THE EXTENDED PLAY-BASED DEVELOPMENTAL ASSESSMENT: CHILDREN FIVE TO NINE YEARS OLD WITH TRAUMA HISTORY

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A dissertation to fulfill the requirements for a DOCTOR OF PSYCHOLOGY IN COUNSELING PSYCHOLOGY at NORTWEST UNIVERSITY 2012

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Abstract

Children who have experienced trauma and abuse require special provisions to navigate successfully through the initial phase of therapy, in particular the assessment process (Briere, Johnson, Bissada, Damon, Crouch, & Gill, 2006; Nader, 2008), which suggests the use of a more child friendly, play-based model of assessment (Shelby & Berk, 2009; Cattanach, 2008; Gil, 2006; Greenspan & Greenspan, 2003). The Extended Play-Based Development Assessment (EPBDA), developed by Eliana Gil (2011), is an integrated assessment model that uses directive and nondirective play approaches, intended to recognize the developmental levels of the different ages, and offers a step by step procedure for standardized use. The purpose of this study was to explore the experiences of participants using the EPBDA following a qualitative, collective case design. Data collection included interviews, questionnaires, direct observation, therapist field notes, and audio/visual materials. The participants included four children with a trauma history, between the ages of five and nine years of age. Further, the study examined the experiences of the parents and therapist. From the constructivism perspective, this study focused on the participant’s viewpoint, the play room setting in which experiences were made, and the meanings behind those experiences. Themes that emerged from this study included the experiences of enjoyment, calmness, and enrichment. Conclusions drawn from this study are in close alignment with the theoretical material that justifies play-based assessment as a practical clinical method. The results of this study will contribute to the body of knowledge in play therapy and the assessment of children with a trauma history; moreover, this study utilized a practical model that a therapist can easily replicate in clinical practice and research.
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Acknowledgements

There are several people who have helped me through my doctoral journey and I feel extremely blessed to have so much support from so many people. First, I must thank Dr. Gustafson, my dissertation chair, for sharing her time and expertise so graciously, and expanding my research sensibilities. I am also very grateful for my committee members: Dr. Drivdahl, who provided encouragement and guidance, and Dr. Lampson, who provided support as a role model and an advocate on many occasions.

I am very thankful for Dr. Phil Templeton, my mentor and teacher. You believed in me, prayed for me, and encouraged me beyond measure. I am thankful to Pastor Joe Fuiten for his generous spirit and support, and many thanks to the staff at Cedar Park Counseling Network and Cedar Park Church for their prayers and support throughout this journey. I thank Dr. Cheryl Azlin and Dr. Peggy Murphy for their critical insight and therapeutic expertise, and a very special thank you to Dr. Eliana Gil for her gracious permission to use the Extended Play-Based Developmental Assessment in research.

To Kelly, my best friend, I appreciate your perpetual optimism, extraordinary wisdom, and unfaltering faith......you help me view the world with a kaleidoscope perspective. Thanks Kelly for always being there. To Mary, whose friendship helped me stay grounded in my faith, and never letting me feel as if I was “friendship abandoned” which so often happens when in graduate school. Thank you Mary for your support and cheerleading.

Most importantly, I am grateful and blessed for my family, whose love and prayers kept me motivated to stay focused on my work. And to Ken, my loving husband, I thank you for your endless patience, strength, understanding, and encouragement to follow my dream. Finally, I thank my Lord and Savior, Jesus Christ, for only through Him was I able to persevere and accomplish my goals, and in Him goes all the glory.
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Chapter 1

Introduction to the Study

Historically, psychiatrists understood the origin of most psychopathology to be childhood trauma (Van der Kolk, 1987; Wolf, Reinhard, Cozolino, Caldwell, & Asamen, 2009). How an individual reacts to trauma essentially represents that individual’s psychological resilience and ability to cope with the events that occurred (Cicchetti, Rogosch, Lynch, & Holt, 1993; Perry & Szalavitz, 2006). Research in psychiatric inpatient and outpatient populations report a frequency of more than 50% of childhood cases has trauma from abuse (Hanson, Hesselbrock, Tworkowski, & Swan, 2002).

The National Child Traumatic Stress Network (2010) defines trauma in two categories: acute (e.g. as in natural disasters, witnessing a violent act or a serious accident, sudden death of a loved one, or physical and sexual abuse) and chronic (e.g. as in ongoing experiences of domestic violence, physical and sexual abuse, or war). Statistics collected from the Data Archive on Child Abuse and Neglect (Administration for Children and Families, 2011) reported in 2009 that over 78.3% of Child Protective Service cases were considered child neglect, 17.8% physical abuse, 9.5% sexual abuse, and 7.6% psychological maltreatment. Over 3.3 million cases were referred to CPS, with ¾ of these cases dismissed on unsubstantiated evidence. Approximately 1,770 children died from abuse; 80% of these children were 4 years and younger.

Traumatic events can have long-term negative consequences on a child’s behavioral, physical, cognitive, and emotional development (Goodyear-Brown, 2010; Van der Kolk, 2005; Wolf et al., 2009). A child’s reaction to trauma is influenced by age, developmental ability, personality, parental support, environmental structure, and whether the trauma experience was acute or chronic (Briere & Scott, 2006; Cohen, Mannarino, & Deblinger,
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2006; Nader, 2008). Considering the potentially adverse effects of childhood trauma, developmentally appropriate assessments are needed for these children as they embark in therapeutic recovery (Findley, 2004; Findling, Bratton, & Henson, 2006).

Children who have experienced trauma require the assessment of symptoms, needs, and overall functioning in order for practitioners to create developmentally and age appropriate recommendations for treatment (Briere, Johnson, Bissada, Damon, Crouch, & Gil, 2001; Greenspan & Greenspan, 2003). Therefore, it is essential that the clinician evaluate the problematic domains (cognitive problems, relationship problems, affective problems, family problems, and somatic problems) in the assessment process (Cohen, Deblinger, & Mannarino, 2006; Gil, 2006; Shelby & Felix, 2006). In addition, Greenspan and Greenspan (2003) suggested a systematic approach in observation of physical development, mood, relational capacity, affect, and use of space (e.g. play room and toys) (p. 35).

**Background.** Standardized measures utilizing objective endorsements via parent or teacher endorsements, such as The Child Behavioral Checklist ([CBCL] Achenbach & Rescorla, 2001) and UCLA PTSD Index for DSM-IV (Pynoos, Rodriquez, Steinberg, Stuber, & Fredrick, 1998), reliably report information regarding observable symptoms; however, many instruments professed to be effective in assessing young children lack the sufficient information of a child’s self-report (Drake, Bush, & van Gorp, 2001; Westby, 2000).

Some researchers report the most important assessment of a child’s internal distress is the child’s self report (Nader, 2008; Rey, Schrader, & Morris-Yates, 1992). Popular standardized assessments for collecting a child self report include the Trauma Symptom Checklist for Children ([TSCC] Briere, 1995) and the Screen for Child Anxiety Related Emotional Disorders ([SCARED] Birmaher, Khetarpal, Brent, Cully, Balach, & Kaufman,
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1997), which assesses a broad range of trauma-related symptomology such as anxiety, depression, dissociation, rage/anger, and sexual behavior concerns. Inasmuch as these assessments are beneficial in measuring various levels of trauma, they require a child to articulate to some degree the insight of self.

One difficulty in assessing children is that those younger than ten years of age are still in the process of developing the capacity for abstract thought; consequently, these young children lack the ability to exhibit meaningful verbal expression and understand complex issues, reasoning, and feelings (Salmon & Bryant, 2002). Due to these challenges in assessing young children alternative methods have been sought after by therapists, such as with play-based assessments. As adults communicate naturally through words, children express themselves naturally through the tangible world of play and movement (Axline, 1947, 1969; Landreth, 2002; Piaget, 1962). There is a significant quality in a play-based assessment for gathering a child’s self report, especially in situations of maladaptive symptoms which children often experience following trauma and/or abuse (Findling, Bratton, & Henson, 2006; Gil, 2006; Schafer, Gitlin & Sandgrund, 1994; Westby, 2000).

Play therapy intervention is based on the understanding of child development and is often used to assist children with developmental and emotional difficulties (Axline, 1947, 1969; van der Kolk, 2005). For children, play is often the vehicle of communication. Through the use of play materials, directly or symbolically, children act out feelings, thoughts, and experiences in a meaningful expression beyond their limited use of words (Landreth, 2001; Piaget, 1924). Play bridges the gap between a child’s experience and understanding, thereby providing the means for insight, learning, problem solving, coping and mastery of skills (Axline, 1969; Landreth, 2001; Schaefer, Gitlin & Sandgrund, 1994).
In essence, the language of play between the child and therapist can assist the therapist in assessing a child’s behavior.

Additionally, by the time a child who has experienced a traumatic event reaches a therapy room, more than likely he/she has been involved with one, if not all, of the following: questioning by parents/caregivers, interviews by state officials, medical examinations by health providers, and evaluations by a school psychologist (Everstine & Everstine, 1993; Gil, 2006; Greenspan & Greenspan, 2003). These experiences often compound the current stressors in a child’s life, resulting in feelings of fear and distrust, escalating defenses toward unfamiliar surroundings and people (Cattanach, 2008). Children need to find their surroundings secure and comfortable and may benefit from more time spent in a new environment in order to adapt and become familiar with the assessment process and the therapist (Axline, 1947, 1969; Goodyear-Brown, 2010). Development of this adaption may require more than the average number of sessions normally accepted by insurances or clinical practices.

Information about the study. Based on the literature, children who have experienced trauma and abuse require specific provisions to navigate successfully through the initial phase of therapy, in particular the assessment process. This finding supports the use of a more child friendly, play-based model of assessment (Cattanach, 2008; Gil, 2006; Greenspan & Greenspan, 2003; Shelby & Berk, 2009). The Extended Play-Based Development Assessment (EPBDA), developed by Eliana Gil (2011), is an integrated assessment model that uses directive and non-directive play approaches, intended to discern the developmental levels of the different ages, and offers a step by step protocol for standardized use.

Eliana Gil (2011) stated in the EPBDA:
The original purpose of the Extended Play-Based Developmental Assessment is to give children more ample opportunities to become comfortable with the therapist and the setting, to encourage children to develop feelings of trust and safety, and to invite them to externalize their thoughts and feelings in child-friendly ways. (p.1)

The EPBDA model is designed to be used alongside other assessment measurements, such as the Child Behavioral Checklist (Achenbach & Rescorla, 2001), the Parent Stress Index (Abidin, 1990), and The Trauma Symptom Checklist for Young Children (Briere, 2005), to ensure sufficient information is collected for treatment planning.

There is support for play therapy as an effective treatment for a variety of problems, such as anxiety, depression, grief, rage, and/or fears (Axline, 1947; Klein, 1955; Landreth, 2002; Le Vieux, 1994). The assessment phase is the initial part of treatment, and in that the therapist would assess the level of need for integrating the appropriate play therapy approach as part of the treatment (Ray, Bratton, Rhine, & Jones, 2001; Schafer, Gitlin, & Sandgrund, 1994). Integrating non-directive with directive play extends the amount of time to the initial phase of the assessment process, from an average of 1-2 sessions to 8-10 sessions (Gil, 2011). Extending the assessment with a preliminary non-directive play phase encourages the development of safety in the therapy room and security within the relationship between the therapist and the child (Gil, 1991; Goodyear-Brown, 2010; Shelby & Felix, 2006). Following a non-directive phase is the directive play phase, concluding the assessment of the different domains of functioning (Rasmussen & Cunningham, 1995; Shelby & Felix, 2006).

Quite possibly in using the EPBDA model, and the integration of a directive and non-directive play approach in assessment, a child’s apprehension can be diffused, as the child adjust to the environment and open expression of thoughts and emotions occur through the play modality. Play becomes the representation of the child’s self-report and ultimately
identifies internal distress (Gil, 2006; Van der Kolk, 2005). The goal of gaining insight into a child’s development and presenting problems can be achieved without further exacerbation of the child’s anxiety; and in so doing, the domains of functioning which are critical to development of treatment plans can be ascertained.

**The research problem/question.** The purpose of this study was to explore the experiences of the child, the parent/caregiver, and the therapist in the use of the assessment model, The Extended Play-Based Developmental Assessment, developed by Eliana Gil (2011). The research question was: What are the experiences of the participants (child, parent, and therapist) as they partake in the EPBDA model? The guiding questions in this study were:

1. How did the child respond to the use of the EPBDA model?
2. What was the experience from the parent perspective?
3. How did the therapist describe the assessment experience using the EPBDA model?

The supporting question was: What was and was not helpful with this assessment approach?

**Methodology.** From the constructivism perspective, this study focused on the participant’s viewpoint, the play room setting in which experiences were made, and the meanings behind those experiences (Creswell, 2005; Denzin & Lincoln, 2000). A qualitative, collective case study design was utilized to gain an in-depth understanding of the experiences and meaning of the participants experiences. The collective case study design was tied to the ethnographic tradition, and can be explained as the process of describing and interpreting behavior (Crane, 2005; Creswell, 2005; Levin, 1992), specifically the experiences in using the EPBDA model.
Assumptions and limitations. There are several assumptions to consider relating to this study. One assumption was in the integrity of the participating children and parents, and the reporting of experiences in the study. Research findings would be significantly influenced by the participant’s reservation to report or express their reactions honestly. A second assumption was in the researcher’s ability to understand and make meaning from the participant’s statements and behaviors. Further assumptions to consider for this study include (a) parent willingness to complete the interview process, post questionnaires, and accompanying their children to sessions, (b) children’s willingness to participate in assessment protocols, (c) participants were willing to not be involved in any other mental health therapy during the study, and (d) participants were willing to complete research assessment process.

Regarding limitations for this study, first there is the limitation of a small sample size. Due to time constraints of the researcher, the sample size was limited based on availability of participants within the window of time that the study was conducted. Further, the study was limited to children between the ages of five and nine years old, with a history of trauma, who live in Snohomish or King County of Washington. Case studies are often considered a concern in qualitative research due to the limitation in their generalizability; therefore, conducting additional studies using the EPBDA model in various clinical settings is suggested. A second limitation is the dual-role of the researcher/participant, and the potentiality of a theoretical presupposition that may have influenced the findings. In order to strengthen the reliability of this study, the following procedures were applied (a) multiple sources of data collection; (b) use of a second rater to code and assimilate data; and (c) triangulation method of data analysis.
**Significance.** Current empirical research paradigms appear to have a void in studies that thoroughly investigate clients’ experiences with assessments for trauma in children (Leblan & Ritchie, 2001; Ray et al, 2001; White & Allers, 1994). In efforts to improve the credibility of play-based therapy and assessment research, it has been suggested that studies by graduate students be conducted in collaboration with practicing clinicians who are currently developing new treatments and interventions (Ray & Schottelkorb, 2010; Snow, Wolff, Hudspeth, & Etheridge, 2009; Urquiza, 2010).

