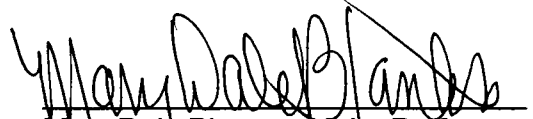


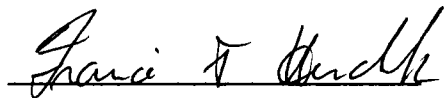
To the Graduate Council:

I am submitting herewith a thesis written by Lisa A. Modenos entitled "Status of Play Therapy Programs Across the State of Tennessee that Service Children with Special Needs." I have examined the final copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science with a major in Recreation and Leisure Studies.

[i.e. Recreation, Tourism & Hospitality Management]


Mary Dale Blanton, Major Professor

We have read this thesis and
recommend its acceptance:





Accepted for the Council:


Associate Vice Chancellor
and Dean of the Graduate School

**STATUS OF PLAY THERAPY PROGRAMS
ACROSS THE STATE OF TENNESSEE
THAT SERVICE CHILDREN WITH SPECIAL NEEDS**

**A Thesis Presented
for the
Master of Science
Degree
The University of Tennessee, Knoxville**

**Lisa A. Modenos
December 1997**

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ABSTRACT

As the review of literature indicated, play therapy is a way for children to explore and express their feelings in a safe environment. Play therapy is a way to work through problems, fears, guilt, and anger. It is a pathway for self-discovery and mastery.

The primary purpose of this study was to determine the status of play therapy programs across the state of Tennessee that service children with special needs. This purpose was addressed by identifying the populations served, the primary funding for play therapy programs, the professionals who perform play therapy sessions, the approaches of play therapy utilized, and the projected benefits from play therapy programs. To achieve this purpose, a questionnaire was developed and administered to Tennessee hospitals and health care professionals that were either members of the Child Life Council, agencies contracted with the University of Tennessee practicum and internship programs, or members of the Association for Play Therapy. Each questionnaire was numbered and color-coded and consisted of twelve checklist and open-ended questions. A total of 62 questionnaires were administered to Tennessee hospitals and health care agencies; thirty-five of these questionnaires were returned to the researcher. Of the 35 that were returned, 22 were returned completed and 19 qualified for the entire study.

A descriptive analysis of the percentages was utilized in order to determine the status of play therapy programs within the state of Tennessee. Based on the data collected, the results indicated that the majority of the respondents were either Recreation Specialists/Activity Therapists, Child Life Specialists, or Social Workers with their certifications including CTRS, CCLS, School Counselor, or Licensed Clinical Social Worker. Of the 22 participants, 19 utilized play therapy in their programming. The majority of the respondents considered the primary function of their agency to be clinical. The number of beds ranged from 0 to 160 and the number of clients per agency ranged from 5 to 200, with an average of 74. The ages of the populations served varied from birth to 100 years of age and the majority that received play therapy were between the ages of 4 and 18.

Most of the service for inpatient programs served populations with physical disabilities, physical abuse, sexual abuse, neglect, behavior problems, and conduct disorders. Most of the service for outpatient programs served populations with learning disabilities. The length of stay for inpatient was short-term and the length of stay for outpatient was both long and short-term. The primary source for funding play therapy programs was insurance. The majority of the respondents incorporated play therapy 41-100% during a client's stay. The majority of the professionals who performed the play therapy sessions were school counselors, music therapists, art therapists, speech pathologists, and clinical psychologists. The most commonly used aspects of play therapy included non-directive and directive play, child-centered play, role playing, and puppets. The projected

benefits from play therapy programs included to release stress, express feelings, build trust, increase self-esteem, explore feelings in a safe environment, and help the child “speak” to the therapist in his/her language of play.

Based on the findings of this study, it was recommended that further studies regarding play therapy should develop a broader range of delimitations. It was also recommended that a more comprehensive and extensive study could be conducted in order to determine the status of play therapy programs across the southeast or even nationwide. In order to ensure a population of infant to eighteen years of age, future studies could include only children’s hospitals and health care agencies. Future research in this area could also be conducted in order to investigate children’s responses or reactions to play therapy.

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CHAPTER I

INTRODUCTION

Play is a central part of children's lives. Play helps children understand the world they live in and gives them the opportunity to freely explore and express their feelings. Cattnach (1992) states, "Play is a journey of self discovery for the child..., a way of making sense of the past, present and future" (p. 47).

Play was not used as a form of therapy with children until 1919 by Hug-Hellmuth. According to Landreth (1991), play therapy is defined as:

A dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child to fully express and explore self (feelings, thoughts, experiences and behaviors) through play (p. 14).

Play therapy is used with a variety of clients who suffer from child abuse, neglect, learning disabilities, physical disabilities, Down's Syndrome, and many others. There are also a number of play therapy techniques, such as the non-directive and directive approach, child-centered approach, sandplay, and role playing. Having such a variety of techniques is beneficial to the therapist because he/she is able to choose the most appropriate form of play therapy for each child's individual needs.

Play therapy helps children explore and express their thoughts, feelings, and emotions in a safe and non-restrictive environment. Play therapy has been known to help children overcome suppressed feelings, such as anger and guilt. It has also been known to help children with physical, mental, and emotional disabilities to

perform new skills and reach higher goals of achievement. Play therapy is a gateway to self-discovery and mastery.

Statement of Purpose

The purpose of this study was to determine the status of play therapy programs in agencies that service children who have special needs in the state of Tennessee.

Subproblems

1. To identify the populations that are served.
2. To determine how play therapy programs are primarily funded.
3. To identify the type of professionals that perform the play therapy sessions.
4. To identify approaches of play therapy that are utilized.
5. To determine the projected benefits from play therapy programs.

Definition of Terms

The terms listed below are defined theoretically and operationally in order to better understand the content of this study.

Play therapy - A form of psychotherapy for children with special needs, which helps

children freely explore and express their feelings and emotions in a safe environment.

Children with special needs - Persons who require special services or therapy due to abuse, trauma, disabilities, etc... (also referred to as special populations).

Symbolic play - Metaphorically expressing emotions and feelings. An example of symbolic play could be sandplay.

Non-directive play - Play therapy that focuses on the child's natural instinct for complete realization (also known as child-centered play).

Directive play - The therapist selects specific play items for a child to explore during the play therapy session.

Assumptions

The assumptions of this study included:

1. The survey is valid and reliable.
2. The subjects will answer the questions in the survey honestly.
3. The data received will be accurate.

Limitations

The limitations of this study included:

1. Identification of health care agencies in the state of Tennessee that

incorporate play therapy.

2. The willingness of these agencies to participate in the study by honestly completing the questionnaire.

Delimitations

The delimitations of this study included:

1. Utilizing Tennessee hospitals and health care agencies that are members of the Child Life Council.
2. Utilizing Tennessee hospitals and health care agencies that offer Therapeutic Recreation practicums and internships.
3. Utilizing Tennessee hospitals and health care agencies that are members of the Association for Play Therapy.
4. Covering the 3 main geographic regions of Tennessee, i.e., East, Middle, and West Tennessee.

Significance of the Study

The findings of this study will determine the status of play therapy programs in Tennessee that service children. It will help determine how prevalent play therapy programs are in Tennessee and the benefits of incorporating play therapy in treatment. This study will also determine the most common aspects of play

therapy that are utilized in a variety of settings in the state of Tennessee and it will describe the populations that typically receive these services as a form of therapy.

Once this information is obtained, there will be an overview of play therapy programs within the state of Tennessee. This research will serve as a valuable tool for a variety of settings because it will determine the status of play therapy programs for children with special needs. The findings of this study will determine the areas of Tennessee that incorporate a number of play therapy techniques with a wide range of populations.

