to the two baseline conditions.

The other two participants, Danny and Andy, did not show any clear pattern of change in inappropriate play behavior across experimental conditions. For Andy, results showed that inappropriate play decreased when the first treatment phase was implemented, however, unlike Abby, his inappropriate play did not elevate to previous baseline levels. Danny, on the other hand, exhibited extreme variability in his inappropriate behavior, moreover, it was present throughout all conditions.

This study evinced a treatment effect on the inappropriate play behavior of one of the three participants, Abby. More specifically, her inappropriate play behaviors occurred less frequently while she received non-contingent attention and no demands in an enriched environment. It should be noted that Abby received a dose of Ritalin before her sessions. This may have increased the potential effectiveness of the intervention. However, another participant also received a third dose of Ritalin and did not show any change in behavior across conditions.
Many non-directive play therapists (Gil, 1991; Landreth, 1982; McMahon, 1992) stress the importance of the relationship between the child and therapist, and argue that it needs to be a warm, positive, and empathic. The NCA which was utilized in this study in the form of facilitative responses would seem to meet these requirements. Another component used in the present study, an enriched environment, is extremely important in non-directive play therapy because it is through toys that a child chooses a mode of communication in which he or she is able to express his or her feelings (Landreth, 1991). The third component used in this study was no demands. Landreth (1991) and Axline (1987) both stated how crucial it is for the therapist to establish a feeling of permissiveness, where there is no attempt to direct play, in order to create an environment that facilitates decision making by the child. By placing no demands on the child, this study attempted to create an environment in which the child was able to direct play and feel in control.

The present study operationalized non-directive play therapy as non-contingent attention, no demands, and an enriched environment. The present study did not allow for a determination of the effective components of this therapy because all of the variables were manipulated at the same time. However, a previous functional analysis (Bauer, 2001) determined that contingent attention was functioning as a reinforcer and, at least in part, governing Abby's inappropriate play behaviors in an environment similar to baseline conditions. Moreover, another previous study with Abby (Wilson, 2000) systematically manipulated the environmental enrichment while keeping attention contingent across both conditions. Results indicated that her inappropriate play was influenced by the level of enrichment in the playroom, with more
inappropriate play during contingent attention plus a non-enriched environment than during contingent attention plus an enriched environment.

Play therapists often attribute great importance to the content of play observed in the play therapy room. This content helps formulate hypotheses about the children and the issues they are trying to work through, however no research has been done that specifically investigated play content. Interestingly, Abby’s sexual and aggressive play content, along with her inappropriate play behavior, was lower in the treatment conditions than in the baseline conditions.

Andy’s play content remained relatively low during the first baseline and treatment, however during the second baseline, both aggressive and sexual content rose. His sexual play content then decreased when the second treatment was reimplemented. Danny’s play content was extremely variable, with the majority being aggressive. Sexual content remained at zero for most sessions, however it did spike twice during treatment conditions and four times in baseline conditions. It should be noted that sexual content was scored when dolls were undressed and then remained undressed while the child played with the doll. This constituted Danny’s sexual content.

There appeared to be a treatment effect on Abby’s play content, with more sexual and aggressive play content during baseline conditions than during treatment conditions. It suggests that NCR, no demands, and an enriched environment not only affected her inappropriate play behavior, but also the content of her play. It is interesting to note the changes in her play content, because, as mentioned above, some play therapists might see this as an attempt to work through or reprocess certain
experiences. In Abby's case, sexual and aggressive play content was high in baseline conditions. One explanation for this could be that the environment was right for her in that condition to process certain information. However, it is difficult to do anything other than speculate as the research in this area is virtually non-existent.

There may have been a treatment effect on Andy's sexual play content. His play content was relatively low in every phase of the study except the second baseline. It would have been interesting to see what would happen to his sexual play content if another baseline phase was implemented. If content rose in that third baseline condition, it would suggests that there was a treatment effect, and that during the first baseline phase content may have been low because he was "feeling out" the new therapist to determine if the environment was safe.

It is interesting to note that in the four experimental sessions when his sexual and aggressive play content was above 50%, his inappropriate play was low below 3.5%. The highest levels of play content are for sexual play and occur during these experimental sessions. An alternative explanation for the high amounts of sexual content during the second baseline could be that he "discovered" the Barbies and became very interested in them. He spent all of his time undressing them, and in this study undressing dolls was scored as sexual content. His destructive play was not high, because his full attention was on the Barbies and getting them undressed.