**Summary.** The purpose of this study was to explore the experiences of the child, the parent/caregiver, and the therapist in the use of the assessment model EPBDA model. Through the exploration of participant’s experiences, the intention was to add to current research and encourage further study of the EPBDA, as there is a need for play-based assessment protocols when working with children who have experienced trauma. The theoretical and conceptual framework for this study is presented in the following chapter, as is the background of child development, the effects of trauma to the child psyche, and the basis for use of play therapy in the assessment of children.
Chapter 2

Literature Review

Introduction.

“Play bridges the gap between concrete experience and abstract thought, allowing children to learn to live in our symbolic world of meanings and values.”

(Piaget, 1962)

This chapter features the concepts of child development, trauma, and play therapy in greater depth, based on the available research in the topic. The specific topics in review include: (a) theories in child development; (b) background in trauma, to include definition; (c) history of play therapy; and (d) directive and nondirective play concepts. In general, the modern concept of play therapy emphasizes the therapist’s role as a facilitator of thematic communication through both nonverbal and verbal means. The therapist must both seek to understand the psychological needs of the child and try to reflect the meaning of the child’s thoughts and emotions back to the child, to enhance the cyclical learning process. This therapeutic method has a long history of success, particularly in its application since Piaget’s contributions.

Theories in child development. Among the foundational theories of child development, Jean Piaget and Lev Vygotsky stand out for providing the basic theoretical models that persist in some form in most of today’s literature on child development (Becker & Varelas, 2001; De Vries, 1997; Fredericks, 1974; Gillen, 2000). While Piaget provided a generalizable model of development stages that children experience, which helps practitioners apply practical approaches to working with children identified as falling within a given stage of development, Vygotsky more specifically formulated a theory of children’s playing (Gillen, 2000). A comparison of the two theories shows that both may operate
simultaneously in a given observation. Piaget’s theory specifies the basic parameters of the child’s psychological functioning, with the emphasis on the learning process, while Vygotsky’s theory focuses on the child’s use of language during play, which takes on distinct forms as the child passes through each of Piaget’s stages of development.

**Jean Piaget.** Jean Piaget’s theory includes four stages of cognitive development, according to which children become actively involved in constructing their own cognitive worlds by the use of schemas, actions, and mental representations to organize knowledge (Piaget, 1962; Piaget & Inhelder, 1969). This refers to the sensori-motor period, which covers the first two years of life; the pre-operational stage, which lasts through approximately the age of six years; the concrete operational stage, which subsequently lasts through the age of 12 years; and finally the formal operational stage, which takes the child through the remainder of the actual childhood period and into adulthood (Piaget, 1962).

In Piaget’s (1962) first stage of cognitive development, which lasts through the age of two years, the child is learning sensori-motor habits, so behavior develops insofar as particular choices of sensory experience result in the perceived effect of that experience. The child thus exercises a maximum range of sensory opportunities, which explains in part why children appear to be willing to taste everything, rather than merely feeling it with their hands and observing it with their eyes. Eventually, by this means, the child develops a sense of the permanence of objects. This refers to the expectation that objects known within the child’s sensory experience persist, even when the child loses sight of them.

In Piaget’s (1962) second stage of cognitive development, which lasts from two to six years of age, the child experiences pre-operational development. Piaget explained that the child becomes strongly egocentric in this phase, which is an aspect of the child’s need to develop a sense of autonomy from the parent, although it falls short of reaching a level of a
fully independent identity. During this stage of development, children adhere to a singular point of view respecting each experience, rather than being open to alternative perspectives. When approached by other children with conflicting points of view, they reject them, if they have already expressed their own point of view on the phenomenon at hand. Nevertheless, this intransigence is temporary, for the presentation of an alternative point of view by a parent usually becomes a new source of information for the child shortly thereafter. Therefore, at first, a child is likely to oppose the new perspective vehemently, only later to adopt it as though there was never any opposition at all.

In Piaget’s (1962) third stage of cognitive development, which lasts from six to about 12 years of age, the child in experiencing concrete operational behavior. This refers most specifically to the ability to perform actions that originate in thought, such as pouring water accurately, drawing pictures that demonstrate detail, operating mechanisms of various kinds, and experimenting with the inner workings of objects to try to understand them better. At this stage of development, the child now has the ability to accept or accommodate alternative modes of understanding about the world, rather than adhering stubbornly to only one. Meanwhile, the child has also acquired a sense of equivalency among configurations of concepts, such as volume, mass, and length, about which the child more easily predicts what the alternative configurations of the noted dimensionality may be. Therefore, at the concrete operational stage of development, the child has become mentally functional in a way that is reminiscent of that of an adult, in the area of comprehending physical dimensionality. The child can therefore perform many work functions that are infeasible for younger children, so specific skills are now within reach of the child’s learning.

In Piaget’s (1962) fourth and final stage of cognitive development, which lasts from about 12 years of age through the end of childhood, the child experiences formal operational
development, which means that the child’s thought processes now extend beyond the realm of the concrete and into the realm of the abstract. This signifies the beginning of the child’s apprehension of logical processes. Thus, in a manner of speaking, the child no longer needs to see the object to imagine its possibilities, but may now imagine the object and do the same. This is the stage at which full creativity at last becomes possible. Children at this age can consequently learn abstractions of all sorts, including mathematical models. Therefore, within this stage, the child becomes an adult in most manifest ways and can function alongside adults on adult projects of various kinds.

Likewise, Piaget believed that children need to experience personal involvement in their own learning to the point of healthy experimentation and application of active thinking to reflect upon their learning (Piaget, 1972). According to Piaget (1924), children below the age of 12 years have yet to develop the ability to engage effectively in abstract reasoning. Therefore, they engage in very limited communication through verbal language. By reference to this understanding, children then have only a restricted potential for language processing and may be unable to express their thoughts and feelings accurately. Play uses the resources of schematic and mental symbols, which bridge the gap between concrete expression and abstract thought. By this means, children may use toys as language symbols to allow freer expression of feelings and ideas (Axline, 1947, 1964; Landreth, 2001; Piaget, 1969).

**Lev Vygotsky.** Lev Vygotsky’s sociocultural theory depicts children as social creatures and suggests that higher-order cognitive development (i.e., comprehending abstract thoughts) occurs primarily through social interaction, in view of the fact that language and thought are mutually discrete functions that eventually merge in terms of relational exchange (Bodrova & Leong, 2007). In the communal environment, children use symbols and
concepts to think. In a form of language that befits their overall cognitive development, children are thus capable of imagining, manipulating ideas, creating new ideas, and sharing those new ideas. Through this language exchange, children are able to appropriate the meaning of mental concepts; thus, in essence, they shift meaning through talking, which leads to an enrichment of their understanding (Fredericks, 1974; cf. Piaget, 1924).

Within the context of language acquisition, Vygotsky also proposed a theory of how children develop through the mechanism of play (Santrock, 2004). Specifically, Vygotsky believed that play facilitates the child’s evolving apprehension of the nature of objects, through sequential appreciation of permanence, concreteness, and abstraction (Santrock, 2004). This follows essentially the same developmental order of events as depicted in Piaget’s model. Importantly, Vygotsky believed that human beings must ultimately develop highly complex mental aptitudes to function effectively in human society (e.g., all human beings must develop an appreciation of the abstract notion of risk in making decisions involving multiple parameters simultaneously), but this development encounters a great deal of resistance without the help of the mechanism of play. For Vygotsky, therefore, play constitutes an essential facet of human development as a whole, rather than merely an optional facet of recreation. It exists among human beings fundamentally to provoke abstract thinking.

Further reinforcing the connection between Vygotsky’s psychology of play and Piaget’s developmental stages is Vygotsky’s illustration of the child who sees someone riding a horse and wishes to do so himself. Vygotsky (1978) explained that a child under the age of three (i.e., in Piaget’s first developmental stage) has yet to develop the ability to form mental abstractions. Consequently, the child may cry in protest, demanding a social response that is impossible to provide. In contrast, a child aged three or beyond (i.e., in Piaget’s
second developmental stage) can now imagine riding the horse and may simulate the action in play. This reflects a significant change in the child’s psychological functioning, by which the impossible now becomes possible on a different plane of thought, that of the imagination. The child’s normal solution is to adopt an artifact that only resembles a horse insofar as the child is capable of wielding it in approximately the same way as one wields a horse, and then simply pretend to ride the horse. Vygotsky (1978) explained that the chosen option, known psychologically as a pivot, serves to enable the child to connect real action (play) with desired action (riding a horse), by means of a mostly arbitrary but deeply meaningful concrete solution.

Vygotsky (1978) argued further that the necessity for pivots, which serve as concrete media enabling the child’s imagination to function fully in play, decreases as the child develops a stronger ability to internalize the abstraction that it represents. Ultimately, imagination loses its dependence on concrete objects, and common activities that replace play become more abstract themselves, such as in the form of structured board games, creative art, or creative writing. This transition occurs during Piaget’s third developmental stage (between the ages of six and 12), after which the child’s interest in play that involves concrete substitutes for known objects subsides, while a new interest in play that occurs at one or two levels of abstraction afield of the objectively identifiable form of play emerges.

For example, a young child in Piaget’s second level of development may pretend to drive a car, by walking around with a kitchen plate as the steering wheel, while making noises that seem to resemble the familiar aspects of the experience of being in a car (Piaget & Inhelder, 1969). A few years later, simulating a car may no longer be entertaining, but simulating space flight may emerge as a new interest. The kitchen plate no longer suffices, because the tax on the imagination exceeds such simplicity. However, the availability of
monkey bars on a playground may provide just enough of a concrete pivot to simulate this more abstract concept. Later, it may suffice to write stories or draw pictures to achieve the same satisfaction from working out an abstraction in accordance with the developing imagination (Gillen, 2000).

**Trauma.** Language and communication constitute a superbly human developmental achievement, but this is vulnerable to significant stunting in the presence of abuse and trauma (Briere & Scott, 2006). Studies of language in maltreated children show critical delays in language development, especially in the verbal expression of children’s internal feelings (Mills, 1995). This reflects the basic theory of Vygotsky, in that it emphasizes the role of language complexity in psychological development (Bodrova & Leong, 2007). That is, Vygotsky’s belief in the central importance of self-talk during play suggests that children who find themselves unable to play will hence fail to engage in self-talk, which in turn suggests that their entire psychological development will lag (1978). Before assessing the presence or impact of trauma, however, it is essential to understand what constitutes a reasonable definition of trauma from abuse or maltreatment.

References to trauma are subject to overuse in the current age, in contexts that often simply imply stress in experiences that otherwise fall short of constituting legitimate traumas (e.g., testing, public speaking, or driving in traffic; cf. Brody & Baum, 2007). The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000) defines a traumatic event as one that involves actual or threatened death, serious injury, or harm to one’s physical integrity, witnessing thereof, or knowledge of an unexpected death, serious harm, or threat of a loved one (Wingenfeld, 2002).

Van der Kolk (1987) explained that the critical issue in defining trauma and methods of resolving it has to do with the debilitating nature of the loss of control in the event at issue,
which individuals experience, especially young children. The lack of a personal sense of control over the event in question is the central determinant of its traumatic impact on the individual (Wingenfeld, 2002). Because very young children are entirely dependent psychologically on their parents, unexpected events that signal the abrupt loss of parental protection can be potentially traumatic (Suedfeld, 1997). The effects of traumatic events can linger long after the traumatizing event has passed and then recur, ebbing and flowing in manifestation over time (Wingenfeld, 2002). Such effects may manifest themselves in symptomatic behaviors associated with posttraumatic stress disorder (PTSD), although the full criteria of PTSD may never reach a point of clear qualification (Gil, 2006; Walsh, Fortier, & DiLillo, 2009; Wolf, Reinhard, Cozolino, Caldwell, & Asamen, 2009).

Children have unique ways of understanding trauma, both among themselves and in comparison to adults (Cohen, Mannarino, & Deblinger, 2006). These distinctions involve how they create meaning from the events in relation to themselves, how they access support systems, and how they cope with psychological and physiological stress associated with the traumatic or abusive event (Cohen et al., 2006). Because a child’s particular mode of responding depends on the child’s own personality, familial situation, and coping mechanisms, it is necessary for the therapist to develop assessments and treatments to fit each child’s uniquely identifiable needs and circumstances (Cicchetti, Rogosch, Lynch, & Holt, 1993; Cohen et al., 2006; Gil, 2006). Taking a phenomenological approach to bringing about this understanding between the therapist and the child often depends on the mere mechanisms available in play therapy (Gil, 1991).

**Play therapy.** The etiology of play in therapy began in 1909 with psychoanalytic theory, as documented by Sigmund Freud in the illustration of Little Hans (Gil, 1991, O’Connor, 2000; Schaefer & O’Connor, 1983). In this illustration, Freud observed a young
boy at play and gave advice to the boy’s father based on his observations of precisely how the child behaved in play (Landreth, 2002). A decade later, Anna Freud began implementing play with children in her own approach to psychotherapy, as an avenue for unlocking the unconscious motivation behind the manifest imagination, especially through drawing and painting. However, Anna Freud considered play to serve more in the manner of a tool for developing the relational bond between the child and the therapist, than in that of a medium for activating the process of transference, for which the interpretation of play is paramount (Freud, 1946). Anna Freud’s assumptions in this regard obeyed the central model of Freudian psychology, namely, the tripartite division of the id, ego, and superego (Schafer, 1980). In theory, these dynamics manifest a significantly different structure in children, as the id is at its greatest relative power respecting the other two, while the superego lags behind in development (Freud, 1946). Therefore, watching children at play theoretically demonstrates the relative positioning of these three psychological components.

In contrast, Melanie Klein considered play as the child’s way of engaging in free association by means of object relations (Landreth, 2002). This is an extension of Freudian theory, in that free association forms an essential part of the therapeutic repertoire (Freud, 1946). Specifically, while adults engage in free association verbally, wherein their selected themes inevitably gravitate toward their strongest complexes, children’s engagement in free association lacks the verbal or imaginary apparatus necessary for a similar use of verbal skills. Therefore, displays of imagination must take on the form of physical, observable play, but this activity then theoretically manifests themes that similarly gravitate toward the child’s strongest complexes (Klein, 1955). From this perspective, a therapist may analyze a child’s internal perspective through observation and interpretation of patterns or themes in play. Klein thus gave play symbolic meaning, believing that play activities actually lead to
transference (Klein, 1955). Such activities therefore encourage children to develop insights into themselves, understanding about their own motivations, and appreciation of their relation to the rest of the world (Klein, 1955).