CHAPTER II

REVIEW OF LITERATURE

Play therapy is a way for children to explore and express their feelings and emotions in a safe environment. Play therapy is a way to work through problems, fears, guilt, and anger. It is a pathway for self-discovery and mastery.

The primary focus of this study was to review the types of play therapy used with children who have special needs and the benefits of incorporating play therapy with special populations. The main topics discussed in this review will be covered in the following manner:

1. The aspects of play therapy
2. Play therapy with special populations
3. Summary and implications

Aspects of Play Therapy

Children with developmental and health disabilities may feel inadequate, isolated, or rejected. According to Dr. Karla D. Carmichael (1993), one method of trying to overcome these feelings is through the use of play therapy. The theoretical article, Play Therapy with Disabled Children emphasizes that play therapy allows children with disabilities the opportunity to explore and discover their emotional and physical strengths (Carmichael, 1993).

She presents two aspects to play therapy, the *I am* approach and the *I can* approach (Carmichael, 1993, p. 165). The *I am* approach focuses on the child's self-esteem, confidence, and overall emotional development. The *I am* approach addresses two methods of play therapy: (a) nondirective and (b) directive. Nondirective is person-centered play therapy. This type of play therapy allows the child and therapist the opportunity to have an interpersonal relationship, where the therapist provides selected material for play and facilitates the development of a safe environment in order for the child to explore him/herself (Carmichael, 1993). Carmichael (1993) states, "Therapists following the nondirective approach believe the child naturally seeks the positive *I am* identity if given a permissive and safe environment" (p. 167).

In directive play, therapists choose the activities and believe that once the child has explored the *I am* stage, he/she will benefit from the use of activities selected by the therapist to help promote personal competency, self-esteem, and self-reliance. According to Carmichael (1993), "Children's creative work provides a method to view their inner world of fears, strengths, and weaknesses" (p. 168).

"The *I can* emphasis in play therapy focuses on the physical development of the child" (Carmichael, 1993, p.168). These activities can be geared specifically towards the developmentally disabled or health disabled. Carmichael (1993) suggests that a couple of accommodations should be incorporated into the child's therapy. The first is to use an interdisciplinary team approach and the second is for the concerns of support from the parents, the parent's needs of support, and

information about the child's treatment.

Carmichael (1993) concluded that play therapy should be considered during the entire treatment plan by an interdisciplinary team including the parents. With the use of the *I am* approach and the *I can* approach, children with developmental and health disabilities will be able to explore and discover their emotional and physical strengths. As Carmichael (1993) states, "Play therapy provides the child with experiences that can help the child define who I am and what I can do" (p. 172).

The nondirective approach was described by Carmichael as person-centered therapy. This same approach is also known as child-centered therapy. Child-centered play therapy is based on the theory that a child's behavior is based on the natural instinct for complete realization. This approach does not try to change or control the child. The review article, Child-Centered Play Therapy discusses the important aspects of this nondirective approach. Landreth (1993) states, "To understand the child-centered play therapy approach it is necessary to first understand the meaning of play in children's lives" (p. 17).

Play is one of the best ways for a child to build self-esteem, explore, and express him/herself in a safe environment. As stated by Landreth, "...play is the child's symbolic language of self-expression, and for children to play out their experiences and feelings in the most natural, dynamic, and self-healing process in which children can engage" (1993, p. 17). The toys used during play therapy gives a child the opportunity to place their fears, frustrations, guilt, etc... on the objects

instead of people. Landreth states,

By acting out through play a frightening or traumatic experience or situation, symbolically, and perhaps changing or reversing the outcome in the play activity, children move toward an inner resolution, and they are better able to cope with or adjust to problems (1993, p. 17-18).

A child-centered play therapist accepts every child for who he/she is and develops rapport with the child. Since the key to growth in child-centered play therapy is the relationship between the child and the therapist, the therapist must communicate four messages to the child: (a) I am here, (b) I hear you, (c) I understand you, and (d) I care about you (Landreth, 1993). This is to assure that the relationship is always focused on the current living experience. The therapist allows the child to move at his/her own pace. The therapist is not trying to change or judge the child. The child's play behaviors are goal oriented to fulfill personal needs. "Personal needs, then, influence the child's perception of reality....therefore, the child's perception of reality is what must be understood if the child and his or her behavior is to be understood" (Landreth, 1993, p.19).

When selecting materials for play therapy, it is important to choose items that allow or encourage exploration of real life experiences, expression of a wide range of feelings, testing the limits, expressive and exploratory play, exploration and expression without verbalization, and success without prescribed structure (Landreth, 1993). It is important that a child has ready access to all play materials. A few examples of necessary items in play therapy include crayons, play-doh, telephone, puppets, rubber knife, play dishes, and costume jewelry (Landreth,

1993). Other recommended items include a punching bag and a plastic container filled with sand (Landreth, 1993).

According to Landreth (1993), "Limit setting is absolutely crucial in prompting the therapeutic dimensions of the child-centered play therapy relationship" (p.23). Even though a child's feeling and desires are accepted, all behaviors are not tolerated. Limit setting gives a child the chance to practice self-control and self-responsibility. Landreth (1993) states, "The child-centered play therapist has an unwavering belief that children will choose positive cooperative behavior when provided with conditions of acceptance of self" (p.24). However, limits are not set until they are needed. If limits are set from the very beginning, the child may not trust the therapist. According to Landreth (1993), there are three steps that should be followed: (a) acknowledge the child's feelings, wishes, wants, (b) communicate the limit, and (c) target acceptable alternatives.

Child-centered play therapy has proved to be effective with a variety of childhood problems and disabilities, such as abuse, depression, neglect, learning disabilities, physical disabilities, and many others. A couple examples of the effectiveness of child-centered play therapy include:

Crow (1989), an elementary school counselor, had ten 30-minute individual child-centered play therapy sessions with 12 first grade students who had been retained because of low achievement in reading and found that their self-concepts were significantly improved as compared to a matched control group (Landreth, 1993, p.25).

Barlow, Strother, and Landreth (1985) reported on the case of a 4-year-old child whose emotional reactions were so severe that she had, over a period of several months, pulled all her hair out and was completely bald. By the

end of the eighth play therapy session, previously reported behavioral symptoms had disappeared and her hair had grown back, a dramatic picture of the effectiveness of child-centered play therapy (Landreth, 1993, p.26).

It is important to remember that "...only through the process of play can the counselor gently touch the emotional world of the vulnerable child" (Landreth, 1993, p.18).

One of the many aspects of play therapy includes the incorporation of puppets. In a review paper, Bromfield (1995) discusses the therapeutic value of puppets, including the psychological functions they serve. Bromfield (1995) states, "Reports have chronicled their productive role in assessment (Irwin, 1975; Gill, 1994), individual therapy (Ekstein, 1965; Hawkey, 1951), family work (Shuttleworth, 1986), pediatric consultation (Linn, 1986; Abbott, (1990), crisis intervention (Webb, 1991), and school-based group counseling (Egge, 1987)" (p.435).