Danny's play content appears to be as variable as his inappropriate play behavior. The majority of the sessions when aggressive content was scored he was playing with the army men. Danny's content, both sexual and aggressive, varied during all conditions, with no apparent pattern whatsoever.
The final data set involved reports from home in which the parent and/or caregiver recorded the occurrence of several inappropriate behaviors throughout the course of the study. The Parent Daily Report for Abby indicated no apparent improvement in her behavior during her participation in the study. However, it should be noted that the mother informed the therapist that Abby’s behavior at home improved dramatically over the last few months. Abby was still emitting the behaviors, but not to the intensity and duration as she had in the past. This report of improvement did not seem to be related to experimental conditions.

Even with Danny and Andy’s lack of a consistent pattern in the playroom, it is interesting to note that the Parent Daily Report for both of them indicated that Andy’s foster mother and Danny’s mother reported an improvement in their behavior during the course of their participation in the study. Many therapists relate parental reports of improvement during the course of play therapy. However, without precise measurement and experimental controls it is difficult to determine the veracity of these reports. In this case, parental reports of improvement could be coincidental improvement, a treatment effect, or could be due to the demand effect of the treatment and parental expectations. Nonetheless, it is encouraging because it may have a positive effect on the child in terms of how he is viewed by the mother.

There are some limitations to the present study that should be noted. First, only three participants were used. This is a small number of participants and treatment was evident in the play room for only one third of them. Second, this investigation did not allow for the determination of factors that could possibly predict treatment response. Third, a reversal replication design (ABAB) assumes that treatment effects
are reversible. Fourth, the treatment phase ran for a relatively short time period and the treatment effects of non-directive play therapy might be delayed.

Drawing on the fact that there is a need for more empirical research in the field of non-directive play therapy and that treatment was effective for one out of the three participants, the direction of future research is wide open. Due to the present investigation's limited number of participants, one very possible direction would be replication of this same study.

Second, improvements on the method of collecting data on the child's at home behaviors could be made. The Parent Daily Report, which was used in this study, had the parents simply check if a behavior occurred. This method does not take into consideration the intensity or frequency of a behavior and thus is a relatively insensitive measure. An improved at home observation sheet might break the day down into hour segments and the parent is to mark whether the behavior occurred during each hour. Reliability checks on these reports would also be beneficial.

Third, it would be interesting to investigate a child's affect while he or she is in the playroom. For example, regardless of whether the child was smiling and dumping rice on the ground or if he was frowning and muttering things under his breath the play was scored as destructive. This variation in affect occurred in the playroom on several occasions. For example, Danny, who was usually destructive by throwing rice on the floor while smiling and in a good mood, became very angry one session and was throwing toys and rice extremely hard against the wall. Even though both were scored as destructive, there was a clear difference in the child's affect while engaging in the two destructive acts.
It is difficult to make generalizations based on this study because treatment was only successful in one out of three cases. That is, no demands, NCA (in Abby’s case a probable reinforcer), and an enriched environment appeared to effectively decrease the inappropriate behavior of one out of the three participants. Nonetheless, this study, to some extent, replicates and extends previous studies with developmentally delayed individuals that found NCR, in the form of attention, decreased problematic behaviors (Derby et al., 1996; Vollmer et al., 1993). This study also extends previous research done on the use of an enriched environment to decrease rates of maladaptive self-directed behaviors for those with mental retardation (Fisher et al., 1999; Horner, 1980). However, the combination of NCR and an enriched environment has not been investigated for developmentally delayed or developmentally normal populations.

Non-directive play therapy, as defined in this study, was effective for one of the participants. It is important to note that it was the same participant, Abby, whose functional analysis revealed that contingent attention was governing her inappropriate behavior (Bauer, 2001). This is significant for a couple of reasons. First, it backs the importance of doing pre-treatment analysis to identify “causal” elements that should be targeted in treatment to optimize success. Second, it suggests that non-directive play therapy may be especially effective with children whose primary reinforcer is attention.