Finally, Virginia Axline (1947) believed that children’s behaviors are the product of internal drives that amount to aspirations for self-realization. Axline thus approached play in a nondirective manner (i.e., treating it more like free association). As a student of Carl Rogers (1951), Axline applied the theory of client-centered (or person-centered) therapy to children, and this approach evolved into a concept of child-centered play therapy (Landreth, 2002). Axline believed that children should have the freedom to be self-directed in play activity and saw the role of the therapist as one that should seek to reflect the feelings and thoughts expressed by the child in this manner (1947). Axline considered the development of a safe and trusting relationship between the child and therapist as constituting the most salient element to the play experience. Axline’s (1947, 1950) insights into this area form the basis for modern conceptions of play therapy.

**Directive and nondirective play.** It is conceivable for the therapist to direct a child in play or to wait for the child to choose a form of play without guidance, such as in a playroom that features many options (Axline, 1950, 1969). Axline (1969) believed that the principle of free association remains crucial to enabling the child to engage in healthy developmental activity, so she made sure to distinguish between these two approaches in terms of the relationship between the therapist and the child. Through childhood generally, free association in this sense is important, and only in later years does directive play emerge. Axline (1969) outlined eight basic principles of a nondirective approach (p. 73). These are construable as follows:

1. The therapist seeks first to nurture a friendly, supportive alliance with the child.
2. The therapist exhibits behavior that communicates unconditional acceptance of the child.

3. The therapist expresses a permissiveness to invite the child to express feelings freely and openly.

4. The therapist is attentive to the child’s emotional expressions and reflects observed feelings back to child in such a way as to serve as a source of insight to aid in the child’s development of trust and understanding in the relationship.

5. The therapist maintains a belief in the child’s identity as the force for change and ability to solve problems without assistance, if given the opportunity.

6. The therapist refrains from directing the child’s conversations or actions.

7. The therapist allows the child time to process information at a pace of the child’s effective choosing.

8. The therapist establishes limits only insofar as these are necessary to keep the child in the realm of reality, with a sense of personal responsibility.

The advantage of the nondirective, child-centered approach to assessment is that it allows children to use their play language to express how they think and feel about their world (Axline, 1950). That is play as self-expression is the most significant consideration in play therapy. Structured, directed approaches can at times contaminate observations of children’s play activity, whereas nondirective approaches tend to create more opportunity for learning about the child (Greenspan & Greenspan, 2003; Shelby & Felix, 2006). For example, in a case study of a grieving girl of five years of age, LeVieux (1994) reported that, when using a nondirective approach, the young girl developed an opportunity to manage what had previously seemed unmanageable, as she felt free to direct her own self-expression of feelings symbolically through her play.
A second advantage of the nondirective approach is that it gives the child a sense of control over the environment. Initially, the therapist’s role is to assist the child in experiencing the playroom as a safe place, to serve as a secure base for the child (Gil, 1991; Goodyear-Brown, 2010; Shelby & Felix, 2006). One of the most widely known cases of play therapy is that of Dibs, a withdrawn child of five years of age, described as a therapeutic enigma (Axline, 1964). The description of this child includes being mute, in a practically catatonic state, punctuated by exhibitions of violent temper tantrums. The child appeared to have a cognitive disability, but revealed superior intelligence. Through nondirective play, this child was able to begin the journey of healthy child development, without the encumbrance of a diagnosis of mental illness (Axline, 1964). Within a safe environment, the child was able to explore and reclaim the attributes of childhood according to the models of Piaget and Vygotsky. The approach to assessment based on nondirective play utilizes the expressive methods of nonverbal communication to encourage children to engage and externalize their thoughts and feelings in an accepting, non-threatening environment (Axline, 1947; Gil, 1991; Landreth, 2002).

After a child has gained safety and security in an environment of nondirective play, the therapist may subsequently begin to direct the child in those forms of creative play that will be most beneficial and developmentally appropriate (Jones, Casado, & Robinson, 2003). In this manner, the therapist uses this structured environment to focus attention on particular domains of functioning and behavior, to stimulate activity, gain information, and make interpretations (Landreth, 2002; O’Connor & Schaefer, 1994). Thus, what begins as purely nondirective play is analogous to verbal free association, but as the child develops according to the noted models of psychological development (Greenspan & Greenspan, 2003), directive play serves as a way to building an experiential dialogue between the therapist and the child.
In this way, it is analogous to following free association with directed inquiries into an adult patient’s specific concerns or complexes. In essence, play serves as the operating language for the therapist’s practice with the child, while verbal expression, which employs the fully developed human imagination, analogously serves as the operating language for the therapist’s practice with the adult.

**Summary.** The governing theories of child development are the developmental models of Jean Piaget and Lev Vygotsky. These models explain what occurs psychologically and in terms of learning, at progressively more mature stages of childhood development and lead to Virginia Axline’s theory of play therapy, based in further measure on Carl Rogers’ client-centered therapy. Axline’s theory essentially applies the Freudian practice of free association to the mechanism of play, rather than using explicit verbal language. In so doing, it obeys the relevant principles outlined by Piaget and Vygotsky. Because trauma is capable of interfering significantly with normal psychological development among children, therapists need an effective way to build a trusting relationship with a child client who has experienced trauma.

Play therapy thus benefits from strong, practical effectiveness and strong grounding in the theoretical models that drive it. The literature suggests that play therapy is a viable approach and, indeed, that it may be the most viable approach to enabling a therapist to build a trusting relationship with a child client. Given the general effects of trauma, particularly as they relate to the child’s sense of a lack of control over the events, particularly in the case of the sudden deprivation of parental protection, creating a new bond of trust to enable the child’s capacity for reengagement with a protective figure is critical to restoring the child’s natural development toward higher stages of cognitive complexity. Interestingly, producing this outcome seems to depend on creating a setting in which the traumatized child returns to a
position of experiencing control over events, this time in the safe setting of the therapist’s workspace. Meanwhile, the presence of the fully supportive therapist may serve to restore the child’s needed sense of having a source of parental protection on which to rely to engage in the imagination-building activities that justify the encounter.

The next chapter describes the methodological model for this study and discusses the parameters for using the Extended Play-Based Developmental Assessment, developed by Eliana Gil (2011). For the purposes of this research, the design was a qualitative, collective case study, with the objective to explore generalizable themes of experience in using the play-based assessment with direct subjects.
Chapter 3

Research Design and Methodology

Introduction. The following chapter provides an overview of the methods and procedures implemented in the study, as well as discussion of the philosophical worldview and rationale for the methodology. Further detailed in this chapter is information concerning the participant selection, credibility of therapist, and intake/exit procedures. Description of setting, materials, the EPBDA field procedures, methods of data collection and analysis follow.

Rationale for qualitative research. The purpose of this study was to explore the experiences of the child, the parent/caregiver, and the therapist in the use of the EPBDA model. This qualitative study followed a constructivism perspective which emphasized the importance of the participant’s view, the play room setting in which experiences were made, and the meanings behind these experiences (Creswell, 2005; Denzin & Lincoln, 2000). An interpretive theoretical approach was utilized in order to focus on the participant’s interpretation of interactions with each other and to gain a deeper understanding of their perspective in using the EPBDA model (Hesse-Biber & Leavy, 2006). Denzin and Lincoln (2000) clarified qualitative research as,

...a socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry.

They seek answers to questions that stress how social experience is created and given meaning (p.8).

A collective case study design was the primary mode of inquiry for this research, which is tied to the ethnographic tradition, and can be explained as the process of describing and
interpreting behavior (Creswell, 2005, Crane, 2005; Levin, 1992); specifically in this study as the experiences of participants in using the EPBDA model.

**Overview of research.** The central goal in this study was to understand the participants experiences and individual meanings as fully as possible. Research in case studies is strengthened in the collection of multiple sources of evidence (Creswell, 2009; Crane, 2005); therefore, data collection included interviews, questionnaires, direct observation, documentation, and audio/visual materials.

The research question was: What are the experiences of the participants (child, parent, and therapist) as they partake in the EPBDA model? The guiding questions in this study were:

1. How did the child respond to the use of the EPBDA model?
2. What was the experience from the parent perspective?
3. How will the therapist describe the assessment experience when using the EPBDA model?

The supporting question was: What was and was not helpful with this assessment approach? The research questions were focused on the experiences of all participants' in the use of this clinical model of child assessment.

**Credibility of therapist.** The therapist/researcher held a Masters Degree in Counseling Psychology, and a license as a Mental Health Counseling Associate in the State of Washington, with over two years experience in counseling practices (1½ years post MA). Play therapy training consisted of graduate level courses and seminars, and active membership in the Association of Play Therapy. Clinical supervision was provided by the Clinical Director for Cedar Park Counseling Network, Dr. Phil Templeton, LMFT. The therapist/researcher played the role as participant/observer.
Participants. Careful consideration in the selection of participants was imperative due to the potential nature of the child’s trauma history. The research focused on children between the ages of five to nine years of age with symptoms of maladaptive behaviors due to abuse or environmental stressors. The selection procedure followed a two-step process which involved initial screening via phone calls, and intake and collection of consents.

Participants were referred through the Cedar Park Counseling Network website, and programs that advocate for children, as well as individual therapists, pediatricians, and churches. Letters, brochures, phone calls, and personal contacts were utilized to inform these referral sources of the study opportunity (Appendix A). Clients who met the following criteria were invited to participate in the study: (a) the child must be between the ages of five and nine years at the onset of study; (b) the child must demonstrate symptoms of maladaptive behaviors due to trauma or environmental stressors; (c) the child should not be currently enrolled in any other type of therapy; (d) the child and guardian must agree to interview questionnaires and video recording of sessions; (e) the child and guardian must agree and sign the informed consent.

Procedures. Initial screenings were conducted over the phone to ensure children met the inclusion criteria, to discuss basic information about the study, to answer any questions, and to arrange for an intake session. The intake session included parents/caregivers of the child participant and therapist/researcher. The following criteria were addressed during intake meetings; (a) participants' verification of legal guardianship if not biological parent of child (e.g. foster parent); (b) participants were informed about the nature of the study; (c) participants were informed about the video/audio recording and observation; (d) participants reviewed clients rights and consent forms.
Upon agreement between all parties, informed consent and clients rights (Appendix B) were signed, and participants completed the child background information (Appendix C) and standard paperwork as required by Cedar Park Counseling Network protocols. At the conclusion of the intake, appointments were arranged to begin the child’s assessment.

Procedures for all sessions followed protocol as directed in the EPBDA model, (Appendix D). Essentially, the study consisted of 8-10 sessions each, 50 minutes in length, on a weekly or biweekly interval. In the beginning, six to eight sessions were conducted with the child; the first two to three assessment sessions were non-directive approaches, which included creative play to encourage expression and allow the child freedom of choice in play and ample time to develop a relationship with the therapist. The remaining assessment sessions included an integrated non-directive and directive approach that incorporated artwork, sand play, developing a family genogram (identification of family members), and developing a feelings chart (affect recognition). After completion of child sessions, a parent session was arranged to discuss assessment evaluation and referral recommendations. To give closure to the assessment process, a final session was arranged to allow closure, family adjustment, and to complete exit questionnaires.

**Video recording.** A video recorder was set up in the play room with a full range of the room. Participants were informed of the camera and recordings continued throughout the duration of each session. Recordings were kept confidential throughout the study, and upon completion of this dissertation were deleted. Consent forms informed participants of video recordings and rights to discontinue participation at any time during the research (Appendix B).

**Human subjects review board.** Initial planning discussions of this research were engaged between the researcher, Dr. Phil Templeton (Clinical Director of CPCN), Dr. Joe
Fuiten (Senior Pastor of Cedar Park Church), and Ben Waggoner (Cedar Park Church Attorney). In support of the research, the Cedar Park Counseling Network and Cedar Park Church granted the research project space in the CPCN Children’s Center at no charge to the therapist or participants. The counsel of the CPCN Attorney, Ben Waggoner, was utilized in the development of intake documents and the consent forms to be given to subjects of this research, and in accordance to Washington Administrative Code (WAC) and the Revised Code of Washington (RCW) regulations. Subsequent application to the Northwest University Human Subjects Review Board (HSRB) was submitted for approval to proceed with research. Upon approval from the HSRB, intake appointments were arranged.

**Materials.** The Extended Play-Based Developmental Assessment (EPBDA) developed by Eliana Gil (2006, 2010) was designed as:

A clinical model to assist in determining a child’s overall functioning by: identifying current clinical symptoms; identifying trauma impact, if any; assessing a child’s perception of parental support and guidance; and determining a child’s perceptions of their internal and external resources. (p.2).

Procedures for the EPBDA model were followed. The list of protocols is exhaustive, and therefore has been provided in detail in Appendix E.

The Child Background Information form (Appendix C) was developed specifically for this study to collect the following demographic information; the parent’s description of presenting problems, environmental stressors, and family of origin history, child’s developmental history, academic history, external systems, and support network. This survey was completed by the child’s parent/caregiver.

**Setting.** The study was conducted in the Cedar Park Counseling Network’s Children’s Center, on site of Cedar Park Christian Schools, (building A), located in Bothell,
Washington. An exclusive play room was developed for this study. It was equipped with standard protocol play room materials considered necessary to engage the child in play activity for therapeutic procedures (Landreth, 2002). Room size was approximately 20 by 20 feet, and included a child size table and four child sized chairs, a chalk board, shelves with toys, a puppet center, an art center, two sand trays (dry and wet), and a storage cabinet for miniatures used in sand trays (Play Materials, Appendix E). The play room had a dual role as office space for the therapist; as a result, the room also included a desk, a file cabinet, and a couch.

**Data collection and analysis.** The participant observer role was congruent to that of a typical therapist role, in which the therapist actively participated in the assessment process of collecting case notes, case management, and evaluation (Creswell, 2009; Hesse-Biber & Leavy, 2006). Observations of child and parent participants were documented in the Play Assessment Observation Forms (Appendix F) directly following the conclusion of each session. Parents completed questionnaires (Appendix G) describing their experiences at the conclusion of the study. The therapist (participant observer) also completed a questionnaire describing the experience with each participating family at the end of each assessment closure (Appendix G). The therapist (participant observer) took field notes after each session, and observed and noted the video recordings of all sessions. A research volunteer, a senior undergraduate student from Northwest University, also observed recordings and assisted in coding observations. These records shall be maintained in confidentiality possession of the researcher post study.

The first step of the analysis process was the organization of data in preparation of coding. Participants in this study were considered one case, and data from participants were analyzed collectively. Data included in formatting consisted of unstructured video data of
sessions, unstructured therapist observer field notes of sessions, and unstructured text data obtained from responses to questionnaires.