The use of puppets in play therapy can be utilized for many functions. For instance, puppets allow the displacement of feelings. In this sense, a child uses self-expression of situations that have occurred in his/her life, but does not feel as though he/she will be neglected or abandoned. "In contrast to displacement, a child may project onto a puppet feelings perceived as unacceptable to herself" (Bromfield, 1995, p.436). An example of this could be a child who portrays the puppet as the one being bad or having greedy thoughts. A child can also use puppets as a means of confronting "interpersonal conflicts" (Bromfield, 1995, p.437). This usually relates to family members and since they are typically not present in the playroom, the puppets are use to act out painful situations that have

occurred. Bromfield (1995) states, "Puppets permit for physical action and nonverbal expression that speech does not" (p.437). In other words, puppets give a child the opportunity to expose complicated or painful events in a way that may be easier than discussing them verbally, which could help him/her overcome feelings of helplessness. Puppets are also used in play therapy to "...serve as a cathartic function..." (Bromfield, 1995, p.439). Even though it may not contribute to therapeutic change, it can help children get through the therapy process. Bromfield (1995) states, "The opportunity to shed mounting and real fears can, for example, buoy children facing painful and serious medical procedures, such as cardiac surgery (Abbott, 1990), or bone marrow transplant (Linn, 1986)" (p.439). Not only does this help the child feel better, but it can also help reduce bodily-symptoms that are related to stress and inappropriate behavior. With this reduction of anxiety, a child could also be "...more accessible to education, reassurance or problem-solving that, in turn, alleviates the source of the distress..." (Bromfield, 1995, p.439).

The type of puppets that are available for children are also important. Puppets that are most common in play therapy includes ones that are appealing to children and are capable of expressing a variety of emotions and positions. The therapist must remember that the actual puppet play must be paced by the child and if a child's puppet addresses him/her, he/she must respond to the puppet not the child. Bromfield (1995) states, "The therapist should watch for continuity, but allow for change, especially over successive sessions" (p.442). He also states,

...both child and therapist need to work together to decipher the meaning and motivations of puppet play (Irwin & Shapiro, 1975), keeping in mind that puppets and their acts often carry multiple meanings and motives (e.g. A sadistic father puppet may reflect qualities of a real toxic parent as well as the child's own hostility) (Bromfield, 1995, p.443).

Bromfield (1995) concluded, "Through its many functions, puppet play both invites and enhances the intimacy, disclosure and self-discovery essential to relationship-based play therapies" (p.444). Puppets give a child the opportunity to *tell their story* without the fearfulness of being rejected or punished. As mentioned previously, the incorporation of puppets has many roles and benefits, such as serving as transitional objects. This allows a child to face current problems and to "...commute, in an increasingly realistic and mature way, between their inner experience and the world-at-large (Bromfield, 1995, p.438).

Play Therapy With Special Populations

As stated previously, play therapy is incorporated with a variety of special populations. Specific categories that will be discussed include children with Down's Syndrome, childhood psychic trauma, children with reading problems, and abused children. Children with Down's Syndrome seem to have the desire and ability to play instinctively, but may not have all the necessary skills to do so. Susan O'Doherty (1989) states, "I believe that it is the cumulative effect of the peculiar early life circumstances of many children with Down's Syndrome, as much as their diminished cognitive capacity, that inhibits their ability to play" (p.171). Some early

life circumstances could include hospitalization, feeding difficulties, and grief and rejection from parents. The theoretical article, Play and Drama Therapy with the Down's Syndrome Child, discusses factors that constrain children with Down's Syndrome from playing freely and imaginatively.

"Down's Syndrome is a developmental disorder associated with mental retardation" (O'Doherty, 1989, p.171). Children with this disorder have feeding problems due to the inability to suck, have low muscle tone, and delays in verbalization. In addition, O'Doherty (1989) states, "Limited intellect, disruptions in early relationships with parent figures, and the necessity for early social and academic training combine in many children to inhibit spontaneity and active imagination" (p.177). Even though it may be difficult for a child with Down's Syndrome to partake in dramatic play, it is important for him/her to try because "through the medium of drama, a child can explore the physical and social environment, address past and current emotional issues as well as concerns for the future, create a role repertoire, and achieve real satisfaction from imaginary events" (O'Doherty, 1989, p.177).

There are several types of play and drama therapy that can be used with children. O'Doherty discusses the therapeutic techniques she uses with Down's Syndrome children. The first thing she does is to help the children learn that their bodies and environment are enjoyable. After this, she incorporates finger paints and play-doh into her therapy sessions. These items are great for expressing feelings, such as anger. O'Doherty also uses a mirroring technique (imitating one's

actions). "Landy (1986) points out that the first step toward role taking is imitation" (O'Doherty, 1989, p.174). The mirroring technique helps the therapist connect with the children. Children may also engage in pretend play, such as house. Humor and laughter also play a big part in play therapy. O'Doherty states, "I believe this to be tremendously important, not only because of the cathartic value of laughter, but because the distancing effects of humor (Landy, 1986) help the children to grasp the concept of 'pretending'" (1989, p.175). Dolls and puppets are also great ways to help a child engage in dramatic play, which can help him/her express feelings of anger, guilt, frustration, and helplessness.

In child development, play is the highest form of self-expression because it freely expressing what is in a person's soul (O'Doherty, 1989). Even though children with Down's Syndrome have difficulty participating in imaginative play, they can still benefit from the experience. When a child makes progress, it is extremely rewarding for the child and the therapist.

Play therapy can also be incorporated with children who suffer from psychic trauma. According to Carol Miller and Dr. John Boe (1990), childhood psychic trauma is usually caused by abandonment, deprivation, neglect, and physical and/or sexual abuse typically by a parent or relative. These victims may feel helpless and scared and may isolate themselves through emotional withdrawal. Miller & Boe (1990) state, "Before mastery of trauma can begin, children need to know they are in a safe, predictable environment with consistent adults to whom they can form attachment (Bettelheim, 1960; Bowlby, 1969, 1973; Erikson, 1963)"

(p.248). The theoretical article, Tears into Diamonds: Transformation of Child Psychic Trauma Through Sandplay and Storytelling, discusses the benefits of incorporating sandplay and storytelling in treatment programs.

The Tears into Diamonds inpatient treatment program was designed for children with psychic trauma between the ages of four and twelve. The average length of stay is between four to six months and during this time, each child has the same staff members. The Tears into Diamonds treatment program is just one component of the overall program. Two types of play therapy that are incorporated in this program include sandplay and storytelling. Sandplay is nondirective "...symbolic play using a tray of dry or wet sand and various miniature figures" (Miller & Boe, 1990, p.248). Sandplay gives a child the opportunity to metaphorically express suppressed feelings. Not only does sandplay help release feelings of fear, anxiety, anger, etc..., but it also gives a child the opportunity to be in control.

Once a child finishes his/her sandplay, the staff at Tears into Diamonds studies the sandplay. Miller and Boe (1990) state, "By studying the child's sandplay, the staff began to evaluate, understand, and speak in the child's own symbolic (and largely unconscious) language..." (p.248). Once this is completed, there is a cross-modal matching of the child's sandtray to related stories. "Matching stories to sandtrays often allowed the staff to start speaking to the child with the child's own symbol, thus validating and supporting the child's fragile defenses" (Miller & Boe, 1990, p.254).

According to Miller and Boe (1990), storytelling is also used as a form of therapy for children who are classified as having psychic trauma. Stories can metaphorically relate to a child's situation, yet still differ so it is not threatening to the child. Many traumatized children have lost all trust in adult figures; however, fairy tales give children hope for good. As Miller and Boe (1990) state, "To many children, the story gives hope where there has been no hope by introducing them to the healing power of the unconscious (Bettelheim, 1977, Storr, 1986)" (p.252). In the Tears into Diamonds treatment program, books also seem to help relax children at bedtime and decrease nightmares.

The use of sandplay and storytelling seem to be very beneficial with childhood psychic trauma. Each child has the opportunity to metaphorically express his/her feelings in a safe environment. As Miller and Boe (1990) state, "The metaphor establishes a bridge between the inner and outer worlds (Linden, 1985; Shengold, 1981), allowing for insight into as well as safe distance from the original trauma (Caruth, 1966; Kalt, 1986; Linden, 1985; Noy, 1978; Shengold, 1981)" (p.249).