As mentioned earlier, non-directive play therapy is becoming more and more popular, however its effectiveness is not well supported empirically. Currently, many play therapists have used case examples to back their support of non-directive play therapy, but with successful empirical evidence, more weight may be given to this
particular form of therapy and more research into the effective components will be 
backed. A leading play therapist stresses the fact that more controlled experimental 
studies and single-case research needs to be done to test specific hypotheses about 
non-directive play therapy (Ryan, 1999). Doing this type of research will help 
therapists become more effective and efficient when working with children, which will 
ultimately make therapy more beneficial.
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Table 1

Observed Agreement (Po) Percentages, Chance Agreement (Pc) Percentages, and Kappa Coefficients for Each Participant

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<th>Pc</th>
<th>Kappa</th>
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<td>47%</td>
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<tr>
<td>Day 2</td>
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<td>Day 3</td>
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<td>Day 4</td>
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<td>58%</td>
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*p<.05.
Table 2

Mean Percentage of CA–P, NCA, and CA Given to Each Participant Across Baseline and Treatment

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<th>Baseline NCA</th>
<th>Baseline CA</th>
<th>Treatment CA–P</th>
<th>Treatment NCA</th>
<th>Treatment CA</th>
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<td>Andy</td>
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<td>64.47%</td>
<td>52.55%</td>
<td>83.09%</td>
<td>16.89%</td>
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Figure Caption

Figure 1. Percent of intervals of Abby's total inappropriate play (TIP) across experimental sessions as a function of baseline (non-enriched environment, demands, and contingent attention) and treatment (enriched environment, no-demands, and non-contingent attention).
Figure Caption

Figure 2. Percent of intervals of Abby's inappropriate destructive and disrupted play behavior across experimental sessions as a function of baseline (non-enriched environment, demands, and contingent attention) and treatment (enriched environment, no-demands, and non-contingent attention).
Figure Caption

**Figure 3.** Percent of intervals of Abby's sexual and aggressive play content across experimental sessions as a function of baseline (non-enriched environment, demands, and contingent attention) and treatment (enriched environment, no-demands, and non-contingent attention).
Experimental Sessions

Percentage of Intervals

A

B

Sexual

Aggressive
Figure Caption

**Figure 4.** Number of Abby's inappropriate behaviors recorded at home across days as a function of baseline (non-enriched environment, demands, and contingent attention) and treatment (enriched environment, no-demands, and non-contingent attention).
Figure Caption

**Figure 5.** Percent of intervals of Danny’s total inappropriate play (TIP) across experimental sessions as a function of baseline (non-enriched environment, demands, and contingent attention) and treatment (enriched environment, no-demands, and non-contingent attention).
Figure Caption

Figure 6. Percent of intervals of Danny's inappropriate destructive and disrupted play behavior across experimental sessions as a function of baseline (non-enriched environment, demands, and contingent attention) and treatment (enriched environment, no-demands, and non-contingent attention).
Figure Caption

Figure 7. Percent of intervals of Danny's sexual and aggressive play content across experimental sessions as a function of baseline (non-enriched environment, demands, and contingent attention) and treatment (enriched environment, no-demands, and non-contingent attention).
Figure Caption

Figure 8. Number of Danny's inappropriate behaviors recorded at home and at daycare across days as a function of baseline (non-enriched environment, demands, and contingent attention) and treatment (enriched environment, no-demands, and non-contingent attention). The days when data points are absent reflect those days when he was with his father.
Figure Caption

**Figure 9.** Percent of intervals of Andy's total inappropriate play (TIP) across experimental sessions as a function of baseline (non-enriched environment, demands, and contingent attention) and treatment (enriched environment, no-demands, and non-contingent attention).
Experimental Sessions
Figure Caption

Figure 10. Percent of intervals of Andy’s inappropriate destructive and disrupted play behavior across experimental sessions as a function of baseline (non-enriched environment, demands, and contingent attention) and treatment (enriched environment, no-demands, and non-contingent attention).
Percentage of Intervals

Experimental Sessions

- Destructive
- Disrupted
Figure Caption

Figure 11. Percent of intervals of Andy’s sexual and aggressive play content across experimental sessions as a function of baseline (non-enriched environment, demands, and contingent attention) and treatment (enriched environment, no-demands, and non-contingent attention).
Figure Caption