The second step in the analysis process included coding data into categories and themes. A second coder assisted the researcher in the development of codes, examining for overlap and redundancy, and collapsing these codes into broad themes common amongst participants. The process of coding into themes followed several steps (Creswell, 2005).

1) All data were proof read for understanding.
2) Data were divided into segments of information.
3) Segments of information were labeled with codes.
4) Codes were reduced to avoid overlap and redundancy.
5) Codes were collapsed into themes.

In addition, there were several types of themes that occurred from the data. Predetermined themes (things that were expected to be found), emergent themes (things that were a surprise to be discovered), hard to classify themes (themes that did not fit with other themes), and major/minor themes (representations of major ideas, or secondary ideas) (Creswell, 2005). Data were analyzed between all participants to provide several viewpoints in support of a theme. The description and development of themes in the data focused on the principal research questions in order to form an in-depth understanding and accurate interpretation of the participant’s experience.

**Summary.** In an attempt to address a void in play-based assessment research, the researcher of this study aimed to thoroughly investigate the participant’s experiences with a play-based assessment for children with a trauma history. In a qualitative approach, the goal of this study was to explore the experiences of the child, the parent/caregiver, and the therapist in the use of the EPBDA model. The results of this study contribute to the body of
knowledge in play therapy and the assessment of children with trauma history. Moreover, this study utilizes a practical model that clinicians can easily replicate in their respective practices and research. The subsequent chapter describes the findings of this study.
Chapter 4

Data Analysis

**Introduction.** The purpose of this study was to describe the experiences of the participants with the Extended Play-Based Developmental Assessment. The approach of a qualitative, collective case study design is linked to the ethnographic tradition, and can be explained as the process of describing and interpreting behavior (Creswell, 2005; Crane, 2005; Levin, 1992). Data analysis and subsequent themes are an interpretation of the culminating behaviors and statements of the participant’s experiences.

**Data analysis.** The preliminary steps in the analysis included categorizing and coding data, examining emerging themes, and triangulating themes to support the research question. The data included video recordings of 30 sessions, child questionnaires, parent questionnaires, and therapist field notes and questionnaire. Coding was the primary mode of data reduction and analysis. Through the use of codes for given behaviors, questionnaire responses, and therapist field note comments, I was able to distinguish and cluster data codes as they related to the research inquiry. Triangulation procedures were implemented to strengthen emergent themes, as well as contribute to the credibility and trustworthiness of the findings in this study (Glasser & Strauss, 1967; Creswell, 2009). The categorization and triangulation of data themes created the essential foundation for the data analysis, thus allowing me to decipher the participant’s experiences.

In consideration of the potential for researcher bias because of the participant-observer role, a second coder was incorporated. As a means to maintain the client’s identity, the children and families were given pseudonyms in this report.
**Snapshot of children.**

*Andrew.* The following information was collected during a parent interview on May 1, 2011. Andrew was 8.6 years old at the onset of the study. He presented with a history of family maladjustment and behavioral problems in school. Andrew recently experienced the loss of his younger sibling to Sudden Infant Death Syndrome, compounded with his parents divorce, and having to move to a new home and school. Presenting symptoms endorsed on the ASEBA included nightmares, headaches, periodic encopresis and enuresis; at home he was reported to be argumentative, displaying tantrums with physical and verbal aggression. At school he was reported as fighting with peers, breaking rules, and telling lies. Andrew’s mother participated in the research and presented with significant measures on domains of Depression, Isolation, and Total Life Stress, as indicated in the Parent Stress Index.

*Bobby.* The following information was collected during a parent interview on May 2, 2011. Bobby was 6.11 years old at the onset of the study. He presented with a history of in utero drug exposure and early childhood trauma. Andrew was born addicted to methamphetamine, eventually removed from his biological family, placed into foster care, and subsequently experienced physical abuse. He was reassigned to a new foster home which later adopted him. Presenting symptoms endorsed on the ASEBA included significant levels of anxiety and depression (fears, crying, nail biting, worries), psychosomatic symptoms (nightmares, headaches, nausea, stomachaches, enuresis), attention issues (can’t concentrate, daydreams, inattentive, stares off), and aggressive behaviors (argues often, destroys things, physically fights, tantrums, and cruelty to animals). Bobby’s adoptive mother participated in research and presented with significant measures in domains of Isolation, Health, Role Restriction, and Total Life Stress, as indicated in the Parent Stress Index.
Carlton. The following information was collected during a parent interview on May 18, 2011. Carlton was 5.0 years old at the onset of the study. He presented with a history of maladjustment to his parents’ divorce and his mother’s recent move. Carlton recently had returned to his father due to increasing signs of distress which developed during a six month stay with his mother. Presenting symptoms endorsed on the ASEBA included worrying, cries easily, afraid to sleep alone, nightmares, stomachaches, overly tired in day, sleeps less at night, arguing and tantrums. Carlton’s father participated in the study and presented with significant measures on the domain of Spouse with Parent Stress Index, indicating he had reasonably adapted in all other domains, specifically to his son’s behavior and family adjustment.

Dawn. The following information was collected during a parent interview on May 2, 2011. Dawn was 5.11 years at the onset of the study. She presented with a history of attachment difficulty and sexual abuse. Dawn was removed from her biological parents within her first year and subsequently lived within the foster care system for three years, until she was adopted at four years of age. Presenting symptoms endorsed on the ASEBA included withdrawn and nervous, cries easily, headaches, nausea, significant social problems (jealous, suspicious, difficulty getting along with peers), and significant aggressive behaviors (argumentative, demanding, fighting, and tantrums). In addition, Dawn was reported as having a tendency to overeat. Dawn and Bobby are biological siblings, adopted by the same family. The adoptive mother’s reports are stated above.

Findings.

Video observation of children. Assessment sessions with the therapist and child were video recorded, and later observed by the researcher and a second coder; behaviors were documented and coded into themes. Overall, 30 sessions were recorded, eight sessions
each with Andrew and Dawn, and seven sessions each with Bobby and Carlton. Focusing on what the child did and what the child said in assessment sessions provided a basis for accurately reconstructing the experiences of the four children. Each session helped qualitatively to enlighten the researcher of the children’s experiences.

Careful consideration of camera placement provided ample footage, although there were times when the observer was unable to determine facial expression or decipher the child’s comments. However, these occurrences were few and observations are considered a good representation of the children’s experiences. Preliminary viewing of video footage of one session from each child assisted observers in familiarization with the data and in development of a rubric (Appendix H) which supported the coding of various behaviors. These data contributed to the interpretation of the child’s experience.

*Coding of behaviors.* Code’s for children’s behaviors was determined by analyzing the nature of the speech, facial expressions, and body language. (*i.e.* if a child made eye contact while talking to therapist, eye contact was coded; if a child did not invite therapist to play, behavior was coded as disengaged; if the child refused a play directive, behavior was coded as un-accepting of play directive, or vice versa). By coding and tallying behavior, a pattern of each child’s experience emerged, yielding themes in behavior that aided in the description of participants experience, the focus of the study.

Coding was developed within the following categories: Speech – talkative (surface subjects), overall quietness, talks to therapist (in-depth feelings and thoughts), talks to self, laughs, and cries. Facial Expression – smiling, frowning, eye contact, and no eye contact. Body Language – active in play, withdrawn into play (self oriented), agitated, restless, calm, rejects play directive, accepts play directive, engages therapist (invites therapist into play), and does not engage therapist (does not invite therapist into play). See rubric (Appendix H).
Overview of observations. Andrew was observed over a period of eight sessions, three nondirective/free play, four directive/structured play, and one closure session. Andrew initially presented as withdrawn and quiet, using mostly nonverbal modes of communication (pointing, smiling, and nodding) and very few words. He made good eye contact. As sessions continued, Andrew’s behavior presented with increasing amounts of smiling and laughter. He appeared to become less agitated, less impulsive, and calmer; however, his appearance of sadness, as evidence in frowning, was displayed in the last session. Throughout the assessment Andrew gradually increased in talking to the therapist, becoming more accepting of play directives, and interacting with the therapist. Andrew appeared increasingly engaged in the assessment; however, he appeared agitated and disengaged during the self-portrait drawing.

Bobby was observed over a period of seven sessions, two nondirective/free play, four directive/structured play, and one closure session. Bobby initially presented with a great deal of self talk during play, which gradually transferred to talking to the therapist. He held consistent eye contact with the therapist, smiling often, with episodes of laughter. He appeared hyperactive and restless near the beginning of the assessment, as evidence of darting about the room and jumping from one activity to another. Gradually, Bobby developed a calmer, purposeful, slower pace, and engaged with activities. Occasionally, Bobby would withdraw back into playing alone and talking to self.

Carlton was observed over a period of seven sessions, two nondirective/free plays, four directive/structured play, and one closure session. Carlton initially presented as quiet and somewhat guarded, as evidenced by shifting eye contact and lack of dialogue. Eventually, he increased his smiling, eye contact, and laughter. Carlton gradually became more engaged with the therapist and play directives, slowly decreasing from withdrawal into
play, and increasing his level of talking to the therapist. Carlton displayed increasing amounts of calmness, however during the sand tray and the feelings chart he appeared agitated.

Dawn was observed over a period of eight sessions, three nondirective/free play, four directive/structured play, and one closure session. Dawn’s initial behavior demonstrated high energy and little display of emotion. However, she held a consistently adequate measure of eye contact and eventually increased her smiling and laughter. She displayed a high measure of talking to the therapist. Dawn varied in her activity in play and engaging the therapist, as sometimes she would engage and others times she would want to play alone. Initial signs of agitation and withdrawal into play quickly dissipated as she became calmer; however, she was slightly agitated during the self-portrait drawing.

*Categories and themes.* Emerging codes and common themes from observation included the following descriptions. In the Facial Expression category all four children demonstrated more smiling and eye contact as compared to frowning and no eye contact from the beginning to the end of the study. Looking at the Body Language category all four children showed increasing measures of engagement with the therapist and accepting play directives with each successive session. Three out of four children displayed more calmness, and less agitation and restlessness across sessions. In the Speech category throughout sessions, three out of four children presented an increase in talking to the therapist; three out of four children also showed a decrease in quietness; and three out of four children demonstrated a general increase in laughter. Overall themes from video observations comprised of smiling and eye contact, an increase in talking to the therapist, a decrease in quietness, and an increase in laughter, increases in engaging therapist and accepting therapist directives, and overall calmness.
In addition, it is noteworthy to describe the equally distributed demonstrations of withdrawing into play, where as two children increased and two children decreased in this pattern of body language. Likewise, were the demonstrations of self talk and talkativeness, as two children showed an increase and two children showed a decrease in these categories of speech.

Table 1 Video Observation Categories and Codes

<table>
<thead>
<tr>
<th>Child</th>
<th>Facial Expression</th>
<th>Body Language</th>
<th>Speech</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andrew</td>
<td>+ smiling</td>
<td>&gt; engages therapist</td>
<td>&gt; talks to therapist</td>
</tr>
<tr>
<td></td>
<td>+ eye contact</td>
<td>&gt; accepting play directive</td>
<td>&lt; quietness</td>
</tr>
<tr>
<td></td>
<td>- no eye contact</td>
<td>&gt; active in play</td>
<td>&gt; self talk</td>
</tr>
<tr>
<td></td>
<td>- frowning</td>
<td>&lt; withdrawn into play</td>
<td>&gt; talkative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt; calmness</td>
<td>&gt; laughter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- agitation/restless</td>
<td></td>
</tr>
<tr>
<td>Bobby</td>
<td>+ smiling</td>
<td>&gt; engages therapist</td>
<td>&gt; talks to therapist</td>
</tr>
<tr>
<td></td>
<td>+ eye contact</td>
<td>&gt; accepting play directive</td>
<td>&lt; quietness</td>
</tr>
<tr>
<td></td>
<td>- no eye contact</td>
<td>&gt; active in play</td>
<td>&gt; self talk</td>
</tr>
<tr>
<td></td>
<td>- frowning</td>
<td>&gt; withdrawn into play</td>
<td>&lt; talkative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt; calmness and restlessness</td>
<td>&lt; laughter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- agitation/restlessness</td>
<td></td>
</tr>
<tr>
<td>Carlton</td>
<td>+ smiling</td>
<td>&gt; engages therapist</td>
<td>&gt; talks to therapist</td>
</tr>
<tr>
<td></td>
<td>+ eye contact</td>
<td>&gt; accepting play directive</td>
<td>&lt; quietness</td>
</tr>
<tr>
<td></td>
<td>- no eye contact</td>
<td>&gt; active in play</td>
<td>&gt; self talk</td>
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<td></td>
<td>- frowning</td>
<td>&lt; withdrawn into play</td>
<td>&gt; talkative</td>
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<td></td>
<td></td>
<td>&gt; calmness</td>
<td>&gt; laughter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- agitation/ restlessness</td>
<td></td>
</tr>
<tr>
<td>Dawn</td>
<td>+ smiling</td>
<td>&gt; engages therapist</td>
<td>&lt; talks to therapist</td>
</tr>
<tr>
<td></td>
<td>+ eye contact</td>
<td>&gt; accepting play directive</td>
<td>&lt; quietness</td>
</tr>
<tr>
<td></td>
<td>- no eye contact</td>
<td>&gt; active in play</td>
<td>&lt; self talk</td>
</tr>
<tr>
<td></td>
<td>- frowning</td>
<td>&gt; withdrawn into play</td>
<td>&gt; talkative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt; calmness</td>
<td>= laughter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- restlessness and agitation</td>
<td></td>
</tr>
</tbody>
</table>

(+ more than; - less than; > increase; < decrease; = equally distributed)

Child questionnaires. The opportunity to deepen the rapport and gather data on individual experiences occurred during child questionnaire interviewing. As part of the closure procedures, each child responded verbally to a standard set of questions in an effort to form comparisons amongst the data sources (Appendix G). Responses were documented verbatim in writing by therapist/participant. All children responded eagerly to participation in answering questions about their experience with the Extended Play-Based Developmental Assessment (2011). The therapist/participant worked to allow the data to emerge naturally, encouraging the children to elaborate on their thoughts until a natural end to a line of inquiry.
occurred. The children’s responses about their experiences served as an essential data source for this study.

Coding of child questionnaires focused on categorizing and deciphering meaning from responses. Codes from the emerging questionnaire data describing the collective experiences of the child participant’s embraced a broad interpretation, which was collapsed with codes from video observations into developing themes, and triangulated with other data sources. Table 2 provides a guide to the development of meaning in codes which emerged from this data source.