The incorporation play therapy with children who have difficulty reading is another way of helping children with special needs. Reading difficulties among many children seem to be associated with having behavior problems. According to Carmichael (1991), incorporating play therapy with remedial reading helps children with their emotional conflicts, which in return, helps to improve their reading abilities. The review paper, Play Therapy: Role in Reading Improvement,

discusses the incorporation of play therapy (sandplay as nondirective play) for improvements in reading. "The definition of play therapy used in this paper is to be activities of a game or play nature that symbolically brings the emotional life of the child to the therapist" (Carmichael, 1991, p.273).

Public schools and special programs tend to be leery about incorporating play therapy into their programs because of the term "play." However, activities that are considered play activities has helped children with comprehension. "A similar point was made by Christi (1990) stating that dramatic play makes an important contribution to a child's early reading and writing development" (Carmichael, 1991, p.274). Play therapy gives a child the opportunity to explore emotions, feelings, and self-worth in an unstructured environment. The child has unconditional acceptance by the therapist, which allows him/her to gain self-confidence. According to Carmichael (1991), "This confidence generalizes to the world outside the playroom....This insight frees the child of learning blocks and allows the child to risk the mistakes necessary for learning (Axline, 1949; Landreth, 1982; Moustakas, 1959)" (1991, p.274).

Individual psychotherapy during remedial reading instruction seems to help the child with his/her reading disability. "Bills (1948) conducted a study of eight readers whose reading level was below the expected for their mental age" (Carmichael, 1991, p.274). At the end of the play therapy session, there was a positive change in the children's reading ability. After six weeks, a follow-up evaluation was conducted and the children still maintained their reading

improvements.

Children with reading disabilities may also have difficulties due to learned helplessness. If a child is afraid that he/she can not complete a task, he/she may not even attempt it. This could cause the child to acquire emotional barriers that may prevent him/her from learning how to read. "Noyes (1981) discovered that by using a sandplay technique in addition to regular remediation that students made dramatic improvements in reading scores" (Carmichael, 1991, p.275). Throughout the school year, Noyes (1981) incorporated sandplay in his six grade class for a few minutes every week. At the beginning of the Noyes' (1981) sixth graders scored between 3.5 and 5.5 on the Gates-MacGinitie Reading Test in September. In May, the end of the school year, the same class showed the largest increase in achievement scores, ranging between 6.1 and 11.6 (Carmichael, 1991).

As children get older and still have reading problems, they tend to develop higher degrees of emotional problems, such as low self-esteem, depression, and anxiety. Carmichael (1991) mentions the benefits of utilizing sand play as a form of play therapy, such as reducing anxiety and depression, increasing self-esteem, and the ability to express internal conflicts.

When using sandplay, the therapist uses very little communication with the child. Instead of trying to interpret the meaning of a child's sandplay, the therapist should observe the child and his/her actions. When using nondirective play therapy, a child has the opportunity to be creative and express feelings or aggression with the use of toys. Overall, play therapy helps to "...support the child,

encourage the child and build self-esteem; thusly creating the optimal learning environment for reading improvement" (Carmichael, 1991, p.276).

The incorporation of play therapy (PT) in early childhood intervention has increased over the last decade. According to JoAnna White and Christopher T. Allers (1994), "PT has been used with children manifesting a wide range of emotional and behavioral concerns (Phillips, 1985)" (p.390). The review article, *Play Therapy with Abused Children: A Review of the Literature*, discusses the application and goals of play therapy with abused and neglected children.

Play is the way children learn and interact with others. White and Allers (1994) state, "Through play, the child attempts to understand the rules and regulations of the adult world (Erikson, 1950) and transforms reality through developing symbolic representations of that world (Piaget, 1962)" (p.390). Play also gives the child the opportunity to overcome any fears or regrets by reenacting previous situations.

According to White and Allers (1994), there are two basic types of play therapy: 1) directed and nondirected. In directed play therapy, the counselor/therapist organizes the activity including toys and regulations. In nondirected play therapy, the child chooses what toys to play with, how he/she is going to play with them, and sets his/her own rules and regulations (as long as they are safe). According to White and Allers, "Although both forms of PT can be successfully used to facilitate communication with children (Guizzi-Delpo & Frick. 1988), many play therapist use combinations of both directed and nondirected play with their young

clients" (1994, p.390). There are three general goals of play therapy. The first goal is for the therapist to create a bonding relationship with the child. This allow the child to improve his/her self-worth and acceptance. The second goal is for the child to comprehend that play is a way to nonverbally or verbally communicate and work through his/her problems. "Last, and most relevant to the abused and neglected child, young clients are encouraged to understand the purpose of their play, its association with past childhood events, and its connection to feelings and behaviors exhibited outside of the playroom (White & Allers, 1994, p.390).

Play behaviors of abused and neglected children have been studied by various researchers. These studies indicate that there are seven basic types of play behaviors with abused and neglected children. "These play behaviors include the following: developmental immaturity, opposition and aggression, withdrawal and passivity, self-deprecation and self-destruction, hyper vigilance, sexuality, and dissociation" (White & Allers, 1994, p.390). Not only do most abused and neglected children have certain play behaviors, but they also display play themes, such as unimaginative and literal play and repetition and compulsion. With unimaginative and literal play, children usually do not truly enjoy themselves. "Martin and Beezley (1977) have reported that these children lack 'the capacity to play freely, to laugh and to enjoy themselves in an uninhibited fashion' (p.374)" (White & Allers, 1994, p.392). White and Allers (1994) state, "An example of unimaginative and literal play is the child who sweeps the floor, washes play dishes and play clothes, carefully arranges the stray toys, and then quietly waits for his or

her parents to arrive" (p.392). With the repetition and compulsion play theme, physically or sexually abused children "...may engage in a rigid set of play behaviors, repeatedly and unconsciously acting out the trauma they have experienced" (White & Allers, 1994, p.392). An example of this could be a child who makes "worms" with play-doh or clay or a child who rams toys into other parts of toys. Even though children who have been abused and/or neglected exhibit a variety of play behaviors and themes, they can still benefit from the incorporation of play therapy in their treatment program because play is one of the best forms of self-expression.

Summary and Implications

The review of literature clearly shows the consistency that play is a natural part of children's lives. The findings that play therapy is a very valuable way of helping children explore and express feelings in a safe environment are also consistent. The variety of techniques used in play therapy gives the therapist the opportunity to select the best suited form of therapy for each child's individual needs.

Even though play therapy is becoming more and more popular in a variety of settings, some professionals still have difficulty understanding the importance of this type of therapy. They have a hard time comprehending that "play" can improve one's ability to improve, achieve, or even express suppressed feelings, incidences,

fears, etc. The findings in this review clearly discuss how children can benefit from play therapy.. Even though different aspects of play therapy are discussed with different populations, there was not much conflict between the results of the research. However, some authors discussed aspects of play therapy that other authors did not cover. For example, Landreth discussed the importance of limit setting, while Bromfield mentioned the importance and benefits of incorporating play therapy before medical procedures, and O'Doherty was the only one who discussed the significance of humor in play therapy.

Play therapy utilizes different techniques with a wide range of special populations; however, the researcher believes it should be incorporated more frequently within therapeutic recreation departments. Therapeutic recreation focuses on the overall well-being of the client and in a sense, so does play therapy. In addition, play therapy before medical procedures and the use of humor as a form of play therapy should also be utilized more often.

The intent and benefits of play therapy are clearly expressed within the review; however, there needs to be an increase in the number of controlled studies with larger samples in order to prove the benefits of play therapy. Smaller studies have concluded this, but the benefits would be more convincing with larger samples in a variety of settings. White and Allers (1994) state, "Consistent training...would help to standardize research efforts and reduce outcome variability between studies" (p.393).

CHAPTER III

METHODOLOGY

The intent of this study was to determine the prevalence of play therapy programs within the state of Tennessee that service children with special needs. The researcher's motivation also includes determining the benefits of play therapy, common aspects of play therapy, populations that receive play as a form of therapy, professionals who perform play therapy, and the primary funding for play therapy programs in the state of Tennessee.