Figure 12. Number of Andy's inappropriate behaviors recorded at home across days as a function of baseline (non-enriched environment, demands, and contingent attention) and treatment (enriched environment, no-demands, and non-contingent attention).
Appendix A

Therapeutic Interview
THERAPEUTIC INTAKE INTERVIEW

NAME OF CHILD ___________________ AGE ___ SEX M F
DATE OF INTERVIEW ________________ INTERVIEWER ____________
RESPONDENT ________________________
ADDRESS ___________________________
PHONE _____________________________

Description of Primary Behavior Difficulties
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Important History
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Primary Problem Settings
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Medications
_________________________________________________________________
Physical Conditions

List names and ages of family members in household

Functional Assessment Interview
List antecedents and typical response of others to the primary behavioral difficulties.

Overall, what do you think the child is trying to communicate when the problem behavior occurs?

Procedures
1. Describe play therapy.
2. Administer Behavior Assessment Scale for Children (BASC)
3. Administer Problem Behavior Questionnaire
4. Schedule play therapy sessions.
Appendix B

Parental Consent Form
PARENTAL CONSENT FORM

Purpose: The purpose of this research project is to determine effective strategies for encouraging appropriate child behavior in a play therapy setting. As a participant in this project, your child will be evaluated using standard and experimental (described below) procedures. These procedures will potentially generate more useful information for parents and teachers.

Procedures: Your child’s behavior will be assessed using a traditional, appropriate standardized instrument known as the Behavior Assessment for Children. In addition, your child will be observed during a play therapy session to determine the most effective strategies for encouraging appropriate behavior. These activities will include free play with a variety of toys and play therapy interventions provided by a graduate student therapist. Play therapy interventions will include non-directive, reflective and descriptive statements made by the therapist regarding the child’s play behavior. All the sessions will be videotaped in order to reliably assess play behavior.

Right to Privacy: All information collected may be used for training and research purposes. All materials and videotaped sessions will be maintained in a locked filing cabinet and no persons will have access to this information expect those individuals directly involved in your child’s evaluation. You will receive a summary of all information in a feedback session provided by the therapist when the project is complete. You may at any time request a copy of all materials and videotapes.

Participant’s Rights: Your child’s involvement in this project is voluntary. You have the right to withdraw from this project at any time. If you have any questions or concerns, or would like more information about our research and therapy program, please contact one of the graduate student therapists, Jessica Bauer, B.S. at 217-345-5364 Heather Sawyer, B.S. at 217-345-6594 or the university supervisor, Keith Wilson, PhD, at 217-581-6411.

I HAVE READ AND UNDERSTAND THE PURPOSE OF THE PROJECT, THE PROCEDURES INVOLVED, AND MY RIGHTS AS THE LEGAL GUARDIAN OF A PARTICIPANT. I AGREE TO ALLOW MY CHILD TO PARTICIPATE IN THIS PROJECT.

__________________________________________  ______________________
Signature                                      Date

______________________________
Child’s Full Name (Please Print)
Appendix C

Parent Daily Report
### Parent Daily Report


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</table>

**Name of Child:**

**Week of:**

**PARENT:** At the end of the day, please place a checkmark by each behaviors observed that day.

**Comments:**
Appendix D

Toy List
Non-Directive Play Therapy Play Room Toys

1. plastic army men, tanks and bunkers
2. rubber snake
3. small rubber rat
4. set of 6 plastic reptiles
5. small camp set (tent and animals)
6. Mickey Mouse bop bag
7. five Hot Wheels cars
8. cell phone
9. toy gun and holster
10. five picture books
11. two masks
12. two puppet families (Caucasian and African American)
13. doll house
14. doll furniture
15. doll house family figures
16. Barbie and Ken dolls, clothes and accessories
17. inflatable sword and shield
18. rice tray and rice
19. Play Doh
20. easel, paper, crayons, paints, colored pencils
21. Teletubbie dolls
22. plastic dish set
23. baby doll
24. baby bottles
25. stuffed pig and stuffed teddy bear
26. plastic food
27. Legos
Appendix E