Table 2 Child Questionnaire

| Meaning tied to play room experience: | Andrew: “It was fine” “It helped me talk” “the toys were fun”  
Bobby: “It was really, really fun”  
Carlton: “It was good” “It’s fun” “I liked the sandbox”  
Dawn: “It was fun” “There are lots of toys”  
Bobby: “It was really, really fun”  
Carlton: “It was good” “It’s fun” “I liked the sandbox”  
Dawn: “It was fun” “There are lots of toys” |
|---------------------------------------|-------------------------------------------------|
| Meaning tied to feeling safe using EPDBA: | Andrew: “I feel safe here” “I feel I can trust you”  
Bobby: “I felt safe…very safe”  
Carlton: “I feel safe…I feel safe here with you but not in my xxxx house”  
Dawn: “I felt safe with you”  
Bobby: “I felt safe…very safe”  
Carlton: “I feel safe…I feel safe here with you but not in my xxxx house”  
Dawn: “I felt safe with you” |
| Meaning tied to feeling comfortable with activities: | Andrew: “I was fine” “I really liked the sandbox” “Nothing was uncomfortable”  
Bobby: “I was comfortable” “I had fun too”  
Carlton: “Yes”, “Everything was fun”  
Dawn: “It was all comfortable”  
Bobby: “I was comfortable” “I had fun too”  
Carlton: “Yes”, “Everything was fun”  
Dawn: “It was all comfortable” |
| Meaning tied to most helpful aspect: | Andrew: “Having someone to talk to”  
Bobby: “I am really happy here, I am not happy other places”  
Carlton: “Playing” “in the sandbox, ha, ha, ha….with the boat, that’s my favorite”  
Dawn: “just playing…that’s all”  
Bobby: “I am really happy here, I am not happy other places”  
Carlton: “Playing” “in the sandbox, ha, ha, ha….with the boat, that’s my favorite”  
Dawn: “just playing…that’s all” |
| Meaning tied to unhelpful aspect: | Andrew: “Everything was helpful”  
Bobby: “Everything was helpful”  
Carlton: “I don’t know…nothing”  
Dawn: “I liked everything, I don’t like dislike anything”  
Bobby: “Everything was helpful”  
Carlton: “I don’t know…nothing”  
Dawn: “I liked everything, I don’t like dislike anything” |
For example, Andrew reported his experience as “It was fine, I liked all the toys” (personal communication, June 7, 2011). Bobby reported in the questionnaire his experience was “really, really fun” (personal communication, June 2, 2011). Carlton reported his experience was “good”, that he would tell other children “about the toys”, and added he “I liked the sandbox… that was fun” (personal communication, July 21, 2011). Dawn reported her experience as “It was fun, I liked being here.”; she would tell other kids “there are a lot of toys, and a sandbox, two sandboxes, and puppets, and a doll house, and animals, and a tea stuff and lots of stuff…it was so much fun” (personal communication, June 2, 2011). An overview of the codes from child questionnaires includes: experiencing fun, helpfulness, and enjoyment, safety, and comfort, talking to someone, and having playtime.

**Parent questionnaire.** Questionnaires were presented to each parent at the conclusion of the parent meeting when the child’s evaluation was reviewed (Appendix G). Parent responses were documented, categorized and deciphered for meaning in describing the collective experiences of the parent participant’s, which was then coded and triangulated with other data sources.

For example, Parent A described her experience with the EPBDA as “very good,” she added “My son is always happy to come in for his appointment” and “I feel secure in knowing that (e.g. he is happy)” (personal communication, June 20, 2011). She reported the most helpful part of the assessment was “helping me to understand my son’s emotions, and what he is going through” (personal communication, June 20, 2011). Parent B responded in describing his experience as “very professional,” and “my son has enjoyed his play time and looks forward to it each day I bring him,” and “We all feel great relief in having him come here” (personal communication, July 22, 2011). He also reported the most helpful part of the assessment was “knowing our son is getting help, we are very grateful” (personal
Parent C responded with “My experience was enjoyable since the children were not stressed, but rather they looked forward to it (e.g. coming to sessions)” (personal communication, June 6, 2011). She reported the most helpful part of the assessment was “gaining a rounded view of their current emotional issues,” and added “the summary reports were right on” (personal communication, June 6, 2011). Parent C also shared her disappointment in that she felt “too optimistic” in the assessment process, as she had hoped to have her child’s issues solved and realized it would require ongoing therapy to fully process the trauma experiences (personal communication, June 6, 2011).

Provided in Table 3 is a guide to the meaning of codes which emerged from this data source. Overall themes in parent questionnaire included: good, enjoyable, gratified, security, relieved for help, and parent gaining an understanding about their child, and parent disappointment.

Table 3 Parent Questionnaire

<table>
<thead>
<tr>
<th>Meaning of Codes in Responses</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meaning tied to experience with EPBDA:</strong></td>
<td><strong>Examples</strong></td>
</tr>
<tr>
<td>Good</td>
<td>Parent A: “It has been very good. “My son is always happy to come to his appointment, I feel secure in knowing that”</td>
</tr>
<tr>
<td>Security</td>
<td>Parent B: “My son has enjoyed his play time, and looks forward to it each day” “I feel great relief knowing that”</td>
</tr>
<tr>
<td>Relief</td>
<td>Parent C: “My experience was enjoyable since the children were not stressed, but rather looked forward to coming”</td>
</tr>
<tr>
<td>Enjoyable</td>
<td></td>
</tr>
<tr>
<td><strong>Meaning tied to the most helpful aspect of EPBDA:</strong></td>
<td><strong>Examples</strong></td>
</tr>
<tr>
<td>Gaining understanding about Child</td>
<td>Parent A: “Helping me to understand how to better understand my son’s emotions and what he is going through”.</td>
</tr>
<tr>
<td>Gratification</td>
<td>Parent B: “Knowing my son is getting help has been very gratifying. We’re grateful”</td>
</tr>
<tr>
<td>In depth summary reports helpful</td>
<td>Parent C: “It was very helpful in so far as gaining a rounded view of their current emotional issues. The summary reports for very helpful”</td>
</tr>
<tr>
<td><strong>Meaning tied to what was not helpful in EPBDA:</strong></td>
<td><strong>Examples</strong></td>
</tr>
<tr>
<td>No reports</td>
<td>Parent A: “I can’t think of anything”.</td>
</tr>
<tr>
<td>Parent disappointment</td>
<td>Parent B: “Nothing comes to mind”</td>
</tr>
<tr>
<td></td>
<td>Parent C: “I feel I was a bit too optimistic in hoping my children would gain the ability to fully process their experiences, but I guess that will come with ongoing therapy”</td>
</tr>
</tbody>
</table>
Therapist field notes and questionnaire. As therapist/participant my subsequent observations and diagnostic field notes served as an important data source as these entries provided a guide to the study’s emergent design. Field notes of each child were gathered and incorporated into supporting responses to the therapist questionnaire. Questionnaires were completed after the last meeting with each parent (Appendix G). As with previous questionnaires, my responses were categorized into codes, aiding in the description of my experience later to be triangulated with other data sources for development of a collective interpretation of themes. Provided in Table 4 is a guide to the meaning of codes which emerged from this data source.

Emerging codes from the therapist questionnaire consisted of: satisfying, flexible, encouraged development of communication, non-directive sessions created calming environment for two of the children and directive sessions created calming environment for the other two children; development of trusting bond between therapist and child; the sand tray was the most popular activity with the children and the most enlightening activity for therapist; and the genogram activity seemed unproductive.
Table 4 Therapist field note/questionnaire

<table>
<thead>
<tr>
<th>Meaning Codes to Responses</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meaning tied to experience in use of EPBDA:</td>
<td>I felt very satisfied with the simplistic process of the EPBDA instructions and format. It was easy to use and made my work satisfying. The non-directive sessions had a calming effect to the playroom environment, specifically with Carlton’s restlessness and agitation during sessions 4-6. Bobby needed the structure in the directive play activities to gain grounding; the non-directives seemed rather over stimulating and chaotic. Andrew was more articulate compared to the other children, however the activities were still engaging and he seemed enthusiastic to participate. Dawn needed several non-directive sessions (1-3) to relax, to become less demanding, and to gain my trust.</td>
</tr>
<tr>
<td>• Satisfying</td>
<td></td>
</tr>
<tr>
<td>• Non-directive = Calming environment</td>
<td></td>
</tr>
<tr>
<td>• Directive ~calming</td>
<td></td>
</tr>
<tr>
<td>• Simple format</td>
<td></td>
</tr>
<tr>
<td>• Encouraged positive bond between therapist and child</td>
<td></td>
</tr>
<tr>
<td>Meaning tied to most helpful aspect of EPBDA:</td>
<td>It was helpful to have specific protocols to follow for each session. It was helpful to have the Sand tray as an activity to work with Carlton. It was helpful to have many options of play activities to work with Andrew. Bobby and Carlton only needed two non-directive sessions, so it was helpful the model is designed to have the flexibility to move through sessions to meet child’s needs.</td>
</tr>
<tr>
<td>• Having guidelines for activities.</td>
<td></td>
</tr>
<tr>
<td>• Flexibility</td>
<td></td>
</tr>
<tr>
<td>• Development of communication</td>
<td></td>
</tr>
<tr>
<td>Meaning tied to non helpful aspect of EPBDA:</td>
<td>I found the genogram activity less desirable compared to the others, and found the protocol’s a bit confusing to follow. Carlton, Andrew, and Dawn were challenged in the genogram directives and had difficulty associating family members with miniature figures. Information gathered from this activity seemed ambiguous.</td>
</tr>
<tr>
<td>• Genogram protocols were confusing.</td>
<td></td>
</tr>
<tr>
<td>Meaning tied to activities in EPBDA:</td>
<td>Activities were fun and therefore an enjoyable experience between child and therapist which assisted in development of a positive bond. However, Andrew did not like the drawing activities. Non directive activities such as make believe, doll house, and puppets encouraged interaction between therapist and child, and development of dialogue in play. The sandbox was most requested play activity, and very enlightening in gathering information through observation of emerging themes in play and child’s self-talk. Bobby was very enthusiastic to be involved in all activities.</td>
</tr>
<tr>
<td>• Fun (except drawing for 1)</td>
<td></td>
</tr>
<tr>
<td>• Enlightening experience.</td>
<td></td>
</tr>
<tr>
<td>• Sandbox big hit (fun)</td>
<td></td>
</tr>
<tr>
<td>Meaning tied to relational experience between client/family/therapist:</td>
<td>Dawn benefitted the most from non-directive play as this allowed her space and time to gain security in environment and with me. Andrew was able to develop a sense of trust after two sessions, and began sharing more about his thoughts and feelings concerning his experiences at home and school. Bobby needed the resources to buffer his experience and allow adjustment to me, and the playroom. He eventually was able to be more relaxed and willing to engage in play and talking with therapist. Carlton became more trusting over time; however he displayed agitation and restlessness during activities in session 4-6. Carlton’s symptoms were reported to have reduced at home. Dawn became more accepting of play directive and less demanding; she began to trust and develop a bond with me. Parent was encouraged by a less stressed child.</td>
</tr>
<tr>
<td>• Helped develop conversation</td>
<td></td>
</tr>
<tr>
<td>• Developing trusting bond</td>
<td></td>
</tr>
</tbody>
</table>
**Triangulation.** Review of the coded data gathered from observational footage, child questionnaire, parent questionnaire, therapist field notes, and therapist questionnaire were analyzed and descriptive themes were generated. Through the process of triangulation of data, common themes were identified, resulting in a narrative interpretation of the collective experiences of the children, the parents, and the therapist in the use of the Extended Play-based Developmental Assessment (2011).

In carrying out the triangulation process, first I compared the eight emergent codes from video observation data (smiling and eye contact, an increase in talking to therapist, a decrease in quietness, and an increase in laughter, increases in engaging therapist and accepting therapist directives, and overall calmness) and the seven emergent codes from child questionnaires (experiencing fun, helpfulness, and enjoyment, safety, and comfort, talking to someone, and having playtime) and collapsed them into four common themes to include fun, calming/comforting, safe/helpful, and development of dialogue.

Secondly, I examined emergent themes from the child participants, with the remaining data sources from parent and therapist participants. Themes which developed from the parent questionnaires included feeling good, enjoyable, gratification, security, relief for help, parent gaining understanding of the child, and parent disappointment. Themes which developed from therapist questionnaire and field notes included fun activities, ease and flexibility, development of a calming environment, development of a trusting bond, development of communication, popular sand tray activity, and less effectiveness of the genogram.

**Summary.** Analysis of the three data sources revealed three common themes. First, the most obvious pattern in the data was the narrative theme, *experience of enjoyment*, as represented by the child’s experiences of fun and playing, which associated with the therapist
experiences of satisfying, which positively triangulated with the parent’s experience feeling good, enjoyable, and gratified. Secondly, the child’s experience of calmness/comfort and safety associated with the therapist experience of a calming environment and development of a trusting bond, which related with the parent’s experience of security and feeling relieved to have help. This theme was narrated as experience of calmness. Third, the child’s experience in engaging and talking with therapist linked with the therapist experience of development of communication, which positively triangulated by the parent’s experience of gaining insight and understanding of their child. This theme was narrated as the experience of enrichment. Themes which did not seem to parallel with participant experiences included the therapist’s experiences of flexibility in the EPBDA, and a parent’s experience of disappointment (too optimistic).

This chapter presented the findings of a study which explored the experiences of participants (child, parent, and therapist) with the EPBDA model. Qualitative data including multiple sources were examined to elucidate the collective experiences of the participants. The final chapter report’s conclusions from these results and discusses the interrelated implications for clinicians and researchers, as well as suggestions for further research in play-based assessments.
Chapter 5

Conclusion and Implications

Introduction. Children who have experienced trauma and abuse require special provisions to navigate successfully through the initial phase of therapy, in particular the assessment process, which suggests the use of a more child friendly, play-based model of assessment (Shelby & Berk, 2009; Cattanach, 2008; Gil, 2006; Greenspan & Greenspan, 2003). Putting this into context, the idea for this study initiated from the researcher’s experiences as a clinician – one who was knowledgeable of best practices in play therapy, mindful of the modalities of child-friendly assessments, but faced with the dilemma of mandated empirical research methods that often times did not support those ideas. Rarely are issues of clinical play-based practices one-dimensional, rather there are multiple layers in need of examination and understanding, specifically the experiences of the individuals involved. This is the dilemma (or perhaps opportunity) that play-based researchers and practitioners face. Therefore, having identified not only a gap in research, but also the potential to affect practice, the researcher sought to describe the experiences of the children, parents, and therapist as participants in using a more child friendly, play-based assessment, in particular the EPBDA.