The procedures for this section are presented as follows: (a) identification of the sample, (b) instrumentation, and (c) data analysis.

Identification of the Sample

The sample of this study included Tennessee hospitals and health care agencies that are either members of the Child Life Council (7), Tennessee hospitals and health care agencies that are contracted with the University of Tennessee Recreation and Leisure Studies Practicum and/or Internship Program (15), and Tennessee hospitals and health care agencies that are members of the Association for Play Therapy (40). The selection included representatives from each of the three main regions of the state of Tennessee (East, Middle, and West Tennessee). All subjects who participate in the study will be giving their informed consent by

completing and returning the questionnaire (Appendix A).

Instrumentation

In order to determine the status of play therapy programs within the state of Tennessee, a questionnaire was developed. The questionnaire addressed the necessary questions in order to obtain specific information about current standing play therapy programs in Tennessee.

The procedures that were utilized within this study included the administration of the questionnaires. The type of questionnaire that was administered is called the Total Design Method (TDM). This method was chosen because it is straight forward, easy to comprehend, and focuses on the quantity and quality of the responses. The researcher selected a jury of experts to review the questionnaire. The jury of experts consisted of three professionals that have extensive knowledge in play therapy and statistics. These professionals included Sandra L. Sneed, Child Life Director, CCLS, CTRS; David Dunlap, CTRS, Counselor, Certified Play Therapist; and John Ray, Professor in Education Science Math Research and Techniques. Revisions recommended by the jury members focused on grammatical structure, and one suggestion was made to add an additional item to the questionnaire (# 6). The questionnaire consisted of twelve questions that relate to play therapy programs within the state of Tennessee. Each question was easy to comprehend and did not take long to answer. The type of

questions that were asked included checklist and open-ended questions. Each questionnaire was number and color coded in order to obtain accurate information according to the specific geographic regions mentioned previously, each questionnaire included a cover letter that explained the scope of the study and why the sample's participation was important, and each questionnaire also included the intended return date of two weeks.

Two weeks after the questionnaires were administered, a follow-up post card was sent to each participant. According to Dillman (1978), a follow-up post card increases the return rate of questionnaires. This briefly stated a reminder of when the questionnaire (Appendix A) needed to be returned and why their involvement was important in the study.

Data Analysis

The responses to the questionnaire provided the information needed to address each subproblem of the study. A descriptive analysis of the percentages determined the status of play therapy programs within the state of Tennessee. This included the populations who receive play as a form of therapy, the primary funding for such programs, the professionals that perform play therapy, the approaches of play therapy that are utilized, and the projected benefits of incorporating play therapy in treatment.

Obtaining an overview of these play therapy programs can serve as a

valuable tool for many professionals and agencies. By evaluating the outcomes of the questionnaire, professionals and agencies will be able to recognize the geographic areas and agencies that utilize play as a form of therapy. Obtaining this information may also help professionals recognize the importance of play therapy and the types of agencies that incorporate play as a form of therapy, which could lead to the expansion of play therapy programs across the state of Tennessee.

CHAPTER IV

RESULTS & DISCUSSION

The purpose of this study was to investigate and determine the status of play therapy programs in agencies that service children with special needs in the state of Tennessee. The subproblems of the study were investigated in order to (a) identify the populations who receive play therapy, (b) how play therapy programs are primarily funded, (c) who performs the play therapy sessions, (d) what approaches of play therapy are utilized, and (e) the projected benefits of play therapy programs.

The results from the questionnaire will be presented in the following manner: (a) participant profile, (b) agency profile, (c) population profile, (d) program funding, (e) play therapy programming, and (f) benefits. The population profile (c) addresses subproblem one. Program funding (d) addresses subproblem two. Play therapy programming (e) addresses subproblems three and four, and the benefits (f) addresses subproblem five.

Participant Profile

The position titles of the participants may be of interest to the reader in order to obtain a better understanding of the type of professionals who participated in the study. An extremely large range of position titles were obtained, ranging from

Recreation Therapist to Clinical Psychologist to Brain Injury Clinical Coordinator. A complete listing of these position titles can be viewed in Appendix B. However, the majority of the participants were Therapeutic Recreation Specialists/Activity Therapists (6), Child Life Specialists (3), Counselors (3), and Social Workers (3).

All of the participants with one exception had some type of certification. The most common types of certifications included Certified Therapeutic Recreation Specialist (8), Certified Child Life Specialist (3), School Counselor (3), and Licensed Clinical Social Worker (5). A complete listing of the certifications the participants possess can be reviewed in Appendix B.

A total of sixty-two questionnaires were administered to hospitals and health care agencies across the state of Tennessee. After a couple of weeks, there was a return rate of thirty-three questionnaires. Two additional questionnaires were returned after the follow-up post cards were administered. The overall return rate was thirty-five. Of these thirty-five questionnaires, only twenty-two were utilized within this study. The reason for this was because some of the questionnaires were returned unanswered due to the participants no longer being in the field or no longer an employee of that agency. Of all of the responses that were obtained, all but three participants utilized play therapy in their programming and an additional participant made it clear that their program used therapeutic play - not play therapy. The three subjects who did not include play therapy in their programming could not complete the rest of the questionnaire; therefore, they were not included within the remaining results of the study. Therefore, a total of 19 questionnaires

were utilized for the remaining portion of the study.

Agency Profile

The study included Tennessee hospitals and health care agencies that are either members of the Child Life Council, members of the Association of Play Therapy, or offer Therapeutic Recreation practicums and internships. The initial intentions were to compare the data according to the three main geographic region of Tennessee (East, Middle, West); however, the response rate was extremely uneven. There was a response rate of twelve from East Tennessee, seven from Middle Tennessee, and only three from West Tennessee. Due to the small number of responses from West Tennessee, a comparison of the various regions within Tennessee could not be made.

Table 1 addressed the primary functions of the agencies that were included in the study (according to the percent of time). From the results of the agency descriptions (Table 1), it was apparent that the majority of the respondents considered the primary function of their agency to be clinical. Eleven of the nineteen respondents considered their agency's primary function to be clinical more than 75% of the time. The next category that received a high response rate included the section labeled other, which gave the respondents the opportunity to fill in the agency description of their choice. These included one psychiatric, two education, one acute care, and one school-based.

TABLE 1. Agency Description and Functions

	greater than 75%	50-75%	25-49%	less than 25%	do not offer
Clinical	11	2	1	1	4
Community	1	3	0	7	9
Rehabilitation	2	1	1	1	13
Residential	0	1	1	1	16
Non-resident.	2	1	1	0	15
Other	5	0	0	0	11

The size of the facility was also included within the program profile, which addressed the number of beds and population numbers. There was a great deal of variation among agencies. The number of beds ranged from 0 to 160. Forty-seven percent of the respondents did not have any beds in their facility due to the fact that they were either an outpatient program or working within the school system. Twenty-six percent of the agencies indicated they had 50-80 beds, sixteen percent of the agencies indicated they had 90-160 beds, and eleven percent indicated they had 23-40 beds.

The population numbers ranged from 5 to 200, with a total average of 74. Three of the nineteen agencies were considered to be exceptional because they had such high population numbers. In order to ensure an accurate average, they were not included within these ranges or the average. These exceptions were as follows: one of the population numbers had a total of 2000 outpatients and two of

the population numbers were indicated by the number of students that attended the school. One of the respondents indicated they had a total of 400 students annually and the other indicated they had a total of 638 students in their school.

Population Profile

This section focused on the clients who receive play therapy. It was important to know the ages of the populations that are served, the primary disability or disorder, and the average length of stay.