Play Observation and Recording System
| # | Dest | Disr | AG SX | att dem | Dest | Disr | AG SX | att dem | Dest | Disr | AG SX | att dem | Dest | Disr | AG SX | att dem | Dest | Disr | AG SX | att dem | Dest | Disr | AG SX | att dem | Dest | Disr | AG SX | att dem | Dest | Disr | AG SX | att dem | Dest | Disr | AG SX | att dem |
|---|------|------|-------|--------|------|------|-------|--------|------|------|-------|--------|------|------|-------|--------|------|------|-------|--------|------|------|-------|--------|------|------|-------|--------|------|------|-------|--------|------|------|-------|--------|------|
| 1 | 1    | Dest | Dist  | AG SX  | att dem | 2    | Dest | Dist  | AG SX  | att dem | 3    | Dest | Dist  | AG SX  | att dem | 4    | Dest | Dist  | AG SX  | att dem | 5    | Dest | Dist  | AG SX  | att dem | 6    | Dest | Dist  | AG SX  | att dem | 7    | Dest | Dist  | AG SX  | att dem | 8    | Dest | Dist  | AG SX  | att dem | 9    | Dest | Dist  | AG SX  | att dem |
| 10| Dest | Dist  | AG SX  | att dem | 11   | Dest | Dist  | AG SX  | att dem | 12   | Dest | Dist  | AG SX  | att dem | 13   | Dest | Dist  | AG SX  | att dem | 14   | Dest | Dist  | AG SX  | att dem | 15   | Dest | Dist  | AG SX  | att dem | 16   | Dest | Dist  | AG SX  | att dem | 17   | Dest | Dist  | AG SX  | att dem | 18   | Dest | Dist  | AG SX  | att dem |
| 28| Dest | Dist  | AG SX  | att dem | 29   | Dest | Dist  | AG SX  | att dem | 30   | Dest | Dist  | AG SX  | att dem | 31   | Dest | Dist  | AG SX  | att dem | 32   | Dest | Dist  | AG SX  | att dem | 33   | Dest | Dist  | AG SX  | att dem | 34   | Dest | Dist  | AG SX  | att dem | 35   | Dest | Dist  | AG SX  | att dem | 36   | Dest | Dist  | AG SX  | att dem |
| 37| Dest | Dist  | AG SX  | att dem | 38   | Dest | Dist  | AG SX  | att dem | 39   | Dest | Dist  | AG SX  | att dem | 40   | Dest | Dist  | AG SX  | att dem | 41   | Dest | Dist  | AG SX  | att dem | 42   | Dest | Dist  | AG SX  | att dem | 43   | Dest | Dist  | AG SX  | att dem | 44   | Dest | Dist  | AG SX  | att dem | 45   | Dest | Dist  | AG SX  | att dem |
| 46| Dest | Dist  | AG SX  | att dem | 47   | Dest | Dist  | AG SX  | att dem | 48   | Dest | Dist  | AG SX  | att dem | 49   | Dest | Dist  | AG SX  | att dem | 50   | Dest | Dist  | AG SX  | att dem | 51   | Dest | Dist  | AG SX  | att dem | 52   | Dest | Dist  | AG SX  | att dem | 53   | Dest | Dist  | AG SX  | att dem | 54   | Dest | Dist  | AG SX  | att dem |
| 55| Dest | Dist  | AG SX  | att dem | 56   | Dest | Dist  | AG SX  | att dem | 57   | Dest | Dist  | AG SX  | att dem | 58   | Dest | Dist  | AG SX  | att dem | 59   | Dest | Dist  | AG SX  | att dem | 60   | Dest | Dist  | AG SX  | att dem | 61   | Dest | Dist  | AG SX  | att dem | 62   | Dest | Dist  | AG SX  | att dem | 63   | Dest | Dist  | AG SX  | att dem |

% Tot % DS % RP % NFP % Hyp % S/N % SI % AG % SX
Appendix F

List and Order of Demands
1. "Move to the table and chair."

2. "Put the tea set in the green tub."

3. "Stop playing with _____ and play with something else."

4. "Move to the table and chair."

5. "Put the bear and the pig on the table."

6. "Stop playing with _____ and play with something else."

7. "Move to the table and chair."

8. "Put the army toys in the green tub."

9. "Stop playing with _____ and play with something else."

*if the child was already at the table and chair, the demand was altered to "Move over to the green tub."