Conclusions of the study. Through the interpretation of the participants point of view, the researcher set out to explore the experiences of participants with the Extended Play-based Developmental Assessment (Gil, 2011), revealing aspects of play-based assessment that may enrich current theory, while demonstrating practical application. The design of this study in seeking an interpretive understanding derived from the qualitative paradigm. As Denzin and Lincoln (2000) have noted, the case study approach accurately produces insights only regarding the case in question, with limited generalizability of
Extended Play-Based Developmental Assessment

observations: “The utility of case research to practitioners and policy makers is in its extension of experience” (p. 104). The anticipated result is new insights that are impractical to construct without the in-depth exploration characteristic of an interpretive approach. Thus, the researcher comes to know what has happened partly in terms of what others reveal in their own experience. The role of the case researcher is therefore to interpret experience, to preserve its comprehensibility in other contexts, and thereby engage in knowledge construction (Denzin & Lincoln, 2000; Creswell, 2005). The results of this collective case study are especially valuable in terms of promoting a continuing dialogue regarding play-based assessment models for children with trauma histories, in particular the use of The Extended Play-Based Developmental Assessment (Gil, 2011).

In the previous chapter, results were organized in a linear way consistent with the concept of experience, that is, what the participants did and said in reference to the EPBDA model. The following conclusion is an integration of experiences describing the broader themes that were suggested and/or supported by the findings. Those themes include (a) enjoyment, (b) calmness, and (c) enrichment. Within each of these themes key findings are discussed. Accordingly, my intention for this chapter is to articulate the contributions of this study, review the results, and discuss implications for future research and practice.

Calmness. The theme of calmness manifested in the case in that the children gained a sense of control over their environment through the non-directive approach. From there, they gradually moved toward partial control. This provided them the impetus to externalize their thoughts and feelings in an accepting, non-threatening environment. Within this structure, the therapist and child were able slowly to develop a trust-based relationship reducing anxiety and freeing the child of inhibitions against healthy self-expression.
In reference to Axline’s (1947, 1950) theory of the most crucial consideration in the play experience, the play assessment environment created a nurturing and supportive alliance between therapist and child, which expressed openness and acceptance of the child’s feelings. The therapist reflected back to the child observed feelings, through interaction and conversation, which encouraged further development of trust and understanding in the relationship. This exchange reduced the amount of stress and anxiety in the child, therefore creating a calm environment for the child to return and build upon with each new session. The therapist was able to assist the child in experiencing the playroom as a safe place, to serve as a secure base for the child (Landreth, 2002; Gil, 1991; Goodyear-Brown, 2010; Shelby & Felix, 2006). Thus, within the context of play, the child was able to explore and reclaim attributes of childhood expected in the models of Piaget (1969) and Vygotsky (1978). In addition, as the child became less anxious, and more trusting of therapist and playroom, the experience of the parent increased in relief and security in the assessment process and the therapist-child dyad.

**Enjoyment.** The theme of enjoyment was manifest in the case in that the time the children spent in the playroom featured satisfying, child-friendly activities. The children had several options to attract their creative attention, while finding the assessment directives to be fun and entertaining. Play activities included make believe dress-up, playing in the doll house, storytelling with puppets, and board games, drawing and painting, and sand tray. The most popular activity among all child participants was the use of the sand tray, within the non-directive and directive methods. This activity allowed the children to have a sense of control over their environment, to move freely within the play room setting, ultimately gaining association to their inner world. The amount of self-expression in this exercise allowed for greater insight for the therapist.
While the interaction between therapist and child produced the clinical results that the therapist needed to further the child’s psychological interests, the child and therapist also simply had fun. In addition, parents accompanying their children to assessment sessions were encouraged by their child’s excitement and anticipation to participate in the assessment process, which supports the overall experience of feeling enjoyment.

**Enrichment.** The theme of enrichment was manifest in the case in the fact that, as the therapist applied the appropriate assessment procedures and concluded the associated sequence of activities, the amount of information on the child that the therapist gathered was rich, resembling the transference through play themes. The children’s participation in play gave the therapist the opportunity to observe their behavior, while encouraging the children to express their experiences in a combination of language and symbolic behavior with the help of toys and activities.

In consideration of Vygotsky’s (1978) theory of the necessity for pivots, the children used play as a form of language to imagine, manipulate ideas, create new ideas, and then share those ideas. Through this exchange the children placed meaning to their thoughts and then through words, leading to a more enriching environment between the therapist and children’s experience. The therapist analyzed the children’s internal perspective through the observation and interpretation of patterns and themes in play. Thus the free association through the play assessment developed into experiential dialogue between the therapist and child, and resulted in creating an enriching experience.

**Implications for clinical practice.** In the present study, the main focus was with children between the ages of five and nine years old who have experienced trauma. In this realm, it seems apparent that a play-based model of assessment has ample value to offer in future cases evaluating the problematic domains of a child’s functioning and providing a
systematic framework for examination of development, mood, relational capacity, affect, and use of space (Greenspan & Greenspan, 2003). In this respect, The Extended Play-Based Developmental Assessment (Gil, 2011) was instrumental in drawing out the experiences of enjoyment in the play-based assessment, in developing an enriching interaction and environment, and a sense of calming within the child, the parent, and therapist.

Further, it is sufficient to suggest that replication of the EPBDA model to closely matched cases in similar clinical settings is probable. In addition, therapists may wish to set up playrooms equipped for non-directive and directive play that will enable children with trauma history the ability for free association through the tangible world of play and activity, and therefore observe whether this modality provides insight and understanding more than what was previously attainable. A notable advantage with play-based therapy and assessment is that the worst case is simple ineffectiveness; essentially, play encourages children to develop insights into themselves, understanding about their own motivations, and appreciation of their relation to the rest of the world (Klein, 1955). The general exposure of play itself is not harmful to children for its own sake (Greenspan & Greenspan, 2003).

**Implications for future research.** Based on the findings of this study, several recommendations for future research can be made. First, this study represented an initial investigation in the participants experience in use of the EPBDA. Replicating this study with a larger sample size, in multi settings, in various geographical regions, and by other clinician-researchers is needed to expand the evidence for the EPBDA toward recognition as an evidence-based model for assessing children.

Secondly, different strategies and different media are certainly likely to produce variations on the results achieved herein. In consideration of the disappointment of the genogram exercise to produce the expected result, further research could validate or refute
this phenomenon. The possibility that there are certain tools available in the full repertoire of play mediums is immense. Some researchers may wish to try to determine what features of play-mediums are most supportive in the play-based assessment process.

Finally, once it has become possible to collect sufficient examples to support more generalizable conclusions, the personality characteristics of the therapist may become an important focus of exploration, to identify possible connections between professional or trainable qualities, and the suitability of play therapy to a given therapist’s array of clinical options.

**Limitations.** As explained previously, the case study method limits the generalizability of observed results. The conclusions that arise from this study are therefore strictly applicable to each participant’s experiences, rather than to all conceivable cases. Nevertheless, despite the inability to generalize theoretical findings from the observable interactions that happened to characterize the case at issue to larger populations, the results are quite useful in their capacity to promoting play-based assessments and of the EPBDA model in particular.

Moreover, within the dual-role interpretive framework of researcher and observer, the active connection between the inquiring role and that of participant in the phenomenon of study creates further distinctiveness in the case method. In this respect, it is essential to acknowledge that play therapy therefore constitutes a method of study that demands investigation at the level of interaction between the participants within the study, rather than at that of the nuances of behavior present during the actual interaction. Generally, within this structure, the therapist’s entry into engagement with the client always carries theoretical presuppositions with it (Green, 2008). However, the therapist’s unusually active participation in the case of play-based assessment resembles the assumptions of Jungian psychology more
strongly than is the case with traditional (e.g., post-Freudian) methods (Green, 2008). The generalizable facet of play-based assessment involves comparisons of methods or strategies, rather than specific behavioral detail during the associated sessions themselves.

Another limitation is that the EPBDA model is intended for trained play therapists, which have already invested time and resources in the development of a play room setting and have training in use of play room materials. The cost in developing a play room setting, and collecting the appropriate materials necessary to incorporate all the activities suggested in the EPBDA, can be an exhaustive endeavor if the therapist is not already using play mediums (e.g. the sand trays and miniatures necessary for two of the activities are estimated to cost well over $500.00; the doll house ranges from $200.00 to $400.00, depending on size, and furniture and family selections). In order to obtain the array of play materials suggested (Appendix E) a therapist would need to spend ample time collecting selective toys and searching in thrifty ways to avoid the expense of buying new items. It is highly recommended that therapists who are new to play therapy and who will be working with children with trauma histories collaborate and consult with other professionals such as pediatric mental health, forensics, and social work.

Retrospective commentary. What was most satisfying about this study was that the conclusions drawn from the observations were in close alignment with the theoretical material that justifies play-based assessment as a practical clinical method. My experience with actual use of the EPBDA model was a positive one. First, it was enjoyable to work with the children as they participated in the noted activities, while developing a dialogue with them. The activities were enjoyable for the children, and it was quite apparent they helped develop the rich environment which enabled this researcher to engage in learning about the children’s self-perceptions. It was as though the mode provided a linguistic medium that
would have been unavailable. The most effective aspect of the EPBDA was the range of play activities to determine each child’s emotional state and psychological development.

Thus, through the medium of a structure of directive and non-directive activities, a therapist using the play-based assessment can create an enriching experience necessary to accommodate tangible communication despite the children’s limited linguistic and emotional development. While my experience with the genogram exercises was a little disappointing, both in terms of the vague information gathered and in the difficulty that characterized the implementation of the activity with the children, the other activities in both directive and non-directive play were actually quite easy to manage and wholly elucidating in their ability to generate psychological data. The Extended Play-based Developmental Assessment model was instrumental in fostering a positive relationship between therapist and child. The play was fun, even for me, and the activities succeeded in illuminating my full understanding of the child’s inner world.

**Summary.** To conclude this study, the results of the experiential research demonstrate that the use of play-based assessments support valid theoretical premises in assessing children. In particular, the observation is The Extended Play-based Developmental Assessment was effective in drawing out the experiences of enjoyment in the play-based assessment, allowing the child ease in interaction with the therapist, and therefore display of affect, mood, and observation of use of space. In addition, the EPBDA produced a sense of calming within the child and the environment, as well as the parent and therapist, ensuring a foundation for the child to develop a sense of security in the assessment process and therapist-child dyad. Finally, the use of the EPBDA was effective in developing enrichment from interaction in activities and observation of the child’s development. Therefore, the
EPBDA supports the creation of a safe, nurturing, and child friendly environment for children with trauma history and is beneficial in assessing a child’s functioning.
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Webpage and Brochure Announcement

Research Study Seeking Participants

**FREE Counseling Assessment for children 5 to 9 years old for exploring a play based assessment for children who have experienced trauma.**

This study defines ‘trauma’ as an identifiable incident(s) which caused the child to feel helpless, overwhelmed, and continues to cause the child emotional, social, or behavioral difficulties.

Confidentiality is priority to this study.
Supervision and research conducted by licensed therapists.
Research supported by Northwest University and Cedar Park Church

For more information contact:
Janet O'Donnell, MA, LMHCA
425-939-490 (ext 1243)
Janet.o@cedarpark.org
Participants...

...for a study exploring play based assessment for childhood trauma.

Twelve sessions will be provided for the children and families chosen as participants. Children ages 5 to 9 years of age.

This study defines ‘trauma’ as an identifiable incident(s) which caused the child to feel helpless, overwhelmed, and continues to cause the child emotional, social, or behavioral difficulties.

Location

Cedar Park Counseling Network
Children’s Center

Located at:
16300 112th Ave NE, Bothell, WA 98011

Study Procedures

Participants will:

* Attend weekly 50 minute sessions for 6 to 12 weeks, using the Extended Play Based Developmental Assessment.

* Parents complete in-depth intake interview and final evaluation meeting.

* Complete paperwork as necessary.

Confidentiality & Client Rights

Participant’s confidentiality is top priority in this research.

Reported data will use pseudonyms and will remove or change identifying information.

Only individuals bound by legal and ethical confidentiality mandates will be allowed to observe sessions and interviews.

During the initial screening session, questions will be addressed and an in-depth description of the study and clients rights will be explored.

Contact Person

Janet O’Donnell is a Licensed Mental Health Counseling Associate in the State of Washington. She received your Masters of Arts degree in Counseling Psychology from the Graduate School of Behavior and Social Sciences at Northwest University. She is a Doctoral Candidate at Northwest University.

This study is supported by Cedar Park Counseling Network and Cedar Park Church.

FREE Counseling Assessment for Traumatized Children

Study Procedures

Participants will:

* Attend weekly 50 minute sessions for 6 to 12 weeks, using the Extended Play Based Developmental Assessment.

* Parents complete in-depth intake interview and final evaluation meeting.

* Complete paperwork as necessary.

The study will be supervised by professional, licensed Mental Health Professionals and Play Therapy Specialist.

All sessions will be audio/video recorded.
Dear Parents,

My name is Janet O’Donnell and I am a doctoral student at Northwest University. One of the requirements of the doctoral program is to carry out a research study which contributes knowledge to our field. My chosen study will examine the use of a play-based assessment for children who have experienced trauma. For this study, I will provide play-based approaches to assess a child to see if the child benefits from the participation in this research process.

Play therapy is helpful to children who may be experiencing difficulties after a traumatic event. Play is a natural way for children to communicate, and is more beneficial for children than trying to talk to them about their life. The play-based assessment is conducted in a therapeutic play room which allows for privacy, and makes a variety of carefully selected toys available to the child to use and play with. The therapist interacts in non-directive and directive approaches with the child while he or she plays to smooth the process of the assessment.

My interest in working with children with trauma experiences is based on information that suggests emotional and psychological issues are not always addressed in the assessment with this particular group of children. My hope is that the child will gain the ability to process their experiences more effectively after participation in a play-based assessment.

Procedure: Intakes for this research study shall be conducted utilizing the intake protocols of Cedar Park Counseling Network, and shall include all intake forms to be completed prior to conducting intake interview. Sessions will be held at the Cedar Park Counseling Network’s Children’s Center, located at the Bothell campus of Cedar Park Church/School. A total of 12 sessions, each lasting 50 minutes will be scheduled. Sessions will be held weekly (or twice a week, depending on schedules). Each week you and I will communicate so that I can learn about your child’s behavior in between sessions. As part of the research, you will be required to complete pre and post assessment surveys, a parent questionnaire, and agree to video/audio tape sessions. It may be possible to continue counseling following the research process, although I cannot guarantee the availability of service. I will refer you to a therapist on staff with CPCN, as well as therapist in your community, for your child’s counseling needs.

Therapist/Researcher: I am a licensed Mental Health Counselor Associate, a child specialist with CPCN, with training in play therapy interventions. During this research study I will be supervised by Dr. Phil Templeton, LMFT (Clinical Director of CPCN). My research advisors are Jacqueline Gustafson Ed.D. (Committee Chair), Sarah Drivdahl, Ph.D., and Kim Lampson, Ph.D.