The ages of the populations varied from birth to 100 years of age. Within this range, there were a number of percentages that indicated the ages that received play as a form of therapy. Fifty-three percent of the respondents served infants to three years old, seventy-nine percent served four to ten years old, eighty-nine percent served eleven to eighteen years old, and forty-two percent served nineteen years old or older.

The disabilities or disorders that were addressed within the questionnaire included physical disability, learning disability, psychic trauma, physical abuse, sexual abuse, neglect, hearing impairment, down's syndrome, behavior problems, mental retardation, conduct disorder, and other. The disabilities or disorders that the respondents listed within the other category included CVA, grief, school problems, divorce issues, chemical dependency, and physical illness trauma. Those with the most service within an inpatient program included physical

disabilities, learning disabilities, psychic trauma, physical abuse, sexual abuse, neglect, behavior problems, and conduct disorders. Most of the service for the outpatient programs served populations with learning disabilities.

There was a wide range of populations that received play as a form of therapy. Some of the populations received play therapy within an inpatient program while others receive play therapy within an outpatient program. The average length of stay varied according to the client's disability or disorder and whether they were inpatient or outpatient. Looking at the client's length of stay, it appeared that the inpatient population's length of stay was short-term and the outpatient's was both long and short-term. It was assumed that one of the respondents addressed this question in terms of the length of the session (30 minutes - 1 hour). Table 2 exhibits the results of the study for the descriptions of populations that were served and their length of stay.

Program Funding

This section is provided in order to give the reader a better understanding of how play therapy programs are primarily funded. According to the respondents of the questionnaire, the majority of these agencies utilized insurance as their main source for funding their play therapy programs. The primary types of funding for play therapy programs are listed in percentages: insurance (50%), "other" (23%), state (23%), and federal (5%). The "other" forms of funding that the respondents

indicated included private pay, diocese money, nursing administration, grant, and hospital funding.

TABLE 2. Population Description

	Inpatient	Average length of stay	Outpatient	Average length of stay
Physical Disability	8	30 min. -1 hr. 2-3 days 2-8 days 3-5 days 2 days- 3 wks 2 days - several wks 4-12 weeks 27 days	9	8-20 visits 2-8 days 10-14 days 3 weeks 8-16 weeks school year no response no response no response
Learning Disability	7	2-3 days 2-8 days 3-5 days 2 days- 3 wks 2 days- several wks 4-12 weeks	12	8-20 visits 10-15 visits 8-10 days 10-14 days 3 weeks 8-16 weeks 12-14 weeks 12-20 weeks 3 months school year no response no response

	Inpatient	Average length of stay	Outpatient	Average length of stay
Psychic Trauma	7	2-3 days 2 days - several wks 3-5 days 3 days- 2 wks 5-7 days 4 weeks no response	10	8-20 visits 10-15 visits 8-10 days 10-14 days 4-10 weeks 8-16 weeks 12-20 weeks 3-6 months 3-6 months no response
Physical Abuse	9	30 min - 1hr 2-3 days 2-8 days 2 days- several wks 3-5 days 3 days- 2 wks 5-7 days 4 weeks	12	8-20 visits 10-15 visits 8-10 days 10-14 days 4-10 weeks 8-16 weeks 12-20 weeks 2 months 3-6 months 3-6 months school year no response
Sexual Abuse	8	2-3 days 2-8 days 2 days- several wks 3-5 days 3 days- 2 wks 5-7 days 4 weeks no response	11	8-20 visits 10-15 visits 8-10 days 10-14 days 4-10 weeks 8-16 weeks 12-20 weeks 3-6 months 3-9 months school year no response

	Inpatient	Average length of stay	Outpatient	Average length of stay
Neglect	7	2-3 days 2-8 days 2 days- several wks 3-5 days 3 days- 2 wks 5-7 days no response	11	8-20 visits 10-15 visits 8-10 days 10-14 days 8-16 weeks 3-6 months 3-6 months 12-20 weeks school year no response no response
Hearing Impairment	4	2-3 days 2-8 days 2 days - several wks 3 days- 2 wks	4	8-16 weeks school year no response no response
Down's Syndrome	4	2-3 days 2-8 days 2 days- 3 wks 2 days- several wks	4	8-16 weeks school year no response no response
Behavior Problems	7	2-3 days 2-8 days 2 days- several wks 3-5 days 3 days- 2 wks 5-7 days no response	12	3-30 visits 10-15 visits 8-10 days 10-14 days 4-10 weeks 8-16 weeks 12-14 weeks 3-6 months 3-6 months school year no response no response

	Inpatient	Average length of stay	Outpatient	Average length of stay
Mental Retardation	4	2-3 days 2-8 days 2 days- 3 wks 2 days- several wks	5	10-14 days 8-16 weeks school year no response no response
Conduct Disorder	8	2-3 days 2-8 days 2 days- several wks 3-5 days 3 days- 2 wks 3 days- 2 wks 5-7 days no response	11	8 visits 10-15 visits 8-10 days 10-14 days 8-16 weeks 12-20 weeks 3-6 months 3-6 months school year no response no response
CVA	2	30 min-1 hr 21 days	2	3-4 weeks no response
Depression	0		1	12-20 weeks
Grief	0		1	8-16 weeks
School Problems	0		1	8-16 weeks
Divorce Issues	0		1	8-16 weeks
Chemical Dependency	1	3 days- 2 wks	0	
Physical Illness Trauma	1	2 days- several wks	0	

Play Therapy Programming

Play therapy programming focused on the percent that play therapy is incorporated during treatment, who performed the play therapy sessions, and the aspects of play therapy that were utilized.

The researcher found the percent that play therapy was incorporated during a client's stay to be very interesting. Seven agencies responded that they incorporated play therapy in their program 81-100% of the time, and five agencies responded that they incorporated play therapy in their program less than 20% of the time. This was found to be very interesting because these two responses were the two highest percentages and fell within the highest and lowest percentage of time that play therapy was utilized. The number and percent of responses regarding the percentage that play therapy was incorporated during a client's stay is illustrated in Table 3.

Table 3. The Percent of Time Utilized for Play Therapy

	less than 20%	20-40%	41-60%	61-80%	81-100%
# of responses	5	2	3	2	7
% of responses	26%	11%	16%	11%	37%

There was a great deal of variation with the types of professionals who performed the play therapy sessions. The researcher found the results to be very interesting because the largest category (68%) fell within the section labeled other. Within this section, the respondents indicated the professionals who performed the play therapy sessions, included 2 School Counselors, 1 PASAAR Therapist, 1 Music Therapist, 1 Art Therapist, 1 Speech Pathologist, 1 Registered Nurse, 1 Master's Level Therapist, 1 Beyond the Limits Therapist, 3 Clinical Psychologists, and 1 Chaplain. The majority of the respondents indicated that more than one type of professional performed their play therapy sessions. The percentages of the professionals who performed the play therapy sessions were "Other" (68%), Recreation Specialist (37%), Social Worker (37%), Play Therapist (32%), Child Life Specialist (21%), Physical Therapist (21%), Occupational Therapist (21%), Activity Therapist (11%), and Psychiatrist (5%).

There were several different aspects of play therapy that were included within the play therapy programs. These included non-directive play, directive play, child-centered play, puppets, role playing, sandplay, humor therapy, drama, music therapy, medical play, and other. The respondents listed symbolic play, art therapy, and experiential based learning activities within the "other" category. Seventy-nine percent of the respondents incorporate non-directive and directive play in their program, seventy-four percent incorporate child-centered play and role playing in their program, sixty-eight percent incorporate puppets in their program, forty-seven percent incorporate medical play in their program, forty-two percent incorporate

sandplay and humor therapy in their program, thirty-seven percent incorporate drama in their program, thirty-two percent incorporate music therapy in their program, and sixteen percent incorporate other forms of play therapy in their program. The number of respondents who incorporated each aspect of play therapy, the percentage for each of these numbers, and the percentage of time utilizing these different aspects are illustrated in Table 4.

Table 4. Time Utilized with Various Aspects of Play Therapy

Aspects of play therapy	#	%	Percentage of Time			
			75-100%	50-74%	25-49%	0-24%
Non-directive	15	79%	32%	37%	11%	0%
Directive	15	79%	16%	26%	26%	11%
Child-centered	14	74%	42%	16%	16%	0%
Puppets	13	68%	11%	16%	26%	16%
Role playing	14	74%	11%	21%	37%	5%
Sandplay	8	42%	11%	0%	32%	0%
Humor	8	42%	26%	11%	5%	0%
Drama	7	37%	11%	0%	16%	11%
Music	6	32%	11%	5%	16%	0%
Medical play	9	47%	16%	11%	11%	11%
Other	3	16%	5%	0%	11%	0%

Benefits

It is important to recognize the projected benefits from play therapy programs. The respondents indicated the projected benefits for their programs in the space provided in the questionnaire. The responses varied in context, but the overall general benefits were quite similar. A few of the most common projected benefits were to relieve stress associated with hospitalization, to help the child “speak” to the therapist in his/her language of play, to express feelings by acting them out, to build trust, to increase self-esteem, to help resolve current issues, to teach or reteach play skills, and to explore feelings in a safe environment. A complete listing of the projected benefits can be viewed in Appendix C.

CHAPTER V

SUMMARY, CONCLUSIONS, & RECOMMENDATIONS

This chapter includes a summary of the study and presents the conclusions reached by the researcher. The information is presented in three sections: (a) summary, (b) conclusions, and (c) recommendations for further study.

Summary

The purpose of this study was to determine the status of play therapy programs in agencies that service children with special needs in the state of Tennessee. Subproblems were to determine the populations that are served, how play therapy programs are primarily funded, professionals that perform play therapy sessions, approaches of play therapy that are utilized, and projected benefits from play therapy programs.

In order to achieve the purpose of this study, a questionnaire was developed and administered to sixty-two hospitals and health care agencies that were either members of the Child Life Council, contracted with the University of Tennessee practicum and internship program, or members of the Association of Play Therapy. The questionnaire included twelve sets of checklist and open-ended questions that addressed the subproblems of the study. Each questionnaire was numbered and color coded in order to obtain accurate information regarding the three main

geographic regions of the state of Tennessee (East, Middle, West). The initial intentions were to compare the data according to these three main regions; however, the response rate was extremely uneven. There was a response rate of 12 from East Tennessee, 7 from Middle Tennessee, and 3 from West Tennessee.

A total of 35 out of 62 questionnaires were returned to the researcher. Of the 35 that were returned, only 22 of them were used within the study because 13 of the questionnaires were returned incomplete. The reasons for the incomplete questionnaires were due to the participant no longer working in the health care field, no longer an employee of that agency, or did not include play therapy in their programming. Therefore, a total of 19 questionnaires were analyzed within this study. The statistical treatment of the study included a descriptive analysis of percentages in order to determine the status of play therapy programs across the state of Tennessee.

Conclusions

Within the limitations of this study and based on the analysis of the data collected, the following findings and conclusions were reported by the researcher:

1. The professional titles of the participants varied with the most common titles being Therapeutic Recreation Specialist/Activity Therapist (6), Child Life Specialist (3), Counselor (3), and Social Worker (3).
2. The most common types of certifications these professionals hold

included Certified Therapeutic Recreation Specialist (8), Certified Child Life Specialist (3), School Counselor (3), and Licensed Clinical Social Worker (5).

3. Out of twenty-two participants, nineteen utilized play therapy in their programming.

4. The majority of the respondents considered the primary function of their agency to be clinical, with the "other" category, which included psychiatric, education, acute care, and school-based, being the next most common primary function.

5. The number of beds ranged from 0-160. Forty-seven percent indicated that they were either an outpatient program or school-based; therefore they did not have any beds. Twenty-six percent had 50-80 beds, sixteen percent had 90-160 beds, and eleven percent had 23-40 beds.

6. The number of clients per agency ranged from 5 to 200, with a total average of 74.

7. The ages of the populations served varied from birth to 100 years of age. The majority of the populations that received play as a form of therapy were between the ages of 4 and 18.

8. Most of the service for inpatient programs served populations with physical disabilities, learning disabilities, psychic trauma, physical abuse, sexual abuse, neglect, behavior problems, and conduct disorders.

9. Most of the service for outpatient programs served populations with learning disabilities.

10. The length of stay for the inpatient population was short-term.
11. The length of stay for the outpatient population was both long and short-term.
12. Insurance was the primary source for funding play therapy programs.
13. The majority of agencies utilized play therapy 41-100% during a client's stay.
14. The majority of the professionals who performed the play therapy sessions fell within the category labeled "other". Some of these included School Counselors, Music Therapists, Art Therapists, Speech Pathologists, and Clinical Psychologists. The next two highest categories were Therapeutic Recreation Specialists and Social Workers.
15. In various aspects of play therapy, non-directive and directive play were utilized within 79% of the programs, child-centered play and role playing were utilized within 74% of the programs, puppets were utilized within 68% of the programs, medical play was utilized within 47% of the programs, sandplay and humor therapy were utilized within 42% of the programs, drama was utilized within 37% of the programs, music therapy was utilized within 32% of the programs, and other forms of play therapy were utilized within 16% of the programs.
16. A few of the most common types of projected benefits from play therapy programs were to release stress, express feelings, build trust, increase self-esteem, teach/reteach play skills, explore feelings in a safe environment , and help the child "speak" to the therapist in his/her language of play.

Recommendations

Based on the findings of this study, the following recommendations were made for further research:

1. Future studies should develop a broader range of delimitations in order to ensure a sample that utilizes play therapy with children who have special needs.
2. A more comprehensive and extensive study could be conducted in order to determine the status of play therapy programs across the southeast or nationwide.
3. Studies could include only children's hospitals or health care agencies in order to ensure a population from infant to eighteen.
4. A more comprehensive study could be conducted to investigate children's responses/reactions to play therapy.

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APPENDICES

APPENDIX A

Dear

I am a graduate student at The University of Tennessee, majoring in Recreation and Leisure Studies with a concentration in Therapeutic Recreation. I am asking your help in completing a thesis research project as partial fulfillment of the requirements for my Master of Science Degree. The title of my thesis is *The Status of Play Therapy Programs Across the State of Tennessee that Service Children with Special Needs*. It will only take a few minutes to complete the questionnaire, and your participation will be of great value.

Enclosed you will find a copy of the questionnaire. This questionnaire has been administered to other Tennessee hospitals and health care agencies that are either: (1) members of the Child Life Council, (2) contracted with the University of Tennessee Therapeutic Recreation internship and practicum program, or (3) members of the Association for Play Therapy. All data collected from this questionnaire will be held in strictest confidence.

The results of this questionnaire will help determine the status of play therapy programs within the state of Tennessee. Specific objectives that will be addressed include identifying the populations that are served, determining how play therapy programs are primarily funded, identifying the professionals that perform the play therapy sessions, identifying the approaches of play therapy that are utilized, and determining the projected benefits from play therapy programs.

A postage-paid envelope has been provided so that you may return the survey at your earliest convenience. In order for the results to be tabulated in time, the questionnaire needs to be returned within two weeks. Your cooperation and assistance will be greatly appreciated.

Sincerely,

Lisa A. Modenos
Researcher

PLAY THERAPY ACROSS TENNESSEE QUESTIONNAIRE

The completion of this questionnaire is completely voluntary. The purpose of this study is to determine the status of play therapy programs within the state of Tennessee. Your responses to the questions will be treated confidentially and will not be associated with your name or agency. They will be analyzed with the responses of all of the subjects in the study. Please be accurate and truthful in answering the following questions. Completing and returning this questionnaire provides the informed consent of the participants.

I. Employment Description

1. What is your position title?

2. Are you certified? _____ If yes, what is your certification? _____

3. Have you ever used play therapy in your programming? Yes _____ No _____

II. Agency Description

4. The mission of the agency in which you are employed considers it's primary function to be: (circle numbers that apply according to the percentage of time)

	greater than 75%	50-75%	25-49%	less than 25%	don't offer
(1.) Clinical	5	4	3	2	1
(2.) Community	5	4	3	2	1
(3.) Rehabilitation	5	4	3	2	1
(4.) Residential	5	4	3	2	1
(5.) Non-residential	5	4	3	2	1
(6.) Other _____	5	4	3	2	1

5. What is the size of the facility? Beds _____ Population numbers _____

6. What is the age of your populations?

7. With what populations do you utilize play therapy interventions and what is the average length of stay for your clients? (circle all numbers that apply & designate average length of stay)

	no	yes	in-patient	average length of stay	out-patient	average length of stay
(1.) Physical disabilities	1	2	3	_____	4	_____
(2.) Learning disabilities	1	2	3	_____	4	_____
(3.) Psychic trauma	1	2	3	_____	4	_____
(4.) Physical abuse	1	2	3	_____	4	_____
(5.) Sexual abuse	1	2	3	_____	4	_____
(6.) Neglect	1	2	3	_____	4	_____
(7.) Hearing impaired	1	2	3	_____	4	_____
(8.) Down's Syndrome	1	2	3	_____	4	_____
(9.) Behavior problems	1	2	3	_____	4	_____
(10.) Mental retardation	1	2	3	_____	4	_____
(11.) Conduct disorder	1	2	3	_____	4	_____
(12.) Other _____	1	2	3	_____	4	_____

III. Program Description

8. What is the primary funding for your play therapy program? (circle number)

1. Federal
2. State

3. Insurance
4. Other _____

9. What % do you incorporate play therapy during a client's stay? (circle number)

1. Less than 20%
2. 20% - 40%
3. 41% - 60%

4. 61% - 80%
5. 81% - 100%

10. Who performs the play therapy programs? (circle all numbers that apply)

- | | |
|--------------------------|---------------------------|
| 1. Play Therapist | 6. Occupational Therapist |
| 2. Child Life Specialist | 7. Psychiatrist |
| 3. Recreation Specialist | 8. Activity Therapist |
| 4. Social Worker | 9. Other _____ |
| 5. Physical Therapist | |

11. Which aspects of play therapy are incorporated in your program? (circle all numbers that apply and the percent of time it is offered)

	no	yes	75-100%	50-74%	25-49%	less than 25%
(1.) Non-directive	6	5	4	3	2	1
(2.) Directive	6	5	4	3	2	1
(3.) Child-centered	6	5	4	3	2	1
(4.) Puppets	6	5	4	3	2	1
(5.) Role playing	6	5	4	3	2	1
(6.) Sandplay	6	5	4	3	2	1
(7.) Humor	6	5	4	3	2	1
(8.) Drama	6	5	4	3	2	1
(9.) Music	6	5	4	3	2	1
(10.) Medical play	6	5	4	3	2	1
(11.) Other _____	6	5	4	3	2	1

12. What are the projected benefits from your play therapy program?

THANK YOU for your participation in the questionnaire. I will be happy to provide a summary of data collected to interested parties. If you would like to receive additional information, please contact:

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APPENDIX B

For both the position titles and certifications, some of these titles were listed more than once. The complete listing of position titles that were gathered from the data of professional who completed the questionnaire included:

Recreation Therapists	Child Life Specialists
Brain Injury Coordinator	Activity Therapist
Director of Activity Therapy	Program Manager
Beyond the Limits Therapist	School Counselor
Director of Child Life Services	Clinical Psychologist
Counseling Program Coordinator/Counselor	PASAAR Therapist
Health Service Provider/Independent Practitioner	
Therapeutic Recreation Specialist for Pediatrics and Adapted Sports	
LCSW/Clinical Coordinator and Adolescent Day Treatment	
Director of Clinical Services and Outpatient Programs Director of Leisure Services	

The types of certifications these professionals possessed included:

CTRS	National Certified Counselor
CCLS	Registered Play Therapist
WSI-AAI	LPC/LMFT
Certified Master's Social Worker/Licensed Clinical Social Worker	
Board Certification as Therapeutic Recreation Specialist	
Certified Supervisor of Child Psychotherapist and Play Therapist.	

APPENDIX C

For the section labeled benefits, the respondents were asked to state what their projected benefits are for their play therapy program. Their responses varied in context, but were also very similar. Their responses are as followed: (1) to decrease length of stay and increase patient satisfaction, (2) to increase self-esteem, improve social skills, reduce office referrals, improve anti-substance abuse values, decrease withdrawn behaviors, and increase positive comment or contributions to the group, (3) to increase self-expression and resolution of ego-conflict, (4) for children to be more expressive and work out issues for themselves, (5) to help the child “speak” to their therapist in his/her language of play, (6) for the patient to express feelings by acting them out in play, work through/resolve presenting issues, build self-esteem, build trust, accept limits of behavior (follow rules), (7) to increase appropriate interpersonal skills, learn more history from patients about current or past problems, and teach or reteach play skills, (8) to allow patients to explore feelings and offer an alternative expression of issues and ideas, (9) to release stress associated with hospitalization, to help with diversion and the ability to cope, (10) to make the child more comfortable in therapeutic play and make their hospital stay better, (11) for adjustment and functional gains to their injury or illness, (12) to create less trauma in the hospitalization and less fear of hospital and personnel, (13) helps patients express and master affects and conflict at a developmentally appropriate level, allows patient involvement in a non-goal directive level, and allows parents to learn play skills and enjoy their children, (14) to incorporate play into the child’s treatment session, to provide opportunities for

them to apply skills learned in the clinical setting to a functional setting, (15) to create a non-threatening level of communication, (16) to train student/interns for school counseling, (17) to increase self-esteem, improve behavior, to create better organizational skills, and better time management, (18) "So that the child has the opportunity to freely express his/her thought and feelings in a safe, non-threatening way which utilizes his/her primary mode of communication--play. Through expression, can come resolution and healing," (19) "Play therapy is clearly the most appropriate method, inpatient and outpatient, to work with young clients."

The last two responses were cited as quotes because they clearly state the overall picture of the significance of play therapy and why play therapy is an important part of treatment/therapy.

VITA

Lisa A. Modenos was born in New York City on April 9, 1972. She grew up in Atlanta, GA and attended Dunwoody High-School. She moved to Columbia, SC in 1989 and graduated from Spring Valley High-School. She received her Bachelor of Science degree on June 10, 1995 from Georgia Southern University, Statesboro, GA with a major in Family and Child Studies with an emphasis in Child Development. She will be graduating from the University of Tennessee in December 1997 with a Master of Science degree with a major in Recreation and Leisure Studies with a concentration in Therapeutic Recreation.

Working experience has included counselor for a camp for children with disabilities, Child Life intern, and Child Life assistant. These positions involved assisting children with daily living skills, facilitating recreation and leisure activities, assessments, documentation, and assisting during painful procedures.

Lisa is a member of the American Therapeutic Recreation Association. She was a member of the Child Life Council and the Association for the Care of Children's Health from 1994 to 1996. She has her provisional certification in Child Life.

Ms. Modenos has a particular interest in working with children with acute care illnesses and physical disabilities in a clinical setting. In addition to preparing herself for certification in Therapeutic Recreation, she hopes to also receive her professional Child Life Certification.