Appointments: If you need to cancel an appointment, please notify me as soon as you can, at least 24 hours prior, in efforts that we can reschedule you child as quickly as possible. Your child’s progress in this study is dependent on he or she attending sessions regularly. You will have access to my email and office phone number and are encouraged to contact me with any concerns.

Fee Waiver: The usual fees for assessment are waived for the purpose of this research study.

Confidentially: The names and identities of all participants in this research shall be kept strictly confidential. Any reportable data will use pseudonyms and will not use any identifying information. Research records shall remain with CPCN and will be treated as confidential according to state and
federal law. There are exceptions to confidentiality, which are mandated by state and federal law, such as court order, suspected abuse, or threat to self or others.

**Video/Audio Recording:** Sessions of the assessment will be recorded by video and audio recorders for purposes of this research study. These recordings shall be kept confidential and stored in secure location throughout the duration of the study. All video/audio tapes will be destroyed within three years of the publication of the study’s results.

**Risks:** This study is not designed to cause discomfort to the participants. However, possible risks of the study may be that the families may experience include an impact from the time requirements of the study, some stress from dealing with potentially painful issues or uncomfortable feelings in honestly sharing negative reactions about the process. I will work with you and openly discuss any concerns to reduce any potential risks. Please note: participation is completely voluntary. You and your child may decide to participate in this study, and if you do begin participation, you may still decide to end and withdraw from participation. You and your child’s decision will be respected with no coercion, prejudice, or negative consequences.

A copy of this form will be made available to you. If you have any concerns about you and your child’s treatment as a participant in this research, please contact:
- Human Subjects Review Board, Northwest University, Provost: Dr. James Huegel-425-889-5237
- Cedar Park Counseling Network, Clinical Director: Dr. Phil Templeton, 425-939-1490

**I have read the above and understand the nature of this study and agree to participate. I understand that by agreeing to participate in this study I have not waived any legal rights. I understand I have the right to refuse to participate at any point within the study. I agree to allow the Researcher to record our sessions by video and audio recording. I further attest that I have the authority as the minor’s parent or legal guardian to consent to the video and audio recording of these research sessions.**

Parent/Guardian (print) Parent/Guardian (signature) Date

Parent/Guardian (print) Parent/Guardian (signature) Date

Therapist (print) Therapist (signature) Date

Supervising Therapist Supervising Therapist (sig) Date
Appendix C  
Child Background Information

Date: ___________________________________ Patient is: □ left-handed □ right-handed
Name ____________________________
Last ____________________________ First ____________________________ Middle Initial
Sex: M/F _____ Birth Date _______ Age ______ Grade Level ______ Ethnicity ______________________
Parent/Guardian: ____________________________ Lives with ____________________________

PREGNANCY/INFANCY HISTORY

<table>
<thead>
<tr>
<th>Pregnancy Complications</th>
<th>True</th>
<th>Not True</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Had bleeding during the first 3 months</td>
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<tr>
<td>2. Had bleeding during the second 3 months</td>
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<tr>
<td>3. Had bleeding during the last 3 months</td>
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<tr>
<td>4. Gained less than 15 pounds, specify:</td>
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<tr>
<td>5. Gained more than 30 pounds, specify:</td>
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<tr>
<td>6. Had preeclampsia or toxemia</td>
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<td>7. Had to take medications; list</td>
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<tr>
<td>8. Took narcotic drugs; list</td>
<td></td>
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<tr>
<td>9. Drank alcohol; amount</td>
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<tr>
<td>10. Had previous miscarriage; number</td>
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<tr>
<td>11. Had premature baby(ies)</td>
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<tr>
<td>12. Smoked 1 pack or more of cigarettes daily</td>
<td></td>
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<tr>
<td>13. Labor lasted less than 2 hours</td>
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<tr>
<td>14. Labor lasted more than 12 hours</td>
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<tr>
<td>15. Had a difficult labor</td>
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<tr>
<td>16. Was put to sleep for delivery</td>
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<tr>
<td>17. Was given medication for labor; specify</td>
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<tr>
<td>18. Delivery was normal</td>
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<tr>
<td>19. Delivery was breech, caesarian, forceps, induced</td>
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</tbody>
</table>

20. How was the mother's health during the pregnancy of this child? __ good __ fair __ poor __ dk

21. How old was the mother when this child was born? __________________

22. Was this child born on schedule? __<8 mths __term (8-10 mths) __>10 mths __ don’t know

23. What was this child's birth weight? ____ pounds ____ ounces

24. Is this child adopted? ____ yes ____ no  If yes, at what age? ___________

25. Number of previous pregnancies: _________________

26. Number of living children: _________________

Newborn Infant Problems
(first month of life)

<table>
<thead>
<tr>
<th>True</th>
<th>Not True</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td>1. Born with cord around neck</td>
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<tr>
<td>2. Injured during birth</td>
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<tr>
<td>3. Had trouble breathing</td>
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<td>4. Jaundiced (turned yellow)</td>
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<td>5. Cyanosis (turned blue)</td>
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<td>6. Was a twin or triplet</td>
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<td>7. Had an infection</td>
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<td>8. Had seizures</td>
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<tr>
<td>9. Was given medications, specify:</td>
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</tbody>
</table>
10. Needed oxygen
11. Was in hospital more than five days
12. Born with a heart defect
13. Born with other defect(s), specify
14. Had trouble sucking
15. Had skin problems
16. Colic
17. Sleep problems

DEVELOPMENTAL FACTORS
When did this child do the following: (If you cannot recall the age, write either early, normal, or late.)

<table>
<thead>
<tr>
<th>Activity</th>
<th>No</th>
<th>0-3 mo</th>
<th>4-6 mo</th>
<th>7-12mo</th>
<th>13-18mo</th>
<th>19-24mo</th>
<th>2-3 yrs</th>
<th>3-4 yrs</th>
<th>4-5 yrs</th>
<th>5-7 yrs</th>
<th>7+ yrs</th>
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<tbody>
<tr>
<td>1. Hold up head</td>
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<td>2. Roll front to back</td>
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<td>3. Sit alone</td>
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<td>4. Crawl</td>
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<td>5. Walk alone</td>
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<td>6. Speak single words (not mama/dada)</td>
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<td>7. String two or more words together</td>
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<td>8. Toilet trained (bladder control)</td>
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<td>9. Toilet trained (bowel control)</td>
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<td>10. Attend pre-school</td>
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<td>11. Attend kindergarten</td>
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<td>12. Have difficulty separating from parents</td>
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<td>13. Thumb-sucking</td>
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<td>14. Fears (what?)</td>
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<td>15. Nightmares</td>
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<td>16. Hurt self, others, animals</td>
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<td>17. Play with fire</td>
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<td>18. Run away</td>
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<td>19. Temper tantrums</td>
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<td>20. Open Masturbation</td>
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<td>21. Afraid to go to school</td>
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<td>22. Behavior problems at school</td>
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<td>23. Academic problems at school</td>
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</table>

24. How would you rate the activity level of the child as an infant/toddler?
   ______ very active   ______ active   ______ average   ______ less active   ______ not active

25. Approximately how long did toilet training take from onset to completion?
   ______ less than 1 month   ______ 1-2 months   ______ 2-3 months   ______ more than 3 months
### MEDICAL HISTORY

Please rate your child in each of the following areas:

<table>
<thead>
<tr>
<th>Area</th>
<th>GOOD</th>
<th>FAIR</th>
<th>POOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Health</td>
<td></td>
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<tr>
<td>2. Hearing</td>
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<td></td>
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<tr>
<td>3. Vision</td>
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<td></td>
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<tr>
<td>4. Gross Motor Coordination</td>
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<td></td>
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<tr>
<td>5. Fine Motor Coordination</td>
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<tr>
<td>6. Speech Articulation</td>
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</tbody>
</table>

7. Please identify any past medical injuries and illnesses/beginning with most recent:

<table>
<thead>
<tr>
<th>Description</th>
<th>Date</th>
<th>Age</th>
<th>Effects/Impact</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

8. Please check the following problems:

- Suspicion of alcohol/drug use
- History of physical/sexual abuse
- Sleeping problems
- Is this child a restless sleeper

<table>
<thead>
<tr>
<th>Problem</th>
<th>YES</th>
<th>NO</th>
<th>DON’T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspicion of alcohol/drug use</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of physical/sexual abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleeping problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is this child a restless sleeper</td>
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</tbody>
</table>

9. Does this child have bladder/bowel control problems?

<table>
<thead>
<tr>
<th>Bladder</th>
<th>YES/NO</th>
<th>DAY (how often)</th>
<th>NIGHT (how often)</th>
<th>When did this begin?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowel</td>
<td></td>
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</tbody>
</table>

10. Please list any prescription or non-prescription medications this child is presently taking.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

11. When was this child’s last medical exam?

| With whom: | ____________________________ |
| Phone:     | ____________________________ |
| What was the reason? | ____________________________ |

12. Has this child ever had any psychological treatments? If so, please identify:

a) With whom: ____________________________
Phone: ____________________________
What was the reason? ____________________________

b) With whom: ____________________________
Phone: ____________________________
What was the reason? ____________________________

**FAMILY HISTORY**

1. Please identify the following:

<table>
<thead>
<tr>
<th>MOTHER’S HISTORY/MATERNAL</th>
<th>FATHERS HISTORY/PATERNAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse:</td>
<td>Substance Abuse:</td>
</tr>
<tr>
<td>Learning Disabilities:</td>
<td>Learning Disabilities:</td>
</tr>
<tr>
<td>Psychiatric Diagnosis:</td>
<td>Psychiatric Diagnosis:</td>
</tr>
<tr>
<td>Anxiety/Depression:</td>
<td>Anxiety/Depression:</td>
</tr>
<tr>
<td>Behavior Problems:</td>
<td>Rage/Behavior Problems:</td>
</tr>
<tr>
<td>Medical Problems:</td>
<td>Medical Problems:</td>
</tr>
<tr>
<td>Physical/Sexual Abuse:</td>
<td>Physical/Sexual Abuse:</td>
</tr>
<tr>
<td>Arrests:</td>
<td>Arrests:</td>
</tr>
<tr>
<td>Autism Spectrum:</td>
<td>Autism Spectrum:</td>
</tr>
</tbody>
</table>

2. Please describe family home: ___ House ___ Apartment ___ Condo ___ other
   _____ number of rooms _____ number of bathrooms _____ number of bedrooms

3. Please indicate who sleeps in each bedroom:

4. Please describe your neighborhood:

5. Who has taken care of the child most of their life?

6. Who is the primary disciplinarian in the family?

7. Do parents agree on the issues of parenting, rules, and discipline? _________
   Are they ___ strict ___ lenient

8. Do parents get along with one another? ___ always ___ usually ___ sometimes ___ rarely

9. To what extent are you (and spouse) consistent with respect to disciplinary strategies?
   ___ most of the time ___ some of the time ___ none of the time
10. What would you like to change about your family?

11. Please mark any of the statements below which apply to your family.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our family is warm and loving</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People are always fighting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Everyone goes his or her own separate way</td>
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<td></td>
</tr>
<tr>
<td>People say what is on their mind</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. Have there been or are there currently any major changes or stressors in the family where the child was raised?  _____Yes  _____No

If yes, please check all that apply:

<table>
<thead>
<tr>
<th>Change</th>
<th>In Past</th>
<th>Current (6 mo/less)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial</td>
<td></td>
<td></td>
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<tr>
<td>Frequent moves</td>
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<tr>
<td>Job Changes</td>
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<tr>
<td>Drinking/drug usage</td>
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<tr>
<td>Arguments between parents</td>
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<tr>
<td>Separation or divorce of parent’s</td>
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<tr>
<td>Remarriage of parent</td>
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<tr>
<td>Separation from sibling’s</td>
<td></td>
<td></td>
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<tr>
<td>Separation from other family member’s</td>
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<tr>
<td>Frequent physical punishment</td>
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<tr>
<td>Physical confrontations between parents</td>
<td></td>
<td></td>
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<tr>
<td>Separation from significant non-family member</td>
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<tr>
<td>Mental illness in family</td>
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<td></td>
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<tr>
<td>Physical illness in family</td>
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<tr>
<td>Psychiatric hospitalization of a parent</td>
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<tr>
<td>Death in the family</td>
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<tr>
<td>Sexual promiscuity of incestual behavior in family</td>
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<tr>
<td>Family feels isolated</td>
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<td></td>
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<tr>
<td>Other</td>
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</tr>
</tbody>
</table>

13. How has family been changed by the child’s problem(s)?

14. What is the family’s expectation of treatment?

15. What does the family see as their role in treatment?

16. What do you believe are the family’s strengths?

17. What do you believe are the family’s weaknesses?
SOCIAL HISTORY
1. How does this child get along with his/her siblings?
   ____ None ____ Better than average ____ Average ____ Worst than average.
2. How easily does this child make friends? ____ Very Easy ____ Average ____ Not very Easily.
3. On average, how long does this child keep friendships?
   ____ less 6 mths ____ 6mths to year ____ 1+ year
4. Is the child able to form close relationships? ____ Yes ____ No
5. How would you describe a typical day for this child:

SCHOOL HISTORY
1. Please summarize the child’s progress in school:

2. Has the child ever been in any type of special educational program, and if so, how long?
   Learning Disabilities:
   Speech/Language Therapy:
   Advance placement:

3. Check any of the following that apply:

   Disrupt class                   In what grade
   Inattentive in class           ______
   Refuse to go to school         ______
   Fail to turn in work           ______
   Detention                     ______
   In-school suspension          ______
   Out-of-school suspension       ______
   Expelled from school           ______

4. Have any additional instructional modifications been attempted? ____ none
   ____ behavioral program ____ daily/weekly report card ____ other

5. Has this child had any educational testing? ____ Yes ____ No   If yes, what?
   ____________________________________________________________________________ (bring in copies) .
1. What are your primary concerns at this time?

__________________________________________________________________________

2. What are other (related) concerns?

__________________________________________________________________________

3. What strategies have been used to address these problems? (check those that apply and circle those that have been successful):

- Verbal reprimands _______
- Time outs _______
- Removal of privileges _______
- Reward system _______
- Physical punishment _______
- Giving in _______
- Avoiding issues _______
- Other _______

4. How would you rate your child’s overall functioning? (circle)

_________ 1 - ________ 2 - ________ 3 - ________ 4 - ________ 5 - ________ 6 - ________ 7 - ________ 8 - ________ 9 - ________ 10

unable to function in all areas
unable to function in most areas
serious difficulty
mild to moderate difficulty
minimal difficulty
no difficulty

5. What are your goals for treatment and desired outcome?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Parent / Guardian Signature ________________________________ Date __________

Parent / Guardian Signature ________________________________ Date __________

Therapist Signature ________________________________ Date __________
Appendix D

Procedures for Sessions: Extended Play-Based Developmental Assessment

Sessions 1 through 3 – Free Play Activities

Free Play Directives

- Free play allows the child to be creative, expressive, and engage in cooperative play at his/her own pace and in unique ways.
- Free play also empowers the child to have insight into his or her personal choices, and reinforces the curative nature of play.
- DIRECTIVE: “This is the play therapy room. Let me show you around. Feel free to look around and decide how you’d like to spend your time today. This is a place you can play and talk as much or as little as you want. We’ll get to know each other a little and you’ll decide how we spend our time. Later on, I might invite you to do some specific art or play activities or talk together about important topics.”

Free Drawing Directives

- If the child is interested in drawing or painting, they are invited to do anything they like.
- It is important for non-art therapists to understand that the process of making art has inherent curative properties. Thus, clinicians should not talk, ask questions or otherwise interrupt children while they draw or paint. If children talk to clinicians, they listen but don’t actively engage in conversation.
- DIRECTIVE: “You can draw or paint whatever you like and whatever comes to mind.”
- The following is a therapeutic question clinicians can pose after the child is finished with a free art activity: “Tell me about your picture.”
- Stay at the periphery of this activity without initiating idle chatter that distracts from or diffuses engagement with the activity.
- Remain engaged, yet don’t initiate questions or idle conversation.
- Respond briefly to questions, if asked.
- Help child if help is requested but avoid the urge to anticipate the child’s needs; providing assistance that guides the child but doesn’t take the lead away.
- Restrain from making evaluation comments; if you do, children can become accustomed to wanting/needling external validation.
- Become familiar with the vast literature on children’s art and play.

Excerpted from EPBDA, Developed by Eliana Gil (2010)
Session 4 - Individual Play Genogram

Directives

• Miniatures/ organized by categories
• “Find a miniature that best shows your thoughts and feelings about everyone in the family, including yourself. Put that miniature(s) on the square or circle of that person.”
• Once choices are made, view the completed Genogram with the child.
• Express interest and listen as they tell you about their Play Genogram.
• The following are examples of some therapeutic questions to pose after the child is finished with activity:
  - “Say as much or as little as you want about the Play Genogram.”
  - “Tell me about the (miniature)?”
  - “What is it like for the (miniature) to _______?”
  - “How do (miniature A) and (miniature B) get along?”

What would (miniature A) say to (miniature B) if it could?”
  - “What is (miniature) thinking/doing/feeling/wanting?”
  - “What is (miniature) like when not being ______?”
  - “How was it for you to do this activity? Most people report it as more difficult than it looks.”

• Some children may choose more than one miniature for a family member; this is accepted and adds to the complexity of the relationship or mixed feelings.
• Ask questions, make observations, but don’t interpret. Stay within the metaphor language of the child. Instead of saying “the bear looks angry”, say “I notice you picked a bear that’s showing its teeth. What’s he/she thinking, or feeling?”
• If a child feels frustrated by not finding the precise miniature desired, observe how the child tolerates frustration or resolves the problem. A helpful next step is to offer the child a piece of clay so that they can mold whatever they want or to ask them what object they would have used had it been available.
• Some children might have difficulty verbalizing their thoughts /feelings about the Genogram. Do not ask the child to explain why he or she chose a particular object. Beginning a question with “why” often puts children on the spot and asks them to explain choices which they may not fully understand. Instead, ask children to tell you more about the miniature, what kind of miniature it is, what the miniature likes or dislikes to do, etc.
• Use an open and expansive dialogue in which the child can volunteer a broad range of information. Don’t ask questions that elicit “yes/no” responses.
• Ask to take a photograph of the Individual Play Genogram, so you can keep this in your file.

Excerpted from EPBDA, Developed by Eliana Gil (2010)
Session 5 - Build a World in the Sand

Directives

• Sand tray: waist-high, waterproof, painted blue inside. 19.5 x 28 and 3 inches deep.
• Clinicians maintain the role of silent witness and provide unconditional acceptance, exhibiting interest in the sand try scenario, modeling that it’s worth “taking in.” However, clinicians do not initiate conversation while children are building their sand scenarios, and if children talk to them, they acknowledge the child but resist active engagement in conversation.
• “Using as few or as many miniatures as you would like, build a world in the sand. There is no right or wrong way to do this.”
• Or say “Using the miniatures, make anything you would like in the sand.”
• Asking for a “world” may have an organizing or confusing effect for children. The broader directive sometimes results in activities such as drawing a happy face in the sand. After the child creates the sand scenario, walk around the sand box, modeling observation and valuing what’s been created. Tell children that they can say “as much or as little” as they want. Allow for spontaneous communication. If you are so inclined, you may ask about the sand world creation with questions such as the following:
  - “tell me about your world”
  - “tell me what kind of world you’ve built”
  - “what is going on in your world”
  - Ask about objects, i.e. “I noticed the first thing you chose to place in the sand was ______, tell me a little about ______?”
  - “How did it feel to make this part of the world?”
  - Ask about groupings/areas, for example “tell me about the ____ in the left corner of the world?”
  - “What does _____ see or think or feel?”
  - “What is your favorite part of the world?”
  - “What is it like to make your world?”
  - “What kind of reaction do you have when you look at what you built?”
  - “What surprised/delighted/intrigued you about the world you built?”
• If time runs out, take a picture of sand world, and process during the next session.
• Clinician sits opposite of builder, yet close enough to see (don’t hover)
• Stay silent, yet answer briefly if client poses questions
• Keep miniatures organized by categories
• Display undivided attention.

Rules for Sand tray

• Sand stays in tray (provide this information when child needs it, vice at beginning)
• Clinician does not break plain of tray; yet touch the outside of tray
• Clinician does not leave room
• Clinician does not dismantle tray in front of child/client.

Excerpted from EPBDA, Developed by Eliana Gil (2010)
Session 6 – Color Your Feelings

**Directives**

- Use Gingerbread template, crayons, markers, colored pencils and paper
- “Let’s make a list of the feelings you feel most of the time”
- Clinicians or youngsters list these feelings on left hand of paper.
- Clinicians draw a box on right hand of paper that corresponds to the words written on left column.
- Clinicians then say “pick a color that best shows each feeling and fill in the box with that color”.
- Use the gingerbread template – “use your color code to show the feelings you have, and color in on this gingerbread person how big or little those feelings are, and where those feelings are in your body”.
- Clinicians may ask the following questions after child has finished the activity:
  - “Tell me about your picture?”
  - “What do you notice about your picture?”
  - “What do you think is the same or different between the two?”
- Clinicians might also make comments such as:
  - “It seems you feel a lot of worry when you’re with your mother. Tell me about the worries that you feel”.
  - “You seem to have two opposite feelings about this person/situation. Say a little bit about each of these feelings that you have.”
- If child is unable to think of names of feelings, use feeling cards to assist child in labeling feelings.

Session 7 – Self Portrait

**Directives**

- Use of art supplies
- “Draw a picture of you”
- If children look for more direction, tell them whatever they do is fine and that there is no right or wrong way of doing this drawing.
- Clinicians may ask the following questions after the child has finished the activity:
  - “Tell me about your picture?”
  - “What is going on in your picture(s)?”
  - “What is this little girl/boy thinking in this picture?”
  - “How does the little girl/boy feel in this picture?”
- If the child refuses to make self-portrait, go to another activity, for example, a free drawing. Do not engage in power struggles.
- Emphasize to children that they can make whatever kind of picture they want, including an abstract self-portrait (using lines, shapes, colors, images, etc...)

Excerpted from EPBDA, Developed by Eliana Gil (2010)
Session 8 – Kinetic Family Drawings

Directives

- Use of art supplies
- “Draw a picture of yourself and your family doing something...some kind of action.”
- Clinicians may ask the following questions after child has finished the activity:
  - “Tell me about your picture or drawing?”
  - “What is going on in this picture?”
  - “How do the figures in the drawing feel about one another?”
  - “If they could speak, what would they say to each other?”
  - “If the girl could speak, what would she say to ___?”
  - “I wonder what this person is thinking. I wonder what he/she is thinking or feeling?”
  - “If your family wasn’t doing this activity, what else would they do?”

In all of these sessions, clinicians should stay in the periphery of the activity without initiating idle chatter that distracts from or diffuses engagement with the activity. Providing silent involvement; allowing the drawing to proceed without interruption. Use an open dialogue in which the child volunteers a broad range of information. Ask open-ended questions, being cautious not to impose value-laden words – such as asking “I noticed that you seem smaller than everyone in the drawing, tell me more about that?”

Sessions 9 – 12 Closure: Parent meetings - sharing assessment interpretations and recommendations and final session with child

Directives

- “As you know, we are going to have our last meeting on ______, and I would like us to do a few things before then.”
- First I would like us to look back at when you first came here, the things we have done together, the activities you have enjoyed, and what you’ve learned about yourself”.
- “I would then like to give you and your parent some ideas about were we go from here and what I think might be helpful for you.”
- I would also like to plan a goodbye session and celebration so I would like to hear how you would like to celebrate our last assessment meeting.”
- Clinicians may want to present children with a little booklet with pictures and activities that were completed during the assessment.

Excerpted from EPBDA, Developed by Eliana Gil (2010)
Appendix

Play Room Materials

doll, doll bed, clothes, pacifier, bottle, dress up clothes, jewelry, hats, crown, mirror
doll house, wooden doll furniture, bendable doll families (multiethnic)
plastic food, dishes, tea pot and tea cups/saucers

rubber knife, toy gun, dart gun & board games (therapeutic in nature),
hand cuffs, balls (various), Squish balls books, puppets
old cell phone, building blocks,

chalkboard, colored chalk, eraser, whiteboard w/ markers, construction paper,
crayons, colored pencils, paper/several types, watercolors, clay, play-doh
tape, paste, pipe cleaners, popsicle sticks, magazine clippings (pictures and words)
two sand boxes, dry and wet, with miniatures

Miniatures

People
family sets (various sizes)
bride/groom
people who look frightened, happy, sad, etc..

Professions
vet, doctor, police, firemen, sports,
nurse, astronaut, military

Historical
cowboys & Indians
knights & horses
pirates, settlers, modern figures

Boundaries
fences, popsicle sticks,
wooden blocks

Animals
zoo animals, farm animals, dinosaurs, domestic and wild animals, insects,
family of animals, (all of various sizes)

Nature
trees, bushes, rocks, shells, volcano,
coconut shell (cave), branches/twigs

Vehicles
cars, trucks, airplanes, boats
ambulance, police, fire trucks

Religious/Spiritual
minister, Jesus, devil, crosses

Fantasy
wizard, fairy, mermaid, dragons,
ghost, skeleton

Structures
wishing well, bridges, buildings
plastic rocks/stones,

Other
marbles, jewels/sparkly things,
treasure chest, paper flags/umbrella
Appendix F

Play Assessment Observation Form

Date ________________ Child’s
Name ______________________________________________________
Child’s age__________ Gender ________ Cultural
background_____________________________________
Does child use play room alone □ or with parent □?
Sessions occur in play therapy room □ adult room with toys □ or
selected toys taken to other environment □

Physical functioning:

Is child’s communication primarily verbal □ non-verbal □ expressive □
Is child’s affect primarily expansive □ or constrictive □
Is child’s affect appropriate □ inappropriate □
Is child capable of affect tolerance □ affect modulation □
Is child’s typical attention span limited □ average □
Can child begin and end one project/activity before moving on to another?
Yes □ No □

Non-directive work:
Toys selected and sequence of play

Themes in play

Excerpted from EPBDA, Developed by Eliana Gil (updated 2010)
Extended Play-Based Developmental Assessment

Stories Told

Interaction with therapist during play

Depth and richness of symbolic play

Culture-specific symbolism

Issues suggested by the play

Is child’s play mostly adaptive  □  Mostly non-adaptive □

Signs of suicidality □  Homicidal ideation □  Dissociation □  Other □

How does child appear to clinician before/during/ after play therapy?

How do parents or others report child acts before and after play therapy?

Excerpted from EPBDA, Developed by Eliana Gil (updated 2010)
Directive work:
What toys did you select for the child to play with?

Why? What were your goals?

How did you introduce toys/game to child?

Did child engage easily with your idea?

Was there any specific resistance to play?

Did the child initiate interaction with therapist?

Did the child respond to:
Reflective comments □  Specific questions □  Specific interpretations □
How did the child respond?

Did you feel that your interventions were helpful □  not helpful □  neutral
How so?

What ideas do you have for follow up to selected play interventions?

Countertransference responses

Other comments:

Excerpted from EPBDA, Developed by Eliana Gil (updated 2010)
Did you meet your goals for this session? Yes □  No □

Plan for next session?

__________________________________________________________

__________________________________________________________

__________________________________________________________

Issues for supervision/consultation

__________________________________________________________

__________________________________________________________

__________________________________________________________
Appendix G

Research Questionnaires
Therapist Research Questionnaire

1. Describe your experiences in using the EPBDA?

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

2. Describe what you believe has been helpful and effective in using the EPBDA?

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

3. Describe what has not been helpful in using the EPBDA?

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

4. Did most activities go smoothly? Yes ___ No ___ If not, what was the challenge?

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

5. Describe how the use of the EPBDA affected your relational experience with the client/family?

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________
Parent Questionnaire

1. How would you describe your experience with the EPBDA?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

2. Describe what you feel has been helpful for you?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

3. Describe what you feel has not been helpful for you?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
Child Questionnaire

1. What was it like for you to be here in the playroom? What would you tell another child coming to the playroom?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

2. Did you feel safe with all the things we did in the playroom? Yes____ No____
If no, can you explain what you feel is unsafe?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

3. Did you feel comfortable with all the activities? Yes____ No____
If no, can you describe what activities you were uncomfortable with?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

4. Can you describe what has been the most helpful for you?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

5. Can you describe what has not been very helpful for you?
________________________________________________________________________
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### Appendix H

**Video Observation Rubric**

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<tr>
<td>Quiet</td>
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<tr>
<td>Talks to Tx</td>
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<tr>
<td>Talks to self</td>
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<tr>
<td>Laughs</td>
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<tr>
<td>Cries/whines</td>
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<td>Withdrawn in play</td>
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<td>Agitated/fear</td>
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<tr>
<td>calm</td>
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<tr>
<td>Rejects play directive</td>
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<tr>
<td>Accepts play directive</td>
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<tr>
<td>Engages with tx</td>
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<tr>
<td>Does not engage w/ therapist</td>